NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION
NEW DELHI

CONSUMER CASE NO. 38 OF 2010

1. YASHUMATI DEVI & ANR.
W/o Late Raj Ballav Ram, Through POA Dhananjay Kumar,
R/o Aditya Pur-2
Jamshedpur
2. Dhananjay Kumar
S/o. Late Raj Ballav Ram, R/o. Adityapur- 2
Jamshedpur .....Complainant(s)

Versus

1. CHRISTIAN MEDICAL COLLEGE
Vellore-4 .....Opp.Party(s)

BEFORE:
HON'BLE DR. S.M. KANTIKAR,PRESIDING MEMBER
HON'BLE MR. DINESH SINGH,MEMBER

For the Complainant :
For the Opp.Party :

Dated : 11 Aug 2020

ORDER

BEFORE:

HON'BLE DR. S. M. KANTIKAR, PRESIDING MEMBER

HON'BLE MR. DINESH SINGH, MEMBER

		Mr. Jai Dehadrai, Advocate
		Ms. Srishti Kumar, Advocate
For the Complainants	:	Mr. Prashant Vaxish, Advocate
		Mr. R. Krishnaamorthi, Advocate
		Ms. Rashmi Virmani, Advocate
For the Opposite Party	:	Ms. Manasi Kumar, Advocate

Pronounced on: 11th August 2020

ORDER

PER DR. S. M. KANTIKAR, PRESIDING MEMBER

Complaint:

1. On 10.06.2009 Mr. Raj Ballav Ram, aged about 58 years (since deceased, for short the 'patient') visited the Out-patient Department (OPD) at Christian Medical College, Vellore (for short "CMC / Hospital"- the OP). He was known diabetic and hypertensive. Since year 2006, he was suffering off and on pain in his left arm on exertion, walking and/or climbing the stairs. His Treadmill Test (TMT) done elsewhere was positive and he informed the some to the doctors at CMC. The patient got admitted in CMC as a private patient. On next day, after examination, it was diagnosed as a case of Coronary Artery Disease (CAD) [effort angina NYHA class 2].

2. On the 13.06.2009, Dr. Oomen K. George, the treating doctor advised patient to undergo 'Coronary Angiogram' (CAG) test and if needed, Angioplasty be done at the same setting which will be economical. On the same day, the complainants deposited Rs. 1,50,000/- in the hospital. On 14.06.2009, Dr. Oomen K George while conducting the CAG expressed that it would be better for patient to undergo Coronary Arterial By-pass Graft (CABG) surgery instead of angioplasty to avoid multiple stenting. Due to long waiting list, the patient's CABG was not possible within 15 days and therefore no specific date was fixed for CABG. On 16.06.2009, Dr. Sujit discontinued medicines Ecospirin and Clopidogrel, and started Heparin 5000 units 6 hourly. It was alleged that Heparin was started without any laboratory investigations or monitoring protocol. The Complainant no. 2, noted some bleeding at the site of insertion of the intravenous needle, it was informed to the nurse, but despite repeated requests the doctors ignored it. On 17.06.2009 in the morning at 08.30 am the 3rd dose of Heparin injection was given and after about an hour patient showed signs of sudden numbness of his left arm and trouble in walking and/or wearing slippers. Coincidentally there were four doctors including Dr. George Joseph the Head of the Department - Cardiology-I unit saw the patient and confirmed that the patient seems to have suffered a mini stroke and immediate CT Scan to be done, however but Dr. George Joseph did not do stroke evaluation. It was further alleged that around 11.00 AM the patient was transferred to the Thoracic surgery unit in Semi-ICU i.e. 3 ½ hours after the onset of stroke. At around 11:15 AM the neurologist came for primary evaluation of the patient and suggested 'CT Brain-Plain study', but the CT scan was delayed till 12.30 PM. The staff told the 2nd complainant to remit and get a receipt of Rs. 1850/- for the CT Scan, though they have already deposited Rs. 150000/- as an advance. The doctor in thoracic surgery told the complainant that now it became neurology problem and thence the neurology dept. will look after the patient. Due to such condition of patient the CABG was deferred. The Neurosurgeon after seeing brain CT Scan report informed the complainants that as the patient already progressed into coma, nothing more could be done. Finally, doctors suggested the family that they should accept the inevitable event and instead of wasting money allow them to withdraw ventilator support. Thereafter, the 2nd complainant met and discussed about the condition of the patient with few doctors in CMC namely Dr. Roy Thanka Chen, Dr. John Korula, Dr. Binila Chacko. They expressed the delay caused for stroke management was fatal and it was due to lapses in the hospital. It was alleged that on 17.06.2009 the patient suffered stroke in the morning at 08:30 AM, since then the doctors at CMC virtually did nothing till 10.30 PM and after long struggle the patient died on 20.06.2009 at 6.30am. Being aggrieved the patient's wife Yashumati Devi and son Dhananjay Kumar filed the Consumer Complaint against the CMC for the alleged medical negligence and callousness of the doctors at CMC caused death of the health man/patient for seeking compensation of Rs. 2,01,44,000/-.

Defense:

3. The OP raised preliminary objections that the Complainants filed a false complaint and suppressed the true and correct facts. It involves complicated questions of facts and needs elaborate evidence of experts, therefore, it cannot be adjudicated in the summary proceedings under the Consumer Protection Act, 1986 (The Act 1986). Such Complaint shall be tried before Civil Court. The OP further submitted that the deceased was admitted in CMC on 14.06.2009 and not on 09/10.06.2009. The patient came to CMC complaining of chest pain since two years on exertion and it was increasing since last two months. He was known diabetic for the last 11 years and recently detected as a hypertensive. The Angiography revealed a very serious condition of the heart (TVD) and patient was prone to a fatal heart attack. The patient was given urgent medical attention at the CMC. The OP submitted that the patient was informed about the two

kinds of treatment available for coronary arteries blockages namely i) Angioplasty- if blockage is not severe and ii) By-pass Surgery (CABG) - if the blockage is severe. The patient agreed for CABG. On16.06.2009, the patient was transferred from Cardiology Unit III to the Cardiothoracic Surgery Unit-II for elective CABG. The patient, for his cardiac problems, was already taking blood thinners Ecosprin and Clopidogrel which had a risk of causing a bleeding, or leak into, *inter-alia,* the brain, stomach or urine. On the instructions of Dr. Sujith Velayudhan Indira, from 16.06.2009 evening the blood thinners Ecosprin and Clopidogrel were withdrawn and the Heparin injection 5000 units every six hourly started to prevent clotting of blood. The dose of Heparin was calculated on the basis of body weight of the patient (65 kg) and it was the normal dose. As per the common practice the consent is not required for administration of Heparin. In and around Vellore, the doctors prescribe Heparin without obtaining any specific consent from patient. In CMC for all cases the treating doctor decides for Heparin administration, the quantum and frequency determined on the basis of the health condition of the patient, age, and weight, etc. On 17.06.2009 in the morning, the patient felt a tingling sensation in the left side of the body and developed weakness of the left upper and lower limbs. Therefore the patient was immediately transferred to KN ward semi ICU and Neuro consultation was taken from specialists. The patient underwent a CT Scan at about 12:30 p.m., which revealed patient developed stroke due to blood inside the brain (Intra parenchymal bleeding). It might be possible due to blood thinners which patient was taking for long time. On 18.06.2009, at about 1.00 a.m. for difficulty in breathing, patient was kept on ventilator support. The GCS (Glasgow Coma Scale/Score) of the patient was dropped further from 19.06.2009. All the brain stem reflexes were lost, thus repeat CT Scan of the brain was difficult to perform. The neuro and cardiothoracic surgeons reviewed the patient, the prognosis was poor and same was explained to the relatives of the patient. However, despite all the efforts the patient passed away on 20.06.2009 at 6.30 AM, before the CABG could be done. There was no negligence or deficiency in service during the treatment of the patient at CMC, Vellore.

Arguments:

4. The learned counsel from both the sides argued the matter at length. They have reiterated their pleadings and affidavits of evidence. They have filed their brief notes of written arguments and relevant medical literature on the subject of CABG, Heparin administration and stroke.

Arguments from the Complainants:

Learned counsel for the Complainants submitted that the doctors at CMC were fully aware of the risk of initiation of Heparin and it was incumbent on them to outline risk, when there was no urgency of CABG and the date for CABG was not fixed. The blood thinners commonly should be stopped 3-5 days prior to CABG. It was also doubtful how the OP without doing any blood test presumed the patient has no bleeding tendency. After initiation of heparin, APTT test was not conducted. The mere talk / discussion between the doctor and the patient were no way the implied consent and the doctors failed to take the patient's consent before administration of Heparin.

The counsel further submitted that by clinical examination only Intra-cranial hemorrhage (ICH) cannot be differentiated between ischemic stroke and other causes. No medical intervention could be initiated unless the nature and location of stroke was ascertained. Thus C.T. Scan of the brain was to be done immediately as early as possible. In the instant case admittedly the patient suffered a stroke in the morning at 8:30 AM and patient underwent a C.T. Scan at about 12:30 PM i.e. after about 4 hours. The counsel relied upon medical articles "Stroke Management" by Kameshwar Prasad et al and "Management of Intra cerebral haemorrhage" by Ramandeep Sahni and Jesse Weinberger. The learned counsel for the Complainants relied upon the following judgements decided by the Hon'ble Supreme Court:

1. ***Dr. Laxman Balakrishna Joshi vs. Dr. Trimbak Bapu Godbole & Anr.*** (1969) 1 SCR 206: AIR 1969 SC 128

2. ***Samira Kohli vs. Dr. Prabha Manchanda & Anr.*** (2008) 2 SCC 1

3. ***Sarla Verma (SMT) & Ors. Vs. Delhi Transport Corporations & Anr.*** (2009) 6 SCC 121

4. ***Malay Kumar Ganguly vs. Dr. Sukumar Mukherjee & Ors.*** (2009) 9 SCC 221

5. ***Kusum Sharma & Ors. Vs. Batra Hospital and Medical Research Centre & Ors.*** (2010) 3 SCC 480

6. ***Rajesh & Ors. vs. Rajbir Singh & Ors.*** (2013) 9 SCC 54

7. ***Balram Prasad Vs. Kunal Saha & Ors.*** (2014) 1 SCC 384

8. ***Arun Kumar Manglik vs. Chirayu Health & Medicare Private Ltd. & Anr.*** Civil Appeal Nos. 227-228 of 2019

Arguments from the OP:

The learned counsel for OP submitted that in CMC Vellore being the teaching medical institute, the junior level medical staff screens the patients in OPD and in the In-patient department (IPD) and after the availability of diagnostic results the consultants examine the patients and arrive to the diagnosis. This pattern of hierarchy is followed in all teaching hospitals. Dr. Oomen K. George admitted the patient for CAG and then Angioplasty. However, by angiography it revealed Triple Vessel Disease (TVD) and Left main disease, therefore Dr.Oomen K. George informed the patient and his family that it would be better for the patient to undergo CABG rather than angioplasty. The patients who are taking blood thinners have 3.9% to 4.9% chances of major bleeding problems and the doctors need to undertake such risk while treating patients on blood thinners. The OP denied remaining allegations being baseless, misconceived and misleading. When the blood thinner like heparin is used, there will be a risk. The risk has been taken into account considering the patient was above 50 years, hypertensive and on medicines. As per current trend of practice, the mere history of mild hypertension is not contra indication to use heparin. Thus it was not violation of protocol. The OP further contended that the blood test APTT was conducted to know the level of blood thinner. This test was always done after the drug is initiated and to tailor the dose for given patient. It was further argued that the patient's attendants were explained about the result of patient's brain CT scan and the poor prognosis. As per Neurologist advice, the patient was treated with drugs to reduce swelling of the brain. However, there was no improvement and patient was transferred to Medical High Dependency Unit (MHDU) at 10.30 p.m. on 17.06.2009. At that stage if Heparin was to be discontinued, then there was a risk of developing an acute coronary event; it was duly explained to the patient's relatives. Despite all efforts to save the patient, he expired on 20.06.2009.

Discussion:

5. We have perused the entire material on record and the relevant literature on the subject. The points for our consideration are whether the CMC Hospital failed in the standard of care during the treatment of patient thus medical negligence.

i) Advance deposit for CABG:

The complainants are aggrieved as they made to deposit advance amount in the hospital and their allegation was that the CMC was more concerned with deposit of money. It should be borne in mind that Angioplasty or CABG surgery is expensive procedure, therefore about expenses the patients shall be informed in advance. The OP hospital asked for some deposit and patient deposited Rs.150000/- in advance to CMC. We note the instant patient travelled from another city and might need some time to arrange the funds, thus in

our view nothing was wrong to inform the approximate cost of treatment and demand to deposit an advance. Thus the allegation of the complainants is not sustainable that CMC was only concerned with money.

ii) <u>Precautions before administration of Heparin- laboratory tests and informed consent</u>:

Dr. Oomen K. George performed CAG on 14.06.2009 and advised the patient to undergo CABG instead of angioplasty as it was diagnosed as TVD & left main disease. The patient accepted for CABG. As per the protocol of CMC, the treating doctor stopped the blood thinners (Ecosprin and Clopidogeral) from evening of 16.06.2009 which the patient was taking for a long time. The blood thinners were stopped to apply bleeding during CABG. Then the patient was started with injection heparin 5000 units (for every 6 hourly), it was to prevent blood clotting. The allegations of complainants that the doctors at CMC before administration of Heparin failed to do diagnostic laboratory tests and to take informed consent. However, the different cardiac centers in India follow their different standard protocols as a common practice. Usually prior to the CABG the blood thinners are stopped at least three to five days before surgery. The laboratory test before Heparin administration is not mandatory unless patient has any history or signs bleeding tendency. The instant patient had no such history of bleeding tendency. Thus, in our view, the decision of treating doctor/surgeon to stop blood thinners and start Heparin before CABG cannot be faulted. It is pertinent to note that Complainant No. 2 on 15.06.2009 signed the General Consent Form. It reads as follows:

"Permission is hereby given for the performance of any diagnostic examination, biopsy, transfusion or operation and for the administration of any anesthetic as may be deemed advisable in the course of this hospital admission".

Thus, in the instant case, in our view at that stage the General Consent was a valid consent. Specific consent for administration of Heparin was not needed. It squarely covers the principles laid down by the Hon'ble Apex Court in the case **Samira Kohli v. Dr. Prabha Manchanda,** (2008) 2 SCC 1.

iii) <u>Heparin administration - an overdose & failure to monitor</u>

The Heparin activity may be monitored with the Activated Partial Thromboplastin Time (APTT), Activated Clotting Time (ACT) or Thromboelastometric assays.

In the instant case patient was started Heparin 5000 units 6 hourly from the evening of 16.06.2009 and as per the CMC protocol, the (APTT) test is always done to monitor the patient on Heparin. The APTT and Platelet Count were carried out at 9.20 am and found that APTT was high- 165 seconds and low Platelet Count -79,000/ cmm. As per the Harrison's Handbook of Internal Medicine, [17th edition, 2008] (for short 'Harrison's') APTT should not exceed 80 seconds and in the event of any further increase, Heparin should immediately be discontinued. The reduction in platelet count (< 100000/cmm) was a clear indication of Heparin Induced Thrombocytopenia (HIT) and the antidote, Protamine Sulphate to neutralize the heparin should be given. During administration of an anti-coagulant like Heparin, the reference levels for APTT are as follows:

 When APTT is greater than 100 seconds is risky for the patient and there are chances for spontaneous bleeding.

 Panic value usually it is considered above 70 seconds.

We note that on 17.06.2009 at 8.30 AM the patient suffered paresthesia of the left side of the body followed by weakness of both the left and upper and lower limbs and right sided deviation of the angle of the mouth. Though the patient despite showing clear signs of a stroke another dose of Heparin was given to the patient at 11.30 am. The doctors have not taken the corrective steps.

<u>iv) Timing of CABG:</u>

According to the medical literature the antiplatelet and anticoagulant therapy is a key part of the management of patients undergoing cardiac surgery. Most heart operations depend on cardiopulmonary bypass with systemic heparinisation. Postoperatively, every patient's thrombotic and hemorrhagic tendency must be carefully managed.

The timing of CABG surgery in a patient on Clopidogrel depends upon two factors (i) Does Clopidogrel increase the bleeding complications and its sequelae? (ii) Does withholding Clopidogrel in these high-risk patients expose to an increase in thrombotic complications prior to surgery? For patients who require emergency CABG surgery, one must weigh the net benefits of the antiplatelet and antithrombotic drugs against the added risks for perioperative bleeding and blood transfusion that are independently associated with morbidity and mortality.

Criteria for major bleeding in nonsurgical patients include intracranial hemorrhage (ICH), cardiac tamponade, or bleeding from any site associated with >50 g/dL decrease in hemoglobin. The Anti-coagulation intensity can be measured by Anti-Xa assay, APTT and ACT test.

v) The Nurse's daily record and doctor's Clinical findings

On 16.6.2009 at 7 pm, the 1st dose of Heparin (5000 u) was given, thereafter every 6 hours further dose was given at 1200 mid night, 6 am and at 11.30 am on 17.6.2009. Nothing was mentioned in the nursing record about APTT monitoring done. Nursing note on 17.6.2009 at 11.30 am recorded as "patient complaint of left side body weakness" and "informed to TS –II doctor." However, in contrary the clinical findings recorded in progress record were

> on 17/6: morning noticed to have tingling left side of body.
>
> He developed left side weakness (upper limb and lower limb) which progressively increased over hours.
>
> By afternoon noticed to have right side deviation of mouth (9 am to 1 pm) with slurring of speech(9 am to 1 pm)
>
> xxx---
>
> xxx---
>
> CT Brain: Right post frontal hematoma extending deep with corona radiate with no mass effect/midline shift

The goal of the management of patients with acute stroke is to stabilize the patient. Severe hypertension is one of the major risk factors for hemorrhage from Heparin therapy. This patient was had Grade II hypertensive. Immediate initial evaluation with imaging and laboratory studies needed.

vi) Delayed brain CT scan and treatment was fatal.

It is pertinent to note that the patient complained of paresthesia of the left limbs in the morning around 8:30 AM on 17.06.2009 which was immediately brought to the notice of the doctors taking round around the HOD of Cardiology Unit II, Dr. George Joseph who did respond to the frantic call of the Complainant No. 2 and rushed to see the patient. After seeing him Dr. George Joseph instructed the nurses to stop Heparin as patient seems to have suffered a mini-stroke and since the patient belongs to the Cardiology Unit III, it would be informed to the concerned doctors for further care. We note that CT scan got done after 4 hours, though the Radiology Department was hardly 5-7 minutes away from the patient's ward. After a lapse of 2 hours after the onset of stroke the patient was shifted to the Semi-ICU of Thoracic surgery unit at around 10.30 AM and the CT Scan conducted at around 12:30 PM. Thereafter as per neurology advice at 4 PM, the patient was treated with drugs to reduce the swelling of the brain. The Complainants themselves at 16:59 collected the drugs from the Main Pharmacy. The doctors further advised for stat 4 units of Fresh Frozen Plasma (FFP) and 4 to 6 units of Packed RBCs (PRBC), unfortunately it was too late. Thus in our considered view the delay in the diagnosis and treatment of the stroke became fatal in the instant case.

vii) Rigid adherence to the protocols

Although the patient was in most urgent need of the diagnostic CT scan but it was delayed for getting a receipt of Rs. 1850/- towards CT scan charges. The hospital was aware that the complainants had already deposited 150000/- in advance. The OP is salient on the procedural aspects or protocols to be followed

during emergency situation. Moreover, Dr. George Joseph after seeing the patient instructed the nurses to stop Heparin as patient seems to have suffered a mini-stroke. Though patient belongs to the Cardiology Unit III, but the proper attention from Dr. George Joseph and his team was expected at that time to avoid delay in management of stroke. It seems at that relevant time the rigid protocols prevailed over the medical ethics, which amounts to failure of duty of care.

6. Conclusion:

- The patient was known diabetic and hypertensive and taking blood thinners (Ecosprin and Clopidogrel). His CAG was performed by Dr. Oomen K George on 14.06/2009 and diagnosed it as a case of 'TVD with Left main'. Thus due to the seriousness instead of Angioplasty, Dr Oomen K.George advised for CABG which the patient agreed. As per the standard protocol at CMC; prior to the CABG the blood thinners were stopped and injection Heparin (5000u) started from evening on 16.06.2009. Most of the cardiac centers in India don't do any blood tests and don't take informed consent prior to administration of Heparin. The patient herein signed the General Consent form. The advantage of Heparin is, it is short acting and can be stopped just before CABG surgery. The patients taking blood thinners / anti-coagulants have a greater chance of major bleeding. We donot find anything wrong that at CMC there was no practice to test the blood before starting Heparin, unless patient has a bleeding tendency. In our view, in the instant case it was an accepted practice therefore, at this stage we do not find any negligence or dereliction in duty of the doctors at CMC.

- However, it is an admitted fact that the patient suffered stroke after 3rd injection of Heparin and thereafter the inordinate delay in patient's care is visible and thus many questions arose in our mind. The high-risk patients living in the hospital/nursing homes or undergoing cardiac procedures should have monitoring systems to help alert the doctor/staff immediately. Point-of-care blood tests, imaging (CT scan)that can help diagnose a possible stroke should be done. More than that, we feel pre-hospital triage and communication between radiologists, neurologists and emergency physicians is more vital. Much better coordination among the staff is also necessary.However, in the instant case the clear signs of stroke noted at 8.30 AM on 17.06.2009, but immediate CT scan of brain was not conducted, it was delayed till 12.40 PM. In the afternoon the CT scan revealed large hematoma in right fronto-parietal area with left hemiplagia, an indication of Heparin overdose. However, the patient was not given any treatment (medicine) till 5.30 PM and the patient became comatose. The at 9.20 AM the Platelet Count was low 79000/cmm and APTT value was high 165. The Heparin was not stopped despite clear signs of HIT and stroke, but 4th dose was given at 11.30 AM. Thus, the delay in diagnosis and management of stroke was a deficiency and not a reasonable or standard of practice.

- The doctors failed to control Heparin overdose by use of Protamine Sulphate (antidote). If the 4th dose of Heparin had been stopped immediately when the error was identified the incremental anticoagulant effect of further additional Heparin would have been eliminated. An appropriate course would have been to stop the Heparin as soon as the error was detected, to document forthwith APTT and to seek expert medical advice without delay. This would have reduced the on-going risk of anticoagulation overdose and the best chance of avoiding on-going bleeding complications. In the instant case the steps taken by doctors at CMC to correct the overdose of Heparin are not visible. The life threatening side effect of Heparin, ICH was not recognised or treated until it was too late. As per neurology advice the patient was treated for the stroke with anticonvulsants and Mannitol to reduce the cerebral oedema. Patient was transfused stat 4 units of FFP and 4 to 6 units of PRBC. Unfortunately, the actual treatment was delayed by 7 hours, turned to be fatal in this case.

- There was an urgent need for brain CT scan of the patientbut it was delayed more than 3 hours for the want of a fresh receipt of Rs. 1850/- towards CT scan charges even thoughcomplainants had already deposited 150000/- in advance. Hospital has every right to insist the payment but it was also a prime duty to care the emergency patient. In this regard we would like to rely upon the judgment of this Commission in **Pravat Kumar Mukherjee vs. Ruby General Hospital and Ors**, II (2005) CPJ 35 (NC), dealt with the question that "Can doctors insist and wait for money (fees) when death is knocking the doors of the patient?" Obvious answer is recovery of fee can wait - but not the death nor the treatment for trying to save the life. This commission allowed the Consumer Complaint and awarded Rs. 10 lakhs to the Complainant. The Commission observed as follows:

"This may serve the purpose of bringing about a qualitative change in the attitude of the hospitals of providing service to human beings as human beings. A human touch is necessary; that is their code of conduct; that is their duty and that is what is required to be implemented. In emergency or critical cases, let them discharge their duty/social obligation of rendering service without waiting for fee or for consent".

- The "*but for"* causation test :

The onus is on the Complainants to establish *"but for"* approach to causation. It depends on the balance of probabilities, *"but for"* the OP- doctor/ hospital's negligent act, the injury would not have occurred. In **Clements v. Clements,** Supreme Court of Canada 2012 SCC 32 (Can LII)**,** at paras. 8-9, Chief Justice McLachlin described this test as follows:

> 8. The test for showing causation is the *"but for"* test. The plaintiff must show on a balance of probabilities that *"but for"* the defendant's negligent act, the injury would not have occurred. Inherent in the phrase "but for" is the requirement that the defendant's negligence was *necessary* to bring about the injury - - in other words that the injury would not have occurred without the defendant's negligence. This is a factual inquiry. If the plaintiff does not establish this on a balance of probabilities, having regard to all the evidence, her action against the defendant fails.
>
> 9. The *"but for"* causation test must be applied in a robust common sense fashion. There is no need for scientific evidence of the precise contribution the defendant's negligence made to the injury.

In the case on hand the "*but for"* causation test applicable. The complainants alleged that the OP fell below the accepted standard of care when they failed to despite the patient's neurological decline after the administration of 3rd dose of Heparin in the morning on 17.6.2009 and moreover failed to hold future 4th Heparin dose administration. It was a direct result of the deviations from the accepted standard of care, the patient was improperly administered Heparin, causing an intra-cerebral haemorrhage and resulting in a stroke and death. Had the doctors therein complied with the accepted standard of care, the patient would not have been over anti-coagulated and would not have suffered the brain haemorrhage that caused his stroke and the death. Thus, the "*but for"* causation test is applicable to the instant case.

- The spirit in which CMC, Vellore was set up in 1900 cannot be a ground to overlook omission in the requisite standard / duty of care.

- The patient was about 59 years and diagnosed as TVD with left main disease. He was already suffering from comorbidities like diabetes and hypertension. He was on blood thinners for long time, thus such patients are prone for bleeding in brain, stomach etc. Thus, there was possibility that fatal ICH was due to long standing blood thinners which patient was consuming.

- < >n the basis of the examination made above, deficiency / negligence is conclusively established. In our considered view, in the facts and specificities of the instant case, compensation of Rs. 25 lakh with interest at the rate of 8% per annum from the date of the death of the patient appears just and equitable.

7. The complaint succeeds, and is allowed. The compensation is quantified at Rs. 25 lakh with interest @ 8% per annum from the date of the death of the patient till its realization.

8. The compensation shall be paid within 6 weeks of the pronouncement of this Order, without fail.

9. A copy each of this Order be sent to all the parties by the Registry within 3 days of its pronouncement, without fail.

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DR. S.M. KANTIKAR
PRESIDING MEMBER

.....
DINESH SINGH
MEMBER