By- **Adv. Rohit Erande**

The Delay in diagnosis and treatment made the patient to lose her life, which in turn costed Doctors and Hospital hefty sum of Rs.25 lakhs towards compensation + Rs.15 lakhs towards mental pain & agony, totaling to Rs.40 lakhs with interest!!!

The commission gave an interesting example to explain the issue of 1 % risk of serious harm,
"Suppose that, an aeroplane on a long-haul flight developed engine trouble while in mid-air, this gave rise to a one percent risk that the plane would crash and that risk would not increase for the next 12 hours but remain constant".
"A reasonable pilot, knowing this, would not wait for 12 hours to expire but would land his plane as soon as reasonably practicable."

DR. (MRS.) MANIKA ROY & ANR V/s. DR. B.L. CHITLANGRA, Bombay Hospital & ors. CC no.42/2003, decided on 5th January, 2016, by the National Commission.

http://cms.nic.in/ncdrcusersWeb/GetJudgement.do…

Facts in nutshell:

Ms. Kaberi Roy, 29, (since deceased, referred herein as a "patient"), daughter of complainants was initially diagnosed by their family physician as the patient of 'acute appendicitis' and advised her for immediate surgery and therefore the complainants admitted her in Bombay Hospital at 10.30 PM on 27.06.2002.

The casualty Medical Officer examined her and diagnosed it as a case of Acute Appendicitis. The routine checkup also indicated severity of appendicitis and possibility of perforation (leucocytes count 17700 per cmm. The Neutrophils were 87%).

It was alleged by the Complainants that the Opponent Doctors, Senior Surgeons failed in their duty to examine the patient immediately during emergency as Doctors came to examine the patient on next day i.e. 28.06.2002 at 11 AM. i.e. almost after more than twelve hours of her emergency admission. The Surgery turned to not fruitful and it was alleged that the no proper surgical procedure was selected, there was septicemia, no post-op proper treatment and as a result patient died within two days of hospitalization, and within 36 hours of her operation.

The Commission heard the parties at length, studied the medical records and medical literature...

The commission found discrepancy in Medical Record and the statements of Doctors especially regarding removal of Gangrenous fluid. It further observed that the departures of the Opp. Doctors individually and together in the treatment and diagnosis of the patient led to a delay in the patient's surgery, and were a proximate cause or substantial cause contributing to the septicemic shock and death.

The patient was admitted in late night, thus emergency USG scan should have been sought on an urgent basis to rule out the causes of acute abdomen. The opponent Hospital is one of tertiary care hospital and the highest care is expected than from other hospitals & had the USG scan been obtained and interpreted promptly, these complications might have been avoided. If that had happened, patient could have been operated expeditiously as an emergency basis, further observed by the commission. It also held that an appropriate standard of care had not been met as surgery took place after 17 hours.

It relied by the Landmark judgment of Apex court of Dr. Laxman Balakrishna Joshi Vs Dr. Trimbak Bapu Godbole AIR 1969 SC 128, which laid down that a doctor when consulted by a patient, owes him certain duties, namely.

(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 these duties gives a cause of action for negligence to the patient.

This may be the first case of this year wherein the Doctors and Hospital were held negligent and ordered to pay such heavy compensation!! To learn from the mistakes of others, is the crux of this case!!