REPORTABLE

IN THE SUPREME COURT OF INDIA

CRIMINAL APPELLATE JURISDICTION

CRIMINAL APPEAL NOS. 1191-1194 OF 2005

Malay Kumar Ganguly … Appellant

Versus

Dr. Sukumar Mukherjee and others ….Respondents

WITH

CIVIL APPELLATE JURISDICTION
CIVIL APPEAL NO. 1727 OF 2007

Dr. Kunal Saha … Appellant

Versus

Dr. Sukumar Mukherjee and others …Respondents



**J U D G M E N T**

S.B. SINHA, J.

## A. INTRODUCTION

### A. 1. BACKGROUND FACTS:

The patient (Anuradha) and her husband Dr. Kunal Saha (for short, "Kunal") were settled in the United States of America. Anuradha, a child

Psychologist by profession, was a recent graduate from a prestigious Ivy League School ('Columbia University' in the New York State). Although a doctor by profession, Kunal has been engaged in research on H.I.V/ AIDS for the past 15 years.

They left U.S.A. for a vacation to India on 24th March, 1998. They arrived in Calcutta on 1st April, 1998. While in Calcutta, Anuradha developed fever along with skin rash on 25th April, 1998. On 26th April, Dr. Sukumar Mukherjee, Respondent No. 1 herein attended and examined Anuradha at her parental residence on a professional call. Dr. Mukherjee assured the patient and her husband of a quick recovery and advised her to take rest but did not prescribe her any specific medicine. However, two weeks thereafter, i.e., on 7th May, 1998, the skin rash reappeared more aggressively. Dr. Mukherjee was again contacted and as per his instructions, Anuradha was taken to his chamber. After examining Anuradha, Dr. Mukherjee prescribed Depomedrol injection 80 mg twice daily for the next three days. Despite administration of the said injection twice daily, Anuradha's condition deteriorated rapidly from bad to worse over the next few days. Accordingly, she was admitted at the Advanced Medicare Research Institute (AMRI) in the morning of 11th May, 1998 under Dr. Mukherjee's supervision. Anuradha was also examined by Dr. Baidyanath

Halder, Respondent No. 2 herein. Dr. Halder found that she had been suffering from Erithima plus blisters. Her condition, however, continued to deteriorate further. Dr. Abani Roy Chowdhury, Consultant, Respondent No. 3 was also consulted on 12th May, 1998.

On or about 17th May, 1998, Anuradha was shifted to Breach Candy Hospital, Mumbai as her condition further deteriorated severely. She breathed her last on 28th May, 1998.

Kunal sent a lawyer's notice to 26 persons on 30th September, 1998. The first 19 addressees were those who had treated Anuradha at Kolkata while addressee numbers 20 to 26 were those who treated her in Mumbai.

On or about 19th November, 1998 one of his relatives, Malay Kumar Ganguly filed a Criminal Complaint in the Court of Chief Judicial Magistrate, 24 Paraganas at Alipore against Dr. Sukumar Mukherjee, Dr. Baidyanath Halder and Dr. Abani Roy Chowdhury, respondent Nos. 1, 2 and 3 for commission of offence under Section 304-A of the Indian Penal Code.

Thereafter Kunal filed O.P. Nos. 240 of 1999 against 19 persons who had rendered medical advice/treatment/facilities to Anuradha between 23rd April, 1998 and 17th May, 1998 at Kolkata before the National Consumer Disputes Redressal Commission, New Delhi (Commission). However,

pursuant to the orders of the Commission names of some of the respondents were struck off.

In the said petition the complainant claimed an amount of compensation of Rs. 77,76,73,500/- with interest for the alleged deficiency in the service rendered by Respondent Nos. 1, 2, 3, 5, 6 and AMRI hospital (Respondent No.4).

On or about 17.7.1999, a complaint was filed by Kunal against Dr. Sukumar Mukherjee, Dr. Baidyanath Halder and Dr. Abani Roy Chowdhury before the West Bengal Medical Council (WBMC) making allegations similar to the one he had made in his complaint before the Commission.

On or about 29th May, 2000 , OP No. 179 of 2000 was filed by Kunal against the doctors, including Dr. Udwadia of the Breach Candy Hospital at Mumbai and the hospital itself before the Commission.

Before the learned Chief Judicial Magistrate, in the said criminal complaint a large number of witnesses were examined. A large number of documents were also marked as exhibits. The learned Chief Judicial Magistrate, Alipore by his judgment and order dated 29th May, 2002 found Respondent Nos. 1 and 2 guilty of commission of an offence under Section

304-A of the Indian Penal Code and sentenced them to undergo simple imprisonment for three months and to pay a fine of Rs.3,000/- each and in default to undergo a further simple imprisonment for 15 days. Respondent No.3, Dr. Abani Roy Chowdhury was, however, acquitted.

The West Bengal Medical Council dismissed the complaint filed by Dr. Kunal by its order dated 1st July, 2002.

On 25th May, 2003 the complainant-Kunal withdrew O.P. No.179/2009 filed before the Commission against the doctors/Breach Candy Hospital.

Against the order of the learned Magistrate, Respondent No.1 filed Criminal Appeal which was marked as Criminal Appeal No.55 of 2002 and Respondent No.2 filed Criminal Appeal No. 54 of 2002 before the learned Sessions Judge at Alipore, whereas the complainant, Mr. Malay Kumar Ganguly, filed a revision application being C.R.R. No. 1856 of 2002 for enhancement of the punishment imposed on Respondent Nos. 1 and 2. The complainant also filed another revision application before the High Court questioning the legality of the judgment with respect to acquittal of Respondent No.3. The Calcutta High Court withdrew the appeals preferred

by Respondent Nos. 1 and 2 before the learned Sessions Judge to itself and heard the criminal appeals and revision petitions together.

By a judgment and order dated 19th March, 2004 the appeals preferred by Respondent Nos. 1 and 2 were allowed while the Criminal Revision Petitions filed by the complainant were dismissed. The said order has been challenged before us by way of Criminal Appeal Nos. 1191-1194 of 2005.

The Commission also by its judgment and order dated 1st June, 2006 dismissed O.P. No. 240 of 1999. Civil Appeal No.1727 of 2007 arises out of the said order.

**A.2. SUBMISSIONS OF APPELLANT:**

Dr. Kunal Saha, who appeared in person, made the following submissions :-

(i) Respondent No.1 from the very beginning should have referred Anuradha to a Dermatologist as she had skin rashes all over her body.

(ii) Diagnosis of Respondent No.1 that Anuradha was suffering from angioneurotic oedema with allergic vasculitis was wrong. In any event, prescribing a long acting corticosteroid

'Depomedrol' injection at a dose of 80 mg. twice daily for the next three days when it was the beginning of angeioneurotic oedema and the continued treatment on the same line later at AMRI by Respondent No.1 and other doctors led to her death inasmuch as -

(a) The Medical Journals as also the experts' opinion show that although steroid is not to be used when the patient is diagnosed to be suffering from Toxic Epidermal Necrolysis (TEN), and although some doctors still administer steroids, the administering of Depomedrol of 80 mg. twice daily, could not be prescribed under any clinical condition.

(b) For the said purpose the evidence of Dr. Anil Shinde (PW-8), Manager of Medical Service for Pharmacia; Dr. S. Bhattacharyya (PW-11), a highly respected Professor of Pharmacology at the Banaras Hindu University and opinions of Prof. Jo-David Fine ; Professor Gerald Pierard and Prof. Fritsch Peter (Exts. 4, 5 and 6) opining that steroids and in any event Depomedrol could not be

prescribed; far less, in the quantity in which it had been done.

(iii) The pro-steroid experts also only use "quick acting" steroids for a short period and that too at very early stages of the disease and then quickly stop the same to avoid its side effects to enhance the infection or taper it gradually.

(iv) Respondents failed to adhere to the treatment protocol as outlined in the Table of the Textbook "Cutaneous Medicine and Surgery" authored by Prof. J.E. Revuz and J.C. Rojeau recommending – 5 "Primary Emergency Care" and "Symphtomatic Therapy" including specific direction for "fluid replacement', "antibacterial policy", "nutritional support' etc. The aforementioned should have been advised for treatment of Anuradha at AMRI.

(v) The treatment given to Anuradha at AMRI hospital continued as Respondent Nos. 2 and 3 jointly took charge and recommended steroids, despite stopping "'Depomedrol' after 12th May, 1998 without realizing that she had already been a huge amount of a "long-acting" steroid (Depomedrol) and in

that view of the matter they should have administered adopted remedial measures which was not done.

(vi) Respondents Nos.2 and 3 added more fuel to the fire in the form of a new "quick-acting" steroid, "Prednisolone" at 40 mg. three times daily, which was itself an excessive dose. Dr. Udwadia of Breach Candy Hospital noticed the same when Anuradha was examined by him; as according to him not more than 40 mg. Prednisolone daily for one day, to be reduced to 5 mg. within the next 5 to 6 days is the ideal dosage.

(vii) When a patient is diagnosed to be suffering from TEN, supportive therapy is imperative in character but no such advice was rendered.

(viii) On and after 12th May, 1998, Anuradha was not provided any supportive treatment which could be evident from the hospital records seized by the police.

(ix) Although the police seized 71 pages of the record from AMRI, merely 22 pages are in relation to her stay during 11th May to 17th May, 1998, whereas the medical record of Breach Candy Hospital from 17th May to 27th May, 1998 cover around 370 pages.

(x) At AMRI records of vital parameters like temperature, pulse, blood pressure; etc. were not maintained which itself is an act of gross negligence.

(xi) Respondent Nos. 5 and 6, although were junior doctors, also followed the treatment guidelines set forth by the three seniors doctors, even though they were independent physicians with postgraduate medical qualifications and, thus, it was expected of them that they would take their independent decisions.

(xii) The Expert doctors has categorically stated that mal-practice had been committed during the treatment of Anuradha.

(xiii) The High Court committed a serious error in opining that there was no medical negligence on the part of Respondents.

(xiv) The allegation that the appellant had resorted to forgery was arrived at by the High Court without any application of mind as Dr. Anil Kumar Gupta testified that it was Respondent No.5 who had inserted the words "for better treatment" in his presence, which was also supported by Mr. T.R. Nehra, handwriting expert.

(xv) The transfer certificate when issued, in any event, must be held to be 'for better treatment" as otherwise transfer of a patient

from one hospital to the other, in the situation of the present case, was not necessary.

(xvi) The claim that the appellant had interfered in the treatment and had been responsible for his wife's death is absolutely incorrect inasmuch as his name did not even appear in any of the hospital records suggestive of any interference whatsoever.

(xvii) The alleged defence of alibi resorted to by Respondent No.3 and accepted by the High Court is not borne out from the record which clearly shows that he was closely involved in the treatment of Anuradha at AMRI.

**(xviii)** The telephone bills brought on record clearly show that numerous calls were made by Dr. Kunal Saha to Respondent No.3's residence as well as to his office, during Anuradha's stay at AMRI which clearly established that Respondent No.3 was involved with Anuradha's treatment.

**(xix)** The High Court has failed to consider the previous decisions of this Court on criminal negligence, as in the instant case gross negligence on the part of the Respondents establishes the offence committed by them under Section 304-A of the Indian Penal Code.

**(xx)** Negligence in fact in Anuradha's treatment had been admitted by the Respondents at different stages of the proceedings.

## A.3. SUBMISSIONS OF RESPONDENTS

Mr. Kailash Vasdev, learned senior counsel appearing for Respondent Nos. 1 and 2 would submit :-

(i) Kunal misled the doctors from time to time on the drugs/treatment to be administered to Anuradha.

(ii) The Pathological Reports which were carried out on the basis of the prescription of Respondent No.1 had never been shown to him.

(iii) A panel of elected Committee of the West Bengal Medical Council being an Expert Body having come to a specific finding vis-à-vis the Respondents that there had been no deficiency or negligence on the part of the doctors and use of the drugs is demonstrative of the fact that Respondents had not committed an offence under Section 304-A of the Indian Penal Code.

Mr. Ranjan Mukherjee, learned counsel appearing on behalf of Respondent No.3 contended :-

(i) It stands admitted by the appellant during his cross-examination that Respondent No.3 came to AMRI on 12th May, 1998 hours after Dr. B.N. Halder came there.

(ii) There is no evidence that Dr. B.N. Halder and Respondent No.3 were together at AMRI or that those they discussed about the treatment to be given to the patient.

(iii) Dr. B.N. Halder in his examination under Section 313 of the Code of Criminal Procedure has admitted that the prescription was written by him and, therefore, Respondent No.3 cannot be said to have any liability.

(iv) The plea of the appellant that a joint prescription was made by Respondent Nos. 2 and 3 having been found to be in the handwriting of Kunal himself must be held to be a self-serving document.

(v) Apart from making the joint prescription, Respondent No.3 having not been involved in the treatment of the deceased, the prosecution has miserably failed to prove its case.

(vi) So far as the certificate of transfer of the patient is concerned, the same admittedly being interpolated, no credence thereto can be attached.

(vii) As no witness has testified in support of the allegation that he was the principal physician of Anuradha during her stay at AMRI, the courts below must have correctly held.

(viii) Respondent No.3 having been acquitted by both the courts, this Court should not exercise its jurisdiction under Article 136 of the Constitution of India as the view taken by the courts below is a plausible one.

## B. PROCEEDINGS

### B.1. TRIAL COURT PROCEEDINGS

The common defence of all the Respondents in the case is denial of material allegations brought against them as also false implication. Separate defences, however, have been entered into by each of the Respondents. We would notice them *in seriatum*:

**(i)** Dr. Sukumar Mukherjee examined Anuradha Saha (deceased) only on 7th May, 1998 and 11th May, 1998. He left India on 11th May, 1998 which was within the knowledge of her husband. He treated

Anuradha as per medical protocol. He diagnosed her disease as allergic/hypersensitivity vasculitis. Depomedrol was correctly prescribed, being required for the disease Anuradha had been suffering from. The dose prescribed was also correct. He prescribed certain tests to be taken on 7th May as also on 11th May but he was not apprised of the results of those tests. On 11th May, he had also prescribed the requisite supportive treatment which was necessary for the recovery of Anuradha.

**(ii)** Dr. Baidyanath Halder examined the patient for one day only on 12th May, 1998. He diagnosed the disease as Toxic Epidermal Necrolysis (TEN) correctly and prescribed medicines as per the treatment protocol noted in the text books. He examined the patient having been requested by a group of his students who were friends of Anuradha's husband. He did not charge any fees. He prescribed all necessary supportive therapy required for the patient of TEN. He had not been given any feedback by the husband of the deceased after 12th May, 1998.

**(iii)** Dr. Abani Roychowdhury had never seen the patient nor treated her at AMRI at any point of time. He being attached to AMRI visited the hospital once in a week at the outdoor. On 12th May, 1998 having

been requested by Dr. Kunal Saha as also Dr. Prasad, he went to the cabin only for the purpose of boosting the patient's morale. He neither treated her nor was he a member of the team of doctors treating Anuradha at AMRI. As despite requests he had not participated in the treatment of the deceased, Kunal implicated him falsely.

**(iv)** Respondent No. 4 contended that the Appellant was fully aware of the absence of a burn ward in AMRI at the time of admission of the deceased patient. Furthermore, the deceased was shifted to a VIP cabin in the hospital which was fully isolated, with environmental temperature control. Moreover it was Kunal, himself who had prevented the nursing staff from taking the temperature, blood pressure etc. Also the infection, as alleged, aggravated due to transportation of the deceased from Kolkata to Mumbai. Moreover non administration of IV fluids is a matter of judgment for the treating doctor and is not open to the Hospital Management to interfere with.

**(v)** Respondents 5, Dr. Balaram Prasad contended that the medical treatment sheet of AMRI dated 11.5.1998, would show that he not only attended the patient for the first time but he also meticulously noted the diagnosis and continued the same medicine for one day as

was prescribed by Dr. Mukherjee. Before, however, medicines as per his prescription could be administered**,** Respondent Nos.1 and Respondent 2 took over the treatment.

**(vi)** Respondent 6, denied the allegation of the appellant that he did not give effect to the medical protocol while dressing Anuradha. According to him, reference was made to him by Respondent No.5 for the sole purpose of dressing the patient. He took care of the patient as far as wound care was concerned and did the dressing as per medical norms in support whereof reliance was placed on the opinion of Dr. Jean Claude Roujeau of France.

Respondents did not plead guilty, they were put to trial in the criminal matter.

Before the learned Chief Judicial Magistrate, South – 24 Parganas, Alipore, the prosecution examined 11 witnesses. The complainant Malay Kumar Ganguly examined himself as PW-1 whereas husband of the deceased Kunal examined himself as PW-2. Dr. Balaram Prasad who was a visiting consultant of AMRI at the relevant time was examined as PW-3. He is Respondent No 5 in the connected civil appeal. Dr. Aloke Majumdar attached to the B.R. Singh Railway Hospital, Sealdah as Senior Divisional

Medical officer (ENT) examined himself as PW-4. PW-5 is Dr. Anil Kumar Gupta who was attached to the Sub-divisional Hospital, Asansol as a Medical Officer. The President of the West Bengal Medical Council Dr. Ashoke Kumar Chowdhury was examined as PW-6. Prasenjit Bhattacharjee, a Sub-Inspector of Kolkata Police who was attached to the Lake Police Station at the relevant time was examined as PW-7. Dr. Anil Shinde, a medical practitioner and Manager of Pharmacia India Limited, Gurgaon, Haryana (the company manufacturing Depomedrol) was examined as PW-8. Dilip Kumar Ghosh who was the Registrar, West Bengal Medical Council has been examined as PW-9. Dr. Faruk E. Udwadia, a consultant physician with specialization in critical care and respiratory medicine of Breach Candy Hospital, Mumbai who treated the deceased from 12th May, 1998 to 18th May, 1998 was examined as PW-10. Dr. Salil Kumar Bhattacharjee, Professor of Pharmacology Institute of Medical Science, Benaras Hindu University was examined as an expert witness PW-11 on behalf of the prosecution.

The defence has also examined 3 witnesses. DW-1 Smt. Sutapa Chanda is the Nursing Superintendent of A.M.R.I. Dr. Kaushik Nandy, a Plastic Surgeon attached to AMRI, who is a Respondent in the connected Civil Appeal and had treated the deceased, was examined as DW-2. Mihir

Pal, a Group 'D' staff attached to Asansol Sub-Sivisional Hospital was examined as DW-3.

The prosecution proved as many as 20 documents, whereas the defence has proved 4 documents.

Before the learned Trial Judge as also before the Commission, the parties hereto had relied upon several medical text books of different authors, journals, research papers/ deliberations of the National Conference on Medical Science, transcripts of CDs, package insert, etc. One audio cassette has been produced on behalf of the complainant to prove the conversation which took place between him and the President of the West Bengal Medical Council Dr. Ashoke Kumar Chowdhury.

**JUDGMENT OF THE TRIAL COURT**

The Trial Court observed as under:

I. The cause of death of Anuradha was Septicemia shock with multi-organ failure leading to cardio-respiratory arrest.

**II.** The Breach Candy Hospital, Mumbai was not responsible for causing the death of Anuradha.

**III.** Re : Dr. Sukumar Mukherjee:

(i) He having been consulted by Dr. Kunal Saha since the 4th week of April, 1998, i.e., at his residence, at his chamber at Nightingale Diagnostic & Eye Care Rresearch Centre Private Limited and particularly on 3rd May, 1998, 4th May, 1998, 7th May, 1998 as also on 11th May, 1998 at AMRI and his line of treatment having been followed despite his leaving abroad on the night of 11th May, 1998, his defence that his prescription from the afternoon of 11th May, 1998 became automatically redundant and inoperative cannot be accepted from a doctor of his status. Such a stand taken by him was not only a motivated one but beyond the moral obligation of a doctor to his patients. The medicine was prescribed by him [ Corticosteriod, viz., Depomedrol (Methyleprednisolone Acetate) ] without even diagnosing a disease. But, he did not advise symptomatic therapy like bed rest, elevation of the legs and bandage to reduce Oedema nor prescribed any medicine for control of the underlying disease. It was held:

> "…Small vessel vasculitis are of different kinds of which allergic vasculitis is one. It corresponds approximately to Hypersensitivity Angilis. The term allergic is little contentious since it implies a immunological etiology which may be an over simplification. Allergic vasculitis is the

> most common part of Leucocytoclastic vasculitis in adults. It is characterized by purpuric or necrotic skin lesions, with or without systemic features. Rheumatoid Arthritis is the most common association with coetaneous leucocytoclastic vasculitis..."

(ii) At least on 11th May, 1998, Anuradha was correctly diagnosed by Dr. A.K. Ghoshal as also the following day by Dr. B.N. Halder, still application of Corticosteriod Prednisolone for all these days in prohibitive quantity and dosing intervals with no supportive therapy was continued. That made her lose all her immunity to fight out bacteria and become immunosuppressed leading to 'Septicemia' or 'Septic shock'.

(iii) PWs 5 and 11 also deposed about high dose of Depomedrol. Its adverse effects caused 'Immunosuppression' and 'Septicemia' which resulted in the death of Anuradha.

(iv) The working Manager of Pharmacia India Ltd., Dr. Anil Shinde (PW-8) has categorically stated that the maximum recommended dose of Depomedrol for any dermatological or other clinical condition is 40 mg to 120 mg once a week or once in two weeks as

per the severity of the disease and clinical need. Depomedrol cannot be given 80 mg twice daily in any clinical condition and even in the right dose it is not recommended for TEN patients as it is a long acting steroid. Therefore, musking of infection, latent infections become active and opportunistic infections are likely as it has immunosuppressive action. The package insert of Depomedrol in U.S.A. indicates that Corticosteroids may musk some signs of infections and new infections may appear during their use.

(v) Another expert Dr. Salil Kumar Bhattacharya (PW-11) has gone further and stated that Depomedrol has a prolonged duration of action. The half life of the drug is 139 hours for which 80 mg twice daily is excessive which is dangerous for the patient and the immediate adverse effect of overuse of this steroid is immunosuppression and chance of opportunistic infection. Sepsis is a severe infective condition which is systemic in nature and is caused by rapid growth and multiplication of infective organism as opined by PW-11.

(vi) Dr. Anil Kumar Gupta (PW-5) made correspondences with Pharmacia Upjohn to receive the following reply:

> "…our package insert on Depomedrol does not recommend the twice daily dose of injection Depomedrol 80 mg. in any clinical condition…"

(vii) In his opinion, the use of Depomedrol in high doses can cause immunosuppression and H.P.A. Axis suppression as per package insert.

(viii) Dr. Balaram Prasad who admittedly treated Anuradha had doubt with regard to the treatment of the patient and sought immediate advice regarding continuation of the drug from Dr. Mukherjee and others. However, he was asked to continue with the medicine by Dr. Mukherjee which was started by Dr. Roychowdhury, the Dermatologist.

**(ix)** Dr. Mukherjee did not follow the treatment guidelines provided for in the Journals. The resolution taken in an International Conference known as Creteilis Experience, 1987 authored by J. Revus and J.C. Roujeau (Ref. Archives of Dermatology, Vol. 123, pages 1156-57) had also not been followed.

**(x)** Although steroids are used but the supposed advantage of the said therapy are far outweighed by its drawbacks. It is not used as a standard therapy in TEN.

(xi) Although use of Corticosteroid is advocated in the treatment of TEN, reports from early 1980s condemn their use.

**(xii)** The husband of the deceased is a Non-Resident Indian settled in America as a doctor. The complainant examined doctors from different corners of the country. On the other hand, the witnesses examined on behalf of the defence were one doctor, one Nursing Superintendent and one employee of the Department of Health, Govt. of West Bengal.

**(xiii)** It is not denied by Dr. Mukherjee in his examination under Section 313 of the Code of Criminal Procedure that immunosuppression, infection and sepsis are the serious adverse effects of Corticosteroids as also the probable effect of the overuse and excessive dose of the said steroids including Depomedrol.

**(xiv)** Even Dr. Kaushik Nandy (DW-2) admitted that immunosuppression can be a side-effect of overuse or excessive

use of Corticosteriods and may cause a chance of infection in any patient. He admitted that steroids should not be used as a standard therapy for treatment of TEN.

**(xv)** In Fitz Patrick's Dermatology for General Medicine, the text book on which both sides placed reliance, it is stated that "Glucocorticosteroids (steroids) may promote the risk of infection (Pneumonia, Septicemia)".

**(xvi)** Steroid was used in the Breach Candy Hospital, as deposed by PW-10, to completely taper the dose as the patient had very high-circulating steroid level in her body because of her receiving 120 mg. of Prednisolone daily in Kolkata and it was done for her safety only. The point with regard to Haemodialysis was not put to Dr. Udwadia and, thus, no benefit in this behalf can be given to defence.

(vii)Dr. Kaushik Nandy (DW-2) has admitted that a very high circulating steroid level in a patient may appear if large doses of steroids are administered.

(viii)Non-examination of some witnesses like the brother of the deceased Amritava Roy and sisters of AMRI was not very material.

Dr. Sukumar Mukherjee was accordingly held guilty of the charge of negligence.

IV. Dr. Baidyanath Halder

(i) He although diagnosed correctly but prescribed steroids. Although, according to him, he had examined Anuradha only once and no feedback about her condition was given to him. If he was so sincere and careful, he could have collected the information about the condition of the patient with regard to the result of his treatment from the Hospital authorities or the patient party. He had issued a certificate on 16th May, 1998. His prescription of Prednisolone 40 mg. thrice daily and Minabol twice daily was followed by the nurses of AMRI, as stated by Sutapa Chanda (DW-1).

(ii)Dr. Halder was intimated about the prescription of Dr. Mukherjee and the fact that Anuradha had already received 800 mg. of Depomedrol which is equivalent to 1100 mg. of Prednisolone but

despite the same he had advised Prednisolone three times a day without any supportive therapy which is mandatory for the patient of TEN as accepted by different universal protocols.

(iii) As Dr. Halder advised against pricking of needles in case of such patients, no supportive treatment could be administered.

(iv) In view of the certificate given by Dr. Halder, the court had reason to believe that he treated the patient from 12th May, 1998 at least upto 16th May, 1998.

(v) Non-tapering of doses of steroid is in violation of the treatment protocol for the disease TEN. The principles of supportive care have been violated totally in the prescription of Dr. Halder.

(vi) In his statement under Section 313 of the Code of Criminal Procedure, he had taken a specific plea that "journey from Kolkata to Bombay likely to enhance the danger", still, he had issued the certificate.

(vii) The purported interpolation of three words "for better treatment" did not make any difference, i.e., in the certificate itself to show that it was issued at the instance of the patient party.

(viii)The defence that the patient was removed at their own risk is not correct as Dr. Saha did not furnish any risk bond and only some other person not connected with the patient had endorsed the record for taking the patient at his own risk. In any event, such undertaking was not of much significance.

(ix)The accused doctor should not be allowed to raise the question of chance of infection in transit from Kolkata to Mumbai as Anuradha was suffering from TEN which is a non-infectious disorder and she was found fit to travel from Kolkata to Mumbai. In view of her physical condition which was found at Breach Candy Hospital, the certificate issued does not properly reflect the actual physical condition of the patient, which itself amount to avoidance of responsibility on the part of the treating Physician.

V. Dr. Abani Roychowdhury

(i) There is nothing to show that Dr. Roychowdhury treated Anuradha except the entries which appeared in the prescription of Dr. Mukherjee dated 11th May, 1998, viz., "May I request Dr. Abani Roychowdhury to see her" and another endorsement dated 15th May, 1998 wherein PW-3 Dr. B. Prasad wrote to continue as

advised by Dr. Mukherjee and Dr. Abani Roychowdhury. There is nothing to show that he issued any prescription.

(ii) The statement of DW-1 that Dr. Roychowdhury had been to AMRI is wholly unworthy of credence as she is a hearsay witness having heard the same from PW-2 who in his evidence did not state thereabout.

(iii) The statement made by DW-2 in his affidavit affirmed in the case before the Commission stating that "I carried out and suggested necessary treatment in conformity with the general treatment pattern prescribed by senior consultants, namely O.P. Nos. 2 and 3 who were generally heading the medical team looking after the treatment of the deceased. All the steps were taken to minimize chance of infection and discomfort to the patient/deceased" has not been proved as only a Xerox copy of the same had been produced.

(iv) The complainant has failed to establish the role of Dr. Roychowdhury in the treatment of Anuradha.

**VI.** The defence story that Dr. Saha had interfered in the matter of treatment, as deposed by DW-2 is not borne out from the treatment sheet and consultation record maintained and kept by the nurses at

AMRI particularly in view of the statement of DW-1 that Anuradha's nurses had been maintaining all the records.

VII. There is nothing on record to show that any advice was given for biopsy. It was not necessary to conduct the post-mortem on the dead body of Anuradha as the cause of death, as expressed by Dr. Udwadia, was known. Immunosuppression having been found by Dr. Udwadia, permission for laboratory tests was not considered necessary.

**B.2. HIGH COURT JUDGMENT**

(i) The High Court on the other hand in its judgment observed that in view of the nature of the offence under Section 304-A, coupled with the fact that the penalty imposed therefor was imprisonment for two years, the Chief Judicial Magistrate should have converted the summons case into a warrant one.

(ii) The C.J.M. should not have issued warrant of arrest without treating the case into a warrant case.

(iii) It should have been considered that three renowned professors of the State could have been man handled (by the police) on the basis of said arrest warrant.

(iv) The fact that accused doctors did not levy any professional fees was also a matter of relevance.

(v) In absence of the post-mortem examination with regard to the cause of death of Anuradha, it must be held that the death was a natural one. The death certificate issued by the Breach Candy Hospital, Mumbai was not a conclusive proof of the cause of death but was only a tentative one. It was silent about the antecedent cause or other significant conditions contributing to the death. The death certificate could not rule out the possibility of accidental, suicidal or homicidal cause of death. The doctor who issued the death certificate was not examined. Thus immediate cause of death vis-a-vis the link thereof with the treatment at Kolkata and that too specially at the hands of Respondents 1 to 3 was not proved.

(vi) Improvement to her health noticed in the Mumbai hospital after 25th May, 1998 ran contrary to the contention of complainant.

Re : DR. MUKHERJEE

The allegation that he was responsible for causing the death of Anuradha by his rash and negligent act not amounting to culpable homicide by advising, prescribing and treating the deceased with steroid drugs namely

Depomedrol, 80 mg, IM stat twice daily and other drugs in improper dosage at improper interval without any supportive treatment was rejected for the following reasons :-

**(i)** Various tests advised by him were not undertaken and he was not apprised of the treatment chart of Anuradha for the period 3rd April, 1998 to 6th May, 1998.

**(ii)** Anuradha admittedly was suffering from certain allergic disorders which were aggravated due to the intake of Chinese food and for treating such allergic disorders generally steroids would be used and thus the trial court was not correct to hold that Dr. Mukherjee should not have prescribed Depomedrol.

**(iii)** There is nothing on record to show that the drug was actually administered to the patient because no feedback of the treatment was given to him.

**(iv)** At the time of admission at AMRI, Dr. Mukherjee's prescription was not taken into consideration. In fact it was indicated that the patient was being treated by somebody else whose identity had not been disclosed.

**(v)** Diagnosis that Anuradha was suffering from TEN was not done by Dr. Mukherjee. The package insert of Depomedrol did not indicate that it could not be prescribed for the said disease. As Anuradha is stated to be suffering from vasculitis and could be treated with the said medicine, which opinion has been supported by others including Dermatologist - Dr. A.K. Ghoshal, it could not be construed to be incorrect and contrary to medical practice and ethos.

**(vi)** Dr. Ghosal was not examined to explain the basis upon which the patient was diagnosed to be suffering from TEN.

**(vii)** Oral admission of Tab. Wysolone was sufficient to indicate that the treatment of the patient was being carried out as per the prescription of Dr. Mukherjee. However, in any event the evidence on record was sufficient to indicate that from 3rd April, 1998 till her admission at AMRI on 11th May, 1998, Anuradha was being treated after taking advice from different doctors. There was evidence on record to indicate that Kunal's doctor friends contributed in her treatment.

(viii) There is a possibility of Anuradha suffering from drug allergy as well as allergy from Chinese foods. Application of steroid is undoubtedly an accepted treatment protocol for allergic disorders. In fact, Depo-Medrol is a Glucocorticoid which has anti inflammatory and anti-allergic action.

**(ix)** Allergic vasculitis is an allergic and inflammatory condition of the blood vessels in the body and can affect not only the blood vessels of the skin but also any internal vital organs leading to death of the patient at any point of time. Allergic vasculitis is not a dermatological disease. The treatment suggested by Dr. Mukherjee, therefore, could not be considered to be an act of rash and negligence.

Re : DR. HALDER

The allegation of the complainant that the prescription by Dr. Halder of Prednisolone 40 mg. thrice daily had aggravated the disease was held not tenable on the following grounds :-

**(i)** He visited the patient only on 12th May, 1998 which was supported by Dr. Balaram Prasad. He, therefore, had no role to

play in the treatment of Anuradha which would be evident from the record of AMRI.

(ii) There is nothing on record to show that the prescription of Prof. Halder was given effect to.

**(iii)** Occlusive dressings were carried as a result of which infection had been increased

**(iv)** He had suggested Benadryl Syrup as there were eruptions inside the mouth and Cortisone Kemicetin eye ointment for eye care. However, the steroid based Neomycin Antibiotic was prescribed by the Consultant Ophthalmologist Dr. S. Bhattacharya on 12th May, 1998, although Prof. Halder in his prescription advised to avoid Neomycin and Soframycin which are common causes of drug allergy. As such the treatment suggested by Prof. Halder was not followed.

(v) There was no evidence to show that he was incharge of the patient.

**(vi)** There was no evidence to indicate that Dr. Mukherjee ever requested Dr. Halder to see the patient.

**(vii)** Despite the fact that Dr. Halder confirmed that the patient was suffering from TEN, records indicated that his line of treatment was not followed and, thus, the evidence to consider the deceased to be suffering from TEN is of no value.

(viii) Anuradha was thus not suffering from TEN. Although the papers of Breach Candy Hospital mention that the disease was diagnosed as TEN, but the attending physician was not a dermatologist. Thus no one came forward to say that Anuradha was suffering from TEN.

(ix) The death certificate also did not indicate that Anuradha was suffering from TEN.

**(x)** Dr. Kunal Saha, husband of the deceased Anuradha being himself not a Dermatologist; his opinion is irrelevant, particularly when he is said to have become specialist of TEN subsequently upon studying the subject after her death.

(xi) Prescription of Prof. Halder indicted that he stopped Depo-Medrol once he started Prednisolone 40 mg. thrice with other medicines. He also prohibited local anesthesia, Neomycin,

Soframycin. He also gave importance on Elecrtolyte balance, nutrition and advised for prevention of secondary infection.

**(xii)** Prof. Halder is a renowned Dermatologist with numerous publications and teaching experience. His line of treatment was in conformity with the accepted norms particularly in view of the fact that there is no universal protocol for the treatment of TEN. Treatment of each patient will depend upon his/her condition on a particular day.

(xiii) During Anuradha's stay at AMRI there was no indication of any complication like hypovolemia, internal organ failure, infection of septicemia etc.

Re : PROF. ABANI ROY CHOWDHURY.

Allegation that he had also taken active part in the treatment of Anuradha is not established from the record.

There is nothing on record to show that Dr. Halder while writing the prescription had any prior discussion with Dr. Abani Roychowdhury. The

endorsement that the prescription was a joint prescription of Dr. Halder and Dr. Roychowdhury was admittedly made by Dr. Kunal Saha himself

Although some of the doctors of AMRI had stated that they had received the advice of Dr. Roychowdhury but the nature of the advice had not been clarified by them.

RE: CERTIFICATE

The allegation that the certificate was issued at the instance of Dr. Roychowdhury is not correct as the certificate issued by Prof. Halder did not indicate that Anuradha was being carried by a Chartered flight for better treatment. The words "for better treatment" were not written by Prof. Halder and only in the course of evidence it was proved that there was an interpolation in the certificate. The same was also admitted by Dr. Balaram Prasad and thus the certificate of Prof. Halder was held to be forged. The forged certificate demolishes the prosecution story that at the advice of Prof. Halder or Prof. Roychowdhury the patient was taken to Mumbai. The endorsement of Dr. Kunal Saha on the record of AMRI really proved that Anuradha was shifted from the hospital at their own risk. The evidence on record also indicates that till the evening of 18th May, 1998, the dressing of Anuradha was not changed. Thus, by removing Anuradha, her husband

Kunal Saha took upon himself great risk of infection to her in course of transit being aware that infection was very common at that critical stage for the patient.

Kolkata doctors had no hand in shifting Anuradha from Kolkata to Mumbai.

The High Court also opined that the patient party did neither follow the advice of Dr. Mukherjee nor that of Prof. Halder.

GENERAL OBSERVATIONS BY THE HIGH COURT

(i) As Anuradha was treated at AMRI for six days and at Breach Candy Hospital for 12 days, by no stretch of imagination her death had anything to do with the treatment at AMRI ; the cause of death being absent.

(ii) The contention of Dr. Kunal Saha that his wife was almost dead when brought to Breach Candy Hospital, was untrue.

(iii) Anuradha was admitted under Dr. Balaram Prasad, who was a Consultant Physician having Post Graduate Degree. He also claimed to be the physician-in-charge of the treatment.

(iv) Interference by Dr. Kunal Saha was sufficient to indicate that treatment of Anuradha was monitored by him alone and nobody else.

Although, he claimed that Anuradha was suffering from TEN which was a dermatological disease, but Anuradha was admitted by him under a Plastic Surgeon, Dr. S. Keshwani. Even at the initial stage Dr. Kunal Saha gave instructions to the doctors on 17th May, 1998 rejecting the treatment suggested by doctors attending at Breach Candy Hospital, Mumbai. Thus the diagnosis of the disease and the follow-up action was done under the direct supervision of Dr. Kunal Saha and his brother-in-law. Such was the position at AMRI also.

(v) The opinion of three internationally-accepted experts on TEN was not acceptable as none of them were examined in Court. From the records of Breach Candy Hospital it would itself appear that Anuradha was being administered medicines other than the ones prescribed by the doctors. Cash memos for purchase of medicines would show the discrepancy in the medicines prescribed by the doctors like Bactroban Ointment, Efcorlin (one kind of steroid) and Sofratule purchased on 12th, 13th and 16th May, 1998 had not been prescribed by the doctors. Relatives of the patient having not followed the treatment protocol of the doctors under whom the patent is admitted; as soon as any interference is made therewith, the doctors are absolved of their liability.

Charge of professional negligence on a medical person is a serious one as it affects his professional status and reputation and as such the burden of proof would be more onerous. A doctor cannot be held negligent only because something has gone wrong. He also cannot be held liable for mischance or misadventure or for an error of judgment in making a choice when two options are available. The mistake in diagnosis is not necessarily a negligent diagnosis.

Even under the law of tort a medical practitioner can only be held liable in respect of an erroneous diagnosis if his error is so palpably wrong as to prove by itself that it was negligently arrived at or it was the product of absence of reasonable skill and care on his part regard being held to the ordinary level of skill in the profession. For fastening criminal liability very high degree of such negligence is required to be proved.

Death is the ultimate result of all serious ailments and the doctors are there to save the victims from such ailments. Experience and expertise of a doctor are utilised for the recovery. But it is not expected that in case of all ailments the doctor can give guarantee of cure.

**B.3. NATIONAL COMMISSION JUDGMENT**

The Commission in its judgment noted that doctor or a surgeon never undertakes that he would positively cure the patient nor does he undertake to use the highest degree of skill, but he only promises to use fair, reasonable and competent degree of skill. In this regard the commission opined that if there are several modes of treatment and a doctor adopts one of them and conducts the same with due care and caution, then no negligence can be attributed towards him

It went on to note that there was no negligence on part of Dr. Mukherjee because even Dr. A. K. Ghoshal, Dermatologist, who diagnosed the disease of Mrs. Anuradha as TEN, prescribed the same treatment.

Further, it observed that no records were produced by Dr. Saha regarding the treatment given to Mrs. Anuradha from 1st April 1998 to 7th May 1998. As there is no specific treatment for TEN, error of judgment in the process of diagnosis does not amount to deficiency in service, considering that the disease TEN is a rare occurring in 1 case out of 1.3 per million per year.

It went on to observe that the patient was never in the absolute care of Dr. Haldar, who had treated her only on 12$^{th}$ of May 1998. Dr. Haldar, it noted, was, therefore, an unnecessary party.

It opined that all the necessary care was taken by Dr. Mukherjee and Dr. Haldar. It laid special emphasis on the fact that a complaint had been filed before the West Bengal Medical Council, which concluded that there was no deficiency on the part of the doctors. The Writ petition against the said decision before the High Court was dismissed. Therefore, it was concluded that there was no negligence on the part of the doctors.

## C. DETERMINATION OF CERTAIN SALIENT POINTS OF LAW AND FACTS

### C.1. EXPERT EVIDENCE

Section 45 of the Indian Evidence Act speaks of expert evidence. It reads as under :-

> **"45. Opinions of experts -** When the Court has to form an opinion upon a point of foreign law, or of science, or art, or as to identity of hand writing or finger-impressions, the opinions upon that point of persons specially skilled in such foreign law, science or art, or in questions as to identity of handwriting or finger impressions, are relevant facts. Such person called experts.
>
> Illustrations
>
> (a) The question is, whether the death of A was caused by poison. The opinions of experts as to the symptoms produced by the poison by which A is supposed to have died, are relevant.

> (b) The question is whether A, at the time of doing a certain act, was by reason of unsoundness of mind, in capable of knowing the nature of the act, or that he was doing what was either wrong or contrary to law.
>
> The opinions of experts upon the question whether the symptoms exhibited by A commonly show unsoundness of mind, and whether such unsoundness of mind usually renders persons incapable of knowing the nature of the acts which they do, or knowing that what they do is either wrong or contrary to law, are relevant.
>
> (c) The question is, whether a certain document was written by A. Another document is produced which is proved or admitted to have been written by A.
>
> The opinion of experts on the question whether the two documents were written by the same person or by different persons are relevant."

A Court is not bound by the evidence of the experts which is to a large extent advisory in nature. The Court must derive its own conclusion upon considering the opinion of the experts which may be adduced by both sides, cautiously, and upon taking into consideration the authorities on the point on which he deposes.

Medical science is a difficult one. The court for the purpose of arriving at a decision on the basis of the opinions of experts must take into

consideration the difference between an 'expert witness' and an 'ordinary witness'. The opinion must be based on a person having special skill or knowledge in medical science. It could be admitted or denied. Whether such an evidence could be admitted or how much weight should be given thereto, lies within the domain of the court. The evidence of an expert should, however, be interpreted like any other evidence.

This Court in State of H.P. v. Jai Lal and others, [ (1999) 7 SCC 280] held as under :-

> " **17.** Section 45 of the Evidence Act which makes opinion of experts admissible lays down that when the court has to form an opinion upon a point of foreign law, or of science, or art, or as to identity of handwriting or finger impressions, the opinions upon that point of persons specially skilled in such foreign law, science or art, or in questions as to identity of handwriting, or finger impressions are relevant facts. Therefore, in order to bring the evidence of a witness as that of an expert it has to be shown that he has made a special study of the subject or acquired a special experience therein or in other words that he is skilled and has adequate knowledge of the subject.
>
> **18.** An expert is not a witness of fact. His evidence is really of an advisory character. The duty of an expert witness is to furnish the Judge with the necessary scientific criteria for testing the accuracy of the conclusions so as to enable the Judge to form his independent judgment by the application of this criteria to the facts proved by

> the evidence of the case. The scientific opinion evidence, if intelligible, convincing and tested becomes a factor and often an important factor for consideration along with the other evidence of the case. The credibility of such a witness depends on the reasons stated in support of his conclusions and the data and material furnished which form the basis of his conclusions.
>
> **19.** The report submitted by an expert does not go in evidence automatically. He is to be examined as a witness in court and has to face cross-examination. This Court in the case of *Hazi Mohammad Ekramul Haq* v. *State of W.B.* concurred with the finding of the High Court in not placing any reliance upon the evidence of an expert witness on the ground that his evidence was merely an opinion unsupported by any reasons."

ADMISSIBILITY OF EXHIBITS 4, 5 AND 6

Kunal, before us, contended that the High Court committed a serious error in not placing reliance upon medical opinions i.e. Exts. 4, 5 and 6 on the premise that no objection in that behalf was raised at any point of time.

Kunal would argue that this Court having given him permission to examine the expert witnesses on Video Conferencing and he having deposed in terms thereof, Respondents could have asked for their cross-examination at any point of time and not having done so, it does not lie in their mouth to

contend that the opinions of the said experts who are themselves authors on TEN and having done research on the disease TEN, are not admissible.

**FOR THE PURPOSES OF CRIMINAL PROCEEDINGS**

Kunal, however, would contend that the aforementioned documents were exhibited without any demur whatsoever. The respondents, furthermore, did not make any prayer to cross-examine the said witnesses.

It is true that ordinarily if a party to an action does not object to a document being taken on record and the same is marked as an exhibit, he is estopped and precluded from questioning the admissibility thereof at a later stage. It is, however, trite that a document becomes inadmissible in evidence unless author thereof is examined; the contents thereof cannot be held to have been proved unless he is examined and subjected to cross-examination in a court of law.

The document which is otherwise inadmissible cannot be taken in evidence only because no objection to the admissibility thereof was taken. In a criminal case, subject of course, to the shifting of burden depending upon the statutes and/or the decisions of the superiors courts, the right of an accused is protected in terms of Article 21 of the Constitution of India. The

procedure laid in that behalf, therefore, must be strictly complied with. Exhibits 4, 5 and 6, in our opinion, are not admissible in evidence in the criminal trial.

**FOR PURPOSES OF PROCEEDINGS BEFORE THE NATIONAL COMMISSION**

The said exhibits, however, are admissible before the consumer court. This Court in R.V.E. Venkatachala Gounder *v.* Arulmigu Viswesaraswami & V.P. Temple,*(2003) 8 SCC 752*, at page 763 :

> "… Ordinarily, an objection to the admissibility of evidence should be taken when it is tendered and not subsequently. The objections as to admissibility of documents in evidence may be classified into two classes: (*i*) an objection that the document which is sought to be proved is *itself inadmissible* in evidence; and (*ii*) where the objection does not dispute the admissibility of the document in evidence but is directed towards the *mode of proof* alleging the same to be irregular or insufficient. In the first case, merely because a document has been marked as "an exhibit", an objection as to its admissibility is not excluded and is available to be raised even at a later stage or even in appeal or revision. In the latter case, the objection should be taken when the evidence is tendered and once the document has been admitted in evidence and marked as an exhibit, the objection that it should not have been admitted in evidence or that the mode adopted for proving the document is irregular cannot be allowed to be raised at any stage subsequent to the marking of the document as an

> exhibit. The latter proposition is a rule of fair play. The crucial test is whether an objection, if taken at the appropriate point of time, would have enabled the party tendering the evidence to cure the defect and resort to such mode of proof as would be regular. The omission to object becomes fatal because by his failure the party entitled to object allows the party tendering the evidence to act on an assumption that the opposite party is not serious about the mode of proof. On the other hand, a prompt objection does not prejudice the party tendering the evidence, for two reasons: firstly, it enables the court to apply its mind and pronounce its decision on the question of admissibility then and there; and secondly, in the event of finding of the court on the mode of proof sought to be adopted going against the party tendering the evidence, the opportunity of seeking indulgence of the court for permitting a regular mode or method of proof and thereby removing the objection raised by the opposite party, is available to the party leading the evidence. Such practice and procedure is fair to both the parties. Out of the two types of objections, referred to hereinabove, in the latter case, failure to raise a prompt and timely objection amounts to waiver of the necessity for insisting on formal proof of a document, the document itself which is sought to be proved being admissible in evidence. In the first case, acquiescence would be no bar to raising the objection in a superior court."

Section 22 of the Consumer Protection Act, 1986 provides that Sections 12, 13 and 14 thereof and the rules made thereunder for disposal of the complaints by the District Forum, shall with such modification as may be considered necessary by the Commission, be applicable to the disposal of disputes by the National Commission. Section 12 of the 1986 Act provides

for the manner in which the complaint shall be made. Section 13 prescribes the procedure on admission of the complaint. Sub-section (3) thereof reads:-

> "(3) No proceedings complying with the procedure laid down in sub-sections (1) and (2) shall be called in question in any court on the ground that the principles of natural justice have not been complied with."

Apart from the procedures laid down in Section 12 and 13 as also the Rules made under the Act, the Commission is not bound by any other prescribed procedure. The provisions of the Indian Evidence Act are not applicable. The Commission is merely to comply with the principles of natural justice, save and except the ones laid down under sub-section (4) of Section 13 of the 1986 Act.

The proceedings before the National Commission are although judicial proceedings, but at the same time it is not a civil court within the meaning of the provisions of the Code of Civil Procedure. It may have all the trappings of the Civil Court but yet it can not be called a civil court. [ See Bharat Bank Ltd. v. Employees of the Bharat Bank Ltd. [1950 SCR 459] and Nahar Industries Ltd. v. Hong Kong & Shanghai Banking Corporation etc. (Civil Appeal arising out of SLP (C) No. 24715 of 2008 etc decided on 29th July, 2009)]

Mr. Gupta, learned counsel appearing on behalf of Dr. Balram Prasad contended that the opinions, exhibits P-4, P-5 and P-6 are inadmissible in evidence.

The opinions of the experts as contained in the said documents are probably based on the hospital records and other relevant papers. Such opinions have been rendered on the basis of their expertise. They were notarized. The said opinions have been appended to the complaint petition even as documents. Respondents did not question the correctness thereof either before the court or before the Commission. They did not examine any expert to show that said opinion are not correct. The concerned respondents in their depositions before the Commission also did not challenge the correctness or otherwise of the said opinions. Even otherwise the deficiencies pointed out therein are explicit from the records.

This Court in J.J. Merchant (Dr) *v.* Shrinath Chaturvedi, [(2002) 6 SCC 635], held as under :-

> "19. It is true that it is the discretion of the Commission to examine the experts if required in an appropriate matter. It is equally true that in cases where it is deemed fit to examine experts, recording of evidence before a Commission may consume time. The Act specifically empowers the Consumer Forums to follow the procedure which may not require more time or delay the proceedings. The

only caution required is to follow the said procedure strictly. Under the Act, while trying a complaint, evidence could be taken on affidavits [under Section 13(4)(*iii*)]. It also empowers such Forums to issue any commission for examination of any witness [under Section 13(4)(*v*)]. It is also to be stated that Rule 4 in Order 18 CPC is substituted which *inter alia* provides that in every case, the examination-in-chief of a witness shall be on affidavit and copies thereof shall be supplied to the opposite party by the party who calls him for evidence. It also provides that witnesses could be examined by the court or the Commissioner appointed by it. As stated above, the Commission is also empowered to follow the said procedure. Hence, we do not think that there is any scope of delay in examination or cross-examination of the witnesses. The affidavits of the experts including the doctors can be taken as evidence. Thereafter, if cross-examination is sought for by the other side and the Commission finds it proper, it can easily evolve a procedure permitting the party who intends to cross-examine by putting certain questions in writing and those questions also could be replied by such experts including doctors on affidavits. In case where stakes are very high and still a party intends to cross-examine such doctors or experts, there can be video conferences or asking questions by arranging telephonic conference and at the initial stage this cost should be borne by the person who claims such video conference. Further, cross-examination can be taken by the Commissioner appointed by it at the working place of such experts at a fixed time."

## C.2. DIAGNOSIS AND TRAIL OF TREATMENT

OVERVIEW OF TOXIC EPIDERMAL NNECROLYSIS

Toxic Epidermal Nnecrolysis (TEN hereinafter) is also known as Lyell's Syndrome, epidermolysis acuta toxica and scalded skin syndrome. TEN begins with a non- specific prodome of 1- 14 days in atleast half of the patients. It is a severe and extensive variant of erythematobullous drug eruption. In TEN, the patient is ill with high fever occasionally suffers somnolence and lassitude. Because of the extensive area of eroded skin, large amount of body fluid is lost with consequent disturbances of electrolyte and fluid balance. [See Dermatology in General Medicine ( Fitz Patrick's) (5th Ed), and Comprehensive Dermatological Drug Therapy]

NEGLIGENCE IN TREATMENT OF TEN

For determining the question as to whether the respondents herein are guilty of any negligence, we may notice the treatment protocol.

Anuradha, it is conceded, was suffering from TEN. She had been positively diagnosed to be suffering from the said disease on 12th May, 1998. TEN is a spectrum of symptoms. The treatment protocol for TEN has undergone considerable change throughout the world.

TEN was discovered in the year 1956 by Lyell. It leads to immunosuppression. For treating the patients suffering from TEN, doctors used to administer steroid. Later researches showed that they should not be

used. Such a conclusion was arrived at upon undertaking researches of patients suffering from the said disease with administration of steroid as well as non-administration of them. It was found that those patients treated with steroids do not respond properly thereto. Indisputably, however, some doctors still use steroids. It is stated that the researchers found out that use of steroids was more detrimental than beneficial to the TEN patients.

Admittedly, Anuradha was administered steroids. The learned counsel for the parties have brought before us a vast volume of material to contend that the experts in the field as also the doctors or medical practitioners who have specialized in TEN and other dermatological diseases are sharply divided on the administration of steroid. We for the sake of brevity refer to them as the pro-steroid group and anti-steroid group. Medical science, therefore, has a grey area in this respect.

At the outset, we may place on record the treatment pattern prescribed by two experts, viz., Jean Edouard Revuz and Jean Claude Roujeau who are generally accepted world over. According to them, the treatment pattern should be as under:

> "The disease usually begins with non specific symptoms, such as fever, cough, sore throat, burning eyes, followed in 1 to 3 days by skin and mucous membrane lesions. A burning or painful

> rash starts systematically on the face and in the upper part of the tongue and rapidly extends. Most frequently, the initial individual skin lesions form poorly defined margins with darker purpuric centre progressively emerging on the skin, chest and back. Less frequently, the initial manifestations may be extensive scarlatiniform erythema. Symptomatic therapy is a must. IV fluids must be replaced mandatorily.
>
> The treatment protocol includes:
> - Symptomatic treatment
> - Monitoring
> - Fluid replacement and anti-infection therapy
> - Nutrition
> - Warming (30-32 degree Celsius)
> - Skin care
> - Eyes and mucous membrane care"

They hold the view that the current evidence suggests that corticosteroids are more dangerous than useful in these disorders as they increase the risk of death from infections, including systemic candidiasis, a complication that had never been observed in many patients treated without steroids.

After the death of Anuradha, Kunal consulted a large number of experts from various countries including India.

The Canadian Treatment Protocol is as under:

> "IV fluid resuscitation- including internal feeding, use of air- fluidized beds, complete avoidance of steroids, use of narcotics for pain, use of catheters to be avoided, meticulous eye care daily, use of systemic antibiotic therapy for specific infections but not for prophylaxis, topical antibiotic therapy is not used, meticulous wound care and moist saline gauge dressing are applied once daily when most of the involved epidermal surface has sloughed off, usually 3 to 4 days after the onset of TEN the patient is given general anesthesia for washing the wounds vigorously and applying briobrane under tension to be stapled all over".

Dr. George Goris, Managing Director Medical and Drug Information of Pharmacia and Upjohn expressed that "DEPO" dosage of more than the approved indication, that too 80 mg twice daily, was not correct.

Dr. David Fine, Dermatologist from University of North Carolina opined as under:

> "..... conventional therapy of TEN with systemic corticosteroids involves either oral or intravenous preparation. I have personally never seen intramuscular corticosteroids administration for this condition. In addition, intramuscular corticosteroids are never given on a BID schedule (and with some preparations no more frequently than every 4-6 weeks) because of the prolonged Depot effect related to administration by this particular route. In general, intramuscular administration of systemic corticosteroids is not employed in the treatment of dermatological

> diseases since this routes provides very erratic release of medication from the tissue.....”

He also remarked, as far as the treatment in the present case is concerned:

> “ .... manner in which the treatment was instituted in your wife certainly appears to be unprecedented.”

Dr. David Heimbach, Professor of University of Washington holds the view that the injection “DEPO” in twice daily dose was not indicated in TEN protocol and the dosing interval as advised in the prescriptions of the opposite party no. 1 is not recommended for treatment of any medical condition, leave aside for, far less an acute medical condition such as the one the patient was suffering from i.e. TEN.

Dr. Timothy Bradley, noted Physician wrote a famous article on TEN wherein it was stated that several patients of TEN with 95% total BSA involvement were treated without use of steroids and there was 100% survival rate. In his view, the keystone, for survival in patients with TEN is fluid resuscitation and nutritional support and vigilant surveillance for infection.

Gerald Pierard in his treatise on TEN stated:-

a) **Antiseptic measures** are essential to treat TEN patients since septicaemia shock is the first cause of mortality. So a sterile room and antiseptic bathes have to be used. Intact blisters can be left in place but when they burst, the narcotic skin must be eliminated otherwise it becomes an excellent medium for the proliferation of microorganisms. Repeated skin swabs should be done to detect excessive coetaneous infection and to guide prophylactic antibiotherapy. Systematic antibiotics should also be used if direct or indirect signs of septicaemia happen: positive blood cultures, pneumonia, decrease of the urinary flow, fever or rapid fall of the temperature, impairing of the general condition, and decrease in the white cells count with neutropenia. The search of these signs implies a permanent patient's supervision with many blood takes. Of course, unnecessary i.v. catheters should be avoided but in practise it is impossible to totally avoid them. They have to be changed frequently and placed in culture after removal.

b) Supportive measures are also essential. Several litres of fluid per day are needed since fluid loss is enormous in severe cases. The absence of substitution of these fluids leads to important internal problems. The only way to bring such amount of fluid is by catheters. The oral

way is absolutely inadequate, more especially as digestive tract is also often injured. Once more, as previously said, catheters should be changed very regularly (maximum every 3 days), placed if possible in areas of intact skin and examined for bacterial contamination after removal.

c) Any definite TEN drug treatment is currently not recognised. The case of systematic steroids is controversial. The use of high doses of quick acting corticosteroids for a short time could be defensible for patients treated at the beginning of TEN without any sign of septic contamination, to try to stop the advancement of the disease. Steroids are clearly harmful and ineffective when the disease has settled. Long-acting steroids have no place in TEN treatments. Their action is too late.

d) The slough of the skin and mucous membrane is painful and it is medical and ethical concern to relief pain in TEN."

Our attention has also been drawn to the resolutions adopted in the year 1985 at Creteil in France. We would label it as 'Creteil Experience'. It is summarized as under:

> " The absence of dermal inflammatory infiltration in TEN is an argument against steroid therapy. Certain authors have claimed that the extension of necrolysis is arrested by high-dose corticosteroid therapy, but the natural history of TEN is very variable both in extent and time course. In some cases nerolysis is complete within 24 hours. Clearly, steroid therapy is illogical in such patients. In other patients, necrolysis may occur in waves. The unpredictable course of the disease casts further doubt on uncontrolled claims of the efficacy of steroid therapy. The benefits of steroid therapy, if any, would be observed only at an early stage of a slowly evolving case of TEN. It cannot be overemphasised that once a large area of dermis is uncovered i.e. more than 20% of the body surface area, the supposed advantages of steroid-therapy are far outweighed by its drawbacks. The opinion that steroids should not be used as a standard therapy for TEN is shared by the majority of authors and was unanimously agreed on at an international workshop on TEN held in Creteil, France in October 1985. More recently, Halebian et al have reported high improvement of survival in patients treated without steroids when compared with a previous series of patients treated with high dose steroid therapy in the same institution.

Kunal had also consulted several doctors and experts in India. We would notice the opinion of some of them here but we would deal with their admissibility at a later stage.

Dr. S.K. Bose from Apollo Hospital, Delhi, on a query made by the appellant, opined that the treatment protocol should be symptomatic and

corticosteroids should be avoided. The resume of the protocol which should be followed, according to him, is as under:

- Discontinue all drugs implicated in TEN JAAD 1991
- Intravenous canalization for fluid replacement depending upon % of TBSA, Nasogastric tube feeding, catheter if required
- Topical skin care
- Monitoring serum electrolytes by culture
- Room Temperature of about 30-32 degrees Celsius, sterile environment, air fluidized bed, barrier nursing
- Encourage oral fluids
- Hyperbaric oxygen, aerosols, bronchial aspiration, physical therapy, therapies for herpes and mycoplasma.

Appellant also consulted those Indian doctors who still administered steroids. Dr. J.S. Pasricha is one of them. According to him, use of corticosteroids in TEN was very controversial; however, if they are used appropriately, the patient's life can be saved. Death due to usage of corticosteroids in TEN patients, he stated, occurs only when :

- The reaction is not controlled properly
- Corticosteroids are not withdrawn quickly

Attention has also been drawn to the protocol treatment on behalf of the respondents. They have placed reliance on a number of authorities to

suggest a protocol of treatment of the disease TEN in which the administration of glucocorticosteriods plays an integral role. Some of the authorities suggested by them include:

- Journal of Association of Physicians of India.
- Comprehensive Dermatological Drug Therapy.
- Dermatology by O. Brian Falco.
- Dermatology in General Medicine (Fitz Patrick) ($5^{th}$ Ed)
- Goodman and Gillman: The Pharmacological Basis of Therapuetics ($9^{th}$) (Ed)
- Harrison's Principle of Internal Medicine
- Principle's of Pharmacology.
- Journal of Burn Care and Rehabilitation ( A 10 year experience with TEN)
- TEN – Medical Findings and Prognosis in 87 Patients, Jean Revuz, From the archives of Dermatology
- J.S. Pasricha, TEN, International Journal of Dermatology.

Nonetheless the following principles are integral to the treatment of TEN as suggested by the Respondents:

a. Treatment in burn units should be strived for in exceptional cases but is not generally necessary.

**b.** Treatment has to be individually tailored according to cause, type, stage and presence of complications.

c. Systemic glucocorticoids should not be used routinely but are justified in the early stages of drug induced TEN. They should be given in doses from 80 to 120 mg of methlypredisolone per day by mouth, for several days until disease progression has ceased. Dosages should be tapered quickly and cautiously since no further benefit can be expected thereafter and the untoward effects may then predominate.

d. Treatment may focus on early detection and prevention of the most fatal complication e.g. overwhelming infection. Cultures from skin and mucosal erosions, must be regularly performed.

e. Blood gases and fluid, electrolytes and protein balance must be monitored and adjusted appropriately. Fluid replacement regimens as used for burn patients.

f. Supportive care is of great importance and particular attention must be paid to a high calorie and high – protein diet.

g. Debridgement of necrotic skin should not be performed before disease activity ceases.

In the criminal case, the appellant examined Dr. Salil Kumar Bhattacharjee. For the sake of completeness it would be necessary to place on record his opinion in the matter.

Dr. Bhattacharjee, as noticed hereinbefore, is a Professor of Pharmacology at the Institute of Medical Science, Benaras Hindu University. In an answer to a query, on whether he was aware of the drug Depomedrol and its usage, he answered that "it is usually used in chronic clinical condition like Bronchial Asthma and Rheumatiod Arthritis" and on being questioned, whether Depomedrol can be used for TEN, he answered in the negative. He stated that recommended usage is 40 to 120 mg at intervals of at least one week and a daily dose of 80 mg can never be used.

Appellant also examined Dr. Udwadia. He is the Consultant Physician in the Breach Candy Hospital. Anuradha was a patient in the said hospital under him. He has not used Depomedrol although his personal view was that he would have used lesser doses of corticosteroid. Although he had not used Depomedrol and he had no experience with the said drug, he

categorically stated that it could obviously add to steroid. In his statement, he made it clear that "all corticosteroids are double-edged weapons on the one hand, there can be a beneficial effect and on the other, they can have untoward effects and the effect is immunosuppression leading to infection". He also testified that supportive therapy was necessary.

In the criminal case, even Dr. Prasad who was examined as PW-3 stated that he prescribed Depomedrol for a day after seeing the prescription of Dr. Mukherjee. And before the National Commission he stated that Depomedrol 80 mg twice daily cannot be administered to any patient. Before the Commission Dr. Mukherjee admitted that he prescribed the injection of Depomedrol and gave it to the patient at the request of Kunal on compassionate grounds. Dr. Halder accepted that Depomedrol is not the correct medicine for TEN and is used in acute medical condition.

We would, in view of the difference of opinion amongst experts as noticed by us heretoabove in some detail, proceed on the assumption that steroid can be administered in the TEN patients. However, it is clear from the opinion of the pro-steroid experts that:

(i) The nature of steroid which should be used is corticosteroid meaning thereby methyl prednisolone.

**(ii)** It should be used only at the early stages for a few days and then should be stopped or tapered to avoid the effect of immunosuppresion as also sepsis.

(iii) Supportive treatment must be administered.

(iv) It should be individually tailored according to the patients' need.

Supportive treatment is also advised by Dr. Pasricha and others.

Two factors, however, must be noticed at this juncture :

**(i)** The chemical composition of Depomedrol is different from other type of glucocorticosteroid inasmuch as Depomedrol is methyl prednisolone acetate and glucocorticosteroid is methyl prednisolone sodium succinate. The evidence of Kunal in this behalf is absolutely categorical and unequivocal.

(ii) All the authors are one in stating that their opinion is subject to the instructions given in the package insert of the medicine.

Kunal examined Dr. Anil Shinde as PW-8. He is the Manager, Medical Service of Pharmacia India Private Limited. Depomedorol is manufactured by Pharmacia and Upjohn, USA. The company is the

distributor of the said product in India. The packet insert of Depomedrol reads as under:

"DOSAGE:-

The usual dosage for patients with Dermatalogic Lesions benefitted by systemic corticoid therapy is 40-120 MG of Methyl Prednisolone acetate administered intramuscularly at weekly intervals for 1-4 weeks. In acute severe dermatitis due to poison IV relief may result within 8-12 hrs following intramuscular administration of a single dose of 80-120 MG. In chronic Contact dermatitis, repeated injections at 5-10 day intervals may be necessary. Following intramuscular administration of 80-120 MG to asthmatic patient's relief may result within 6-48 hrs and persist for upto 2 weeks.

Intramuscular dosage will vary with the condition being treated when a prolonged effect is desired; the weekly dose may be calculated by multiplying the daily dose by 7 and given as a singular intramuscular injection. Dosage must be individualised according to the severity of the disease and the response of the patients. In general, the duration of the treatment should be kept as short as possible. Medical surveillance is necessary.

PROPERTIES

After a single IM injection of 40-80 MG of Depomedrol, duration of HPA Axis suppression ranges from 4-8 days. An intra-articular injection of 40 MG in both knees given after 4-8 hrs methyl

prednisolone peaks of approximately 21.5 micrograms/ 100 ML. After intrarticular administration, methyl prednisolone acetate defuses from the joint into systemic circulation over approximately 7 days as demonstrated by the duration of HPA Axis suppression and by the serum Methyl Prednisolone Values.

## INDICATIONS

For Intramuscular administration, Methyl Prednisolone acetate (Depomedrol) is not suitable for the treatment of acute life threatening conditions if a rapid hormonal effect of maximum intensity is required the IV administration of highly soluble methyl prednisolone sodium succinate (Solumedrol) is indicated.

## PRECAUTION

Since the complications of treatment with glucocorticoids are dependant on the size of the dose and the duration of treatment ,a risk/ benefit decision must be made in each individual case as to dose and duration of treatment and as to whether daily or intermittent therapy should be used.

Glucocorticoids may musk some signs of infection and new infections may appear during their use.

There may be decreased resistance and inability to localise infection when glucocorticoids are used.

> Do not use intrarticulary, intra bursally or intra tendinous administration in the presence of acute infection. IM administration can only be considered after institution of an appropriate anti microbial treatment."

The necessity of following the instructions given in the packet insert cannot be underestimated. Admittedly, the instructions in the said packet insert had not been followed in the instant case.

EFFECT OF EXCESS DOSAGE

There is, thus, a near unanimity that the doses of glucocorticosteroid and in particular Depomedrol were excessive. From the prescription of Dr. Mukherjee, it is evident that he not only prescribed Depomedrol injection twice daily, but had also prescribed Wysolone which is also a steroid having the composition of Methyl Predinosolone.

From the AMRI records, it would appear that while admitting the patient, it had categorically been noticed that both Depomedrol injection twice daily and Wysolone were being administered from 7th May, 1998 following the prescription of Dr. Mukherjee. It also now stands admitted that Dr. Prasad also prescribed the same medicine. From Dr. Mukherjee's prescription dated 11.05.1998, it is furthermore evident that he had

prescribed Wysolone 50 mg once daily for one week, 40 mg daily for next week and 30 mg daily for the third week. He had also prescribed Depomedrol injection 80 mg twice daily for two days.

> "Depomedrol", is a "long acting" steroid recommended for the treatment of "chronic" clinical conditions like "asthma" or "arthritis" for its prolonged immnumosupressive action. The maximum recommended dose of Depomedrol is 40-120 mg at 1-4 week intervals as clearly mentioned by the drug manufacturer, Pharmacia. Dr. J.S. Pasricha, Prof. and Ex – head of Dermatology at the All India Institute of Medical Sciences (AIIMS) has categorically stated, "Depo – preparations are used for chronic diseases and not for acute disease like TEN. Secondly, Depo preparations are not to be used twice a day".

In his deposition, Dr. Anil Gupta deposed that, he wrote to Pharmacia Upjohn, to know from them if the drug can be used in this fashion (as was done by the Kolkata doctors) in any clinical condition. In the reply sent by Dr. S.P.S. Bindra, it was stated that "our package insert on Depomedrol does not recommend the twice daily dose of injection Depomedrol 80 mg in any clinical condition". Moreover he also testified to the cause of Anuradha's death was due to Septicemia, which happened as a result of profound

immuno – suppression, caused by overuse of steroid as prescribed by Dr. Mukherjee. Further cause of death of Anuradha was lack of supportive treatment and lack of care on the part of Dr. Abani Roycoudhuri and Dr. Halder and other attending Physicians.

In his deposition Dr. Anil Shinde stated that he was working as a Manager, Medical Service with Pharmacia India Pvt. Ltd and elucidated the details of Depomedrol. He stated that the dosage should be between 40 to 120 mg once a week or once in two weeks. On questioned whether 80 mg of Depomedrol can be given twice daily, the answer was "No".

In his deposition Dr. Salil Kumar Bhattacharya stated that he was a ] Professor of Pharmacology. On being questioned whether he is aware of the Drug Depomedrol and its usage, it was answered that "it is usually used in chronic clinical condition like Bronchial Asthama and Rheumatoid Arthritus". On being questioned whether Depomedrol can be used for TEN, the answer was "No" He furthermore stated that the recommended usage is 40 to 120 mg. at intervals of at least 1 week and a daily dose of 80 mg can never be used. On the question whether 'long acting' steroids can accumulate in the body, he replied 'Yes, it can accumulate.' On being questioned, whether it is discretion of the Physician to decide the mode of

administration of any drug, he answered that the choice is "prerogative". However, he has to follow the pharmaco- therapeutic norms of the drug chosen.

SUPPORTIVE THERAPY

No symptomatic therapy was administered. No emergency care was provided. Dr. Halder himself accepted that the same was necessary. This has also been stated by Roujeau and Revuz in their book in the following terms:

> "Withdrawal of any suspect drug, avoidance of skin trauma, inserting a peripheral venous line, administration of macromolecular solution, direct the patient to burn unit or ICU."

AMRI records demonstrate how abysmal the nursing care was. We understand that there was no burn unit in AMRI and there was no burn unit at Breach Candy Hospital either. A patient of TEN is kept in ICU. All emphasis has been laid on the fact that one room was virtually made an ICU. Entry Restrictions were strictly adhered to. Hygiene was ensured.

But constant nursing and supervision was required. In the name of preventing infection, it cannot be accepted that the nurses would not keep a watch on the patient. They would also not come to see the patients or

administer drugs. No nasogastric tube was given although the condition of mouth was such that she could not have been given any solid food. She required 7 to 8 litres of water daily. It was impossible to give so much water by mouth. The doctors on the very first day found that condition of mouth was bad.

The ENT specialist in his prescription noticed blisters around the lips of the patient which led her to difficulty in swallowing or eating.

No blood sample was taken. No other routine pathological examination was carried out. It is now beyond any dispute that 25-30% body surface area was affected (re. prescription of Dr. Nandy, Plastic Surgeon)

The next day, he examined the patient and he found that more and more body surface area was affected. Even Dr. Prasad found the same.

Supportive therapy or symptomatic therapy, admittedly, was not administered as needle prick was prohibited. AMRI even did not maintain its records properly. The nurses reports clearly show that from 13th May onwards even the routine check-ups were not done.

LINE OF TREATMENT

Kunal and Anuradha came on a vacation to Calcutta on 1st April, 1998, principally to attend a wedding in the family. Anuradha supposedly, after eating some Chinese food in some restaurant, developed fever and skin rash on or about 25.4.1998. Respondent No.1, Dr. Sukumar Mukherjee, indisputably is a very reputed Physician. He was a Professor of Medicine in Calcutta Medical College. Anuradha and Kunal were advised to consult him.

Respondent No.1 examined Anuradha at her residence in the evening of 26th April, 1998. He suggested certain pathological examinations. On that date no medicine was prescribed. Two weeks thereafter i.e. on or about 7th May, 1998, Respondent No.1 was informed by Kunal Saha that Anuradha's condition had deteriorated and the skin rash and fever were back. She was taken to his chamber at 11, Shakespeare Sarani, Calcutta. Maculopropular rash, palpable penpina, enlarged neck glands were found to be present. She was diagnosed to be suffering from 'Anglo-Neurotic Oedema with allergic vasculitis'. Respondent No.1 prescribed Depomedrol stat (immediately) injection 80 mg. on a twice daily schedule(B.I.D) for 3 days to be followed by other oral steroids. One injection was given by him.

Despite the institution of Depomedrol, Anuradha's condition worsened from bad to worse in the next few days and Dr. Kunal Saha,

contacted Respondent No. 1 from time to time for advice on telephone, who, however, insisted on continuing Depomedrol in the same dose. Anuradha was said to have also examined by two Consulting Dermatologists - Dr. A.K. Ghoshal and Dr. S. Ghosh, who diagnosed disease to be a case of Vasculitis. The injection, as suggested by Respondent No.1, however, was continued to be given.

On or about 11th May, 1998 Respondent No.1 was informed by Kunal that his wife's condition had not been improving. The skin rash was persisting alongwith the fever and palpable neck glands whereafter he was recommended that Anuradha be hospitalised immediately. On the same date Anuradha was admitted in the Advanced Medicare Research Institute (AMRI) (Respondent No. 4). On being admitted she was examined by Dr. Balaram Prasad, Respondent No.5, who also continued with the injection of Depo-Medrol 80 mg.(2 ml.) I/M B.D. x 1 day.

Anuradha was examined by Respondent No.1 at 2.15 p.m. on the same date. The prescription provided for Inj. 'Depomedrol' 80 mg IM twice daily x 2 days (then 40 mg IM twice x days) among other things.

On the basis of the said advise Anuradha was examined by Consultant Dermatologist Dr. A.K. Ghoshal. Anuradha was diagnosed to be suffering from TEN. The bed ticket reads as under :-

> "Toxic Epidermal Necrolysis.
>
> Separation of large sheets of skin from back and limbs, many small/ large bulla on limbs. Dusky red areas of vasculitis almost all over the body. Mild conjunctivitis. Erosive lesions on tongue and buccal mucosali.
>
> Adv.
>
> Maintain fluid and electrolyte balance.
> Maintain maximum asepsis.
> Continue same medicines.
> Soframycin cream to apply on rash areas only
> Capsule Zevit - 1 Cap daily
> To be reviewed later."

Respondent No.3, Prof. Dr. Abani Roy Chowdhury, Consultant, as recommended by Respondent No.12 was also consulted on 12th May, 1998. It is however, stated that he did not examine the patient as he had not been contacted by the hospital. Anuradha was also examined by Respondent No.2, Dr. Baidyanath Halder, a Consultant Dermatologist of fame and author of several Books on Skin Disorders. He also diagnosed that it could be a case of TEN. He recommended treatment with Steroids like Pedmeslan and and others and the application of ointments. Dr Halder found that

Anuradha was suffering from Erithima plus blisters. However, no abnormality in the eyes or lungs was detected. He, although opined that an electrolytic balance of the patent should be maintained and steps should be taken to prevent any secondary infection, but did not prescribe any medicine or indicated the steps to be taken therefor.

Dr. Prasad referred the patient to the following Consultants.

(i) Dr. K. Nandy – a Plastic Surgeon ;

(ii) Dr. Purnima Chatterjee – a Gynecologist ;

(iii) Dr. S. Ahmed – an E.N.T. Surgeon ;

(iv) Dr. S. Bhattacherjee ; and

(v) Dr. N. Iqbal – General Surgeon.

Her condition deteriorated further. On or about 17th May, 1998 Kunal was advised to shift Anuradha to Breach Candy Hospital, Mumbai. For the aforementioned purpose Respondent No.2 issued a certificate. Three words in the said certificate, namely – "for better treatment" were said to be added. A Chartered Plane was arranged for taking Anuradha to Mumbai from Kolkata on 17th May, 2009. She was admitted in the said hospital at about

9.30 p.m. On her admission to the Breach Candy Hospital, it was recorded inter alia :-

> "Mrs. Anuradha Saha has been admitted to Breach Candy Hospital, on 17.5.98 at night - 9.30 PM. Her condition on admission is serious. She has been accompanied by her husband Dr. Saha, who has given the history of antibiotic injection for respiratory tract injection - Rovamycin, Routhromycin, Ampicillin and Ampiclox and Nemuslide followed by development of Toixc Epidermal Necrolysis. She has received T Prednisolone 120 mg/day for 7 days and also Inj. Depomedrol Im x 3 days. She has been hemodynamically stable till now. She is able to swallow liquids, which has been her only nourishment over the past few days."

She was examined by Dr. Farokh E. Udwadia at the Breach Candy Hospital in the afternoon of 18th May, 1998. His diagnosis was as under :-

> "Patient has come with a diagnosis Toxic Epidermal Necrolysis (TEN). She has had a number of drugs at Calcutta form antibiotics to non-steroid and inflammatory agents. Is there any way of distinguishing this from a Stevens & Johnson Syndrome? There is no skin left. The mucus of the mouth, genitals and area is also severely affected. And have not seen the evolution of the skin lesions to the point where there is now no skin left. So far there is no organ evolvement in particular. No pulmonary lesions nor any urinary lesions (organs commonly involved as in a Steven Johnson Syndrome). In any case the basic management is the same. I do feel that the dose of steroids used in

> Calcutta is either excessive - 120 mg. Daily for a number of days, preceded by 80 mg Depomedral Injections. I would not give more than 40 mg /day Kg. body weight."

On the same date Kunal's brother who is also a doctor practicing in U.S.A. flew to Mumbai. He brought with him a new antibiotic known as "Quinolone". There was some difference of opinion between the brother-in-law of Anuradha and Dr. Udwadia, which was noted by Dr. Udwadia. It reads as under :-

> "He was claiming of blood transfusion – insisted that his blood or the relatives or friends blood be used – no objection. But I have requested that this is done quietly. The advice was to give whole blood. My view is that 'blood' is being used to increase Hb., and it is unusually accepted that to do so one gives packed cell and not whole blood.
>
> He was also advising the use of Erthropoitin as a marrow stimulant. My view was that at the point of time Erythropeitin will make no difference to her condition. To increase her Hb., from the present and Requested packed RBC infusions.
>
> He was keen on immediately giving a tonic supplement. In my experience at this point of time, Zinc supplement was not of immediate importance that if gut was working and her external feed could be increased, she would receive sufficient tonic."

However, some differences between Kunal and his elder brother on one hand and Dr. Udwadia persisted. He noted as under :-

> "Have had great problems with the husband and brother-in-law. It is with great difficulty that I have controlled myself. When presented with his arrogance and condescends – merely and solely for the patient's sake. To keep the peace, I have compromised on the following:
>
> To allow the use of Erythropoeitin. I reasoned that though it cannot do much good, it does not do harm.
>
> To allow the use of a Zinc preparation – totally unnecessary but not likely to lead to Zinc poisoning.
>
> I would not allow parental alimentation through the same central line as fluids and electrolytes as I feel that gut if viable used at IV alimentation at this point of time may add to her hazards".

Her condition was better during 24th May and 25th May, 1998. She, however, breathed her last on 28th May, 1998.

NOSOCOMIAL INFECTIONS:

Nosocomial infections are infections which are a result of treatment in a hospital or a healthcare service unit, but secondary to the patient's original condition. Infections are considered nosocomial if they first appear 48 hours or more after hospital admission or within 30 days after discharge. Thus it

becomes the liability of the hospital to prevent such infection specially in the cases where the patient has high risk of infection due to the nature of disease suffered.

AMRI as also the other respondents say that the room was made infection free. Certain restrictions on the visitors had also been taken. It is, however, not disputed that the dressing of body surface by Dr. Kaushik Nandy started only on 13th May, 1998. What type of dressing was to be done is a matter of dispute. We may not go into the said question. But, we must notice that in Breach Candy Hospital, the dressing was done in operation theatre, firstly, on 18th May, 1998 and then on all subsequent days. No dressing was done at AMRI in operation theatre.

It is now almost accepted worldwide that the hospital is liable to prevent such infections specially in the case where the patient has high risk thereof due to the nature of the disease suffered. It also almost stands established that use of Depomedrol and other high dose of glucocorticosteroid may first lead to immunosuppression which may in turn lead to septisis.

In April, 1998, when she started suffering, she had skin rash. By the time, she came to AMRI on 11th May, 1998, 25-30% of body surface area was infected. Admittedly, by 14th May, 1998, her entire body except the skull denuded of skin. Plastic Surgeon at Breach Candy Hospital who had been doing the dressings on 19th May, 1998 stated that green tinge had appeared on the back. Such a green tinge would not occur within a day. Thus, infection was widespread. It might have been controlled to some extent at Breach Candy Hospital. In the said hospital, the entire body was put in bandage without leaving any part of the body open. It is only with a view to control such bacterial infection, the antibiotics were administered.

## C.3. FINDINGS AND ANALYSIS WITH RESPECT TO SO CALLED CLEAVAGE OF OPINION

FINDINGS ON SO CALLED CLEAVAGE OF OPINION

Appellant, thus, has placed on record the view points of experts - both of the pro-steroid and anti-steroid group. Would it amount to cleavage of opinion so as to enable the court to arrive at a safe conclusion that no negligence is proved or there was no deficiency in service? In other words, the question is as to whether the treatment of Anuradha was in accordance with the medical protocol. In our opinion, the answer must be rendered in

the negative. Those who support use and administration of steroid do so with note of caution. They in no uncertain terms state that the same should be used at a preliminary stage. Respondents do not spell out as to what would be the preliminary stage. The preliminary stage must have started with the onset of the disease. She had been suffering from skin rash from 3rd week of April, 1998. It increased with the passage of time. The cause of such eruption was not ascertained. In fact what caused the onset of disease was not known. It may be from Chinese food or it may even be from use of vitamin.

On and from 7th May, 1998, she was prescribed injection Depomedrol twice a day and Wysolone. It was continued upto 13th May, 1998, nobody even thought of stopping the injection. Dr. Halder although stopped Depomedrol injection from 13th May, 1998, but prescribed a high dose of steroid.

No doctor posed unto themselves a basic question why despite use of steroid, condition of the patient was going from bad to worse. It is agreed across the board and at least during trial, that supportive treatment should have been given. The medicine was propagated which did not exist. The medical literatures were not consulted. Even for pulse therapy Depomedrol could not have been used and only Solumedrol could have been used. Kunal

in his evidence explained the difference between the two. Dr. Mukherjee in his deposition indirectly accepted the same. Each of those pro-steroid group spoke of a single injection. Nobody suggested on the face of the voluminous medical literature and authoritative opinions of the experts that two injections daily could be prescribed by any prudent physician. A great deed of confusion was sought to be created between one kind of steroid and another. Vague questions were asked from the experts to show that steroids may be used but Dr. Pasricha stated that only a quick acting steroid should be used. Depomedrol is not a quick acting steroid.

Kunal in his evidence categorically stated so in the following terms:

> "Prednisolone can be used daily at 200 mgs for multiple sclerosis. But if instead of Prednisolone, Depomedrol which is Methyl Prednisolone Acetate is used to this patient he or she is likely to die. Depomedrol is not Prednisolone. And majority of the dermatologists in the West do not do not use any steroid whatsoever on TEN patients." "However there is no controversy even among the "Pro-steroid" dermatologists that once more than 20% of the BSA is affected no steroid should be used as it would only enhance the chance of development of septicemia and death."

ANALYSIS

The High Court as also the Commission principally proceeded on the premise that the respondents herein are not liable either for any act of criminal misconduct or negligence because of cleavage of opinion. The cleavage of opinion, if any, as we have noticed hereinbefore, is between pro-steroid group and anti-steroid group. Accepted treatment protocol so far as the pro-steroid group is concerned has also been noticed by us. We have proceeded to determine the question of negligence on the part of the respondents herein principally on the premise that even if the opinion of the pro-steroid group is followed, the respondents have failed and/or neglected to even act strictly in terms of the treatment protocol laid down by them. The opinion of the anti-steroid group appears to be more scientific and structured but the same by itself, we are conscious of the fact, would not lead us to the conclusion that the respondents are guilty of gross negligence.

We may, however, notice that Mr. Fitz Patrick in his book Dermatology in General Medicine (5th Edition), inter alia, opined as under:-

> "Treatment:
>
> 2. According to our view, agreement should be used on following for the treatment of TEN:
>
>    a. Treatment in burn units should be strived for in exceptional cases but is not generally necessary.

b. Treatment has to be individually tailored according to cause type and stage and presence and type of complications.

c. Systemic glucocorticoids should not be used routinely but are justified in the early stages of drug induced TEN. They should be given in doses from 80 to 120 mg of methlypredisolone per day by mouth, for several days until disease progression has ceased. Dosages should be tapered quickly and cautiously since no further benefit can be expected thereafter and the untoward effects may then predominate.

d. Treatment may focus on early detection and prevention of the most fatal complication e.g. overwhelming infection. Cultures from skin and mucosal erosions, must be regularly performed.

e. Blood gases and fluid, electrolytes and protein balance must be monitored and adjusted appropriately. Fluid replacement regimens as used for burn patients.

f. Supportive care is of great importance and particular attention must be paid to a high calorie and high – protein diet.

g. Debridgement of necrotic skin should not performed before disease activity ceases.

**3.** Course and Prognosis: The following factors appear to be unfavourable prognostic signs: old age, extensive skin lesions, nuetropenia, impaired renal function and intake of multiple drugs. Septesemia, gastrointestinal hemorrhage, pnuemoina and fluid and electrolyte imbalance leading to

> renalinsufficiency are major complications leading to death."

As noticed hereinbefore, precautions as also the course of actions suggested by the authors have not been undertaken by the respondents. It is to be noted that the learned authors' expertise in the field is neither in doubt nor in dispute, particularly when both parties have extensively relied thereupon. Even the suspected offending drug was not withdrawn at later stages. This drug is considered to be a real risk for the patient suffering from TEN. The medicine has also been administered having regard to the physical condition of the patient. They were required to be given only as a part of the total program. We may also place on record that there has been a cleavage of opinion in regard to mortality rate. Whereas according to the one group of experts in TEN patients when properly treated and in particular given supportive treatment, the mortality rate is 0-10%' the respondents contend that that in fact the mortality rate is quite high being 30-70%.

We would assume that the mortality rate is very high. If that be so, we feel that the doctors should have been more careful. They should have treated the patient upon exercise of more care and caution. For the said purpose, if they had not been able to diagnose the disease properly or identify the proper drug they would have undertaken some research. It is

clear that they did not have any expertise in the field and therefore they ought not to have behaved as experts

We are, therefore, of the opinion that the universally accepted medicated treatment protocol had also not been followed.

It is also to be noted at this juncture, that there may well be a difference of opinion on the course of action to be adopted while treating a patient of TEN, but the treatment line followed by Dr. Mukherjee which entailed administration of 80 mg of Depomedrol injection twice is not supported by any school of thought. The treatment line, in this case, does not flow from any considered affinity to a particular school of thought, but out of sheer ignorance of basic hazards relating to use of steroids as also lack of judgment.

**C.4. BURDEN OF PROOF**

Kunal had not only obtained opinion of a large number of experts, he examined some of the including Dr. Anil Shinde P.W. 9,; Dr. Udwadia (P.W.10) and, Dr. Salil Kumar Bhattacharyya, P.W. 11.

Respondents did not examine any expert. They, however, relied upon some authorities to which we have referred to heretobefore. The onus of proof, therefore, on a situation of this nature shifted to the respondents.

While we say so we must place on record that we are not oblivious of the fact that the principle of res ipsa loquitur may not be strictly applicable in a criminal case, although certain authorities suggest application of the said principle.

In Spring Meadows Hospital v. Harjol Ahluwalia, [(1998) 4 SCC 39], this Court has held as under :-

> **"10.** Gross medical mistake will always result in a finding of negligence. Use of wrong drug or wrong gas during the course of anaesthetic will frequently lead to the imposition of liability and in some situations even the principle of res ipsa loquitur can be applied. Even delegation of responsibility to another may amount to negligence in certain circumstances. A consultant could be negligent where he delegates the responsibility to his junior with the knowledge that the junior was incapable of performing of his duties properly."

However, in Rattan Singh ***v.*** State of Punjab**,** [(1979) 4 SCC 719}**,** this Court has held :-

> "3**.** This, however, does not excuse the accused from his rash driving of a "blind Leviathan in berserk locomotion". If we may adapt the words of Lord Greene, M.R. : "It scarcely lies in the mouth of the truck driver who plays with fire to complain of burnt fingers". Rashness and negligence are relative concepts, not absolute abstractions. In our current conditions, the law under Section 304-A IPC and under the rubric of Negligence, must have due regard to the fatal

> frequency of rash driving of heavy duty vehicles and of speeding menaces. Thus viewed, it is fair to apply the rule of res ipsa loquitur, of course, with care. Conventional defences, except under compelling evidence, must break down before the pragmatic Court and must be given short shrift. Looked at from this angle, we are convinced that the present case deserves no consideration on the question of conviction."

In B. Nagabhushanam v. State of Karnataka, [(2008) 5 SCC 730],this Court held as under :-

> **"**12. Reliance placed by Mr Kulkarni on Syad Akbar v. State of Karnataka[1] is not apposite. It proceeded on the basis that res ipsa loquitur stricto sensu would not apply to a criminal case as its applicability in an action for injury by negligence is well known. In Syad Akbar this Court opined: (SCC p. 41, para 30):
>
> > "30. Such simplified and pragmatic application of the notion of res ipsa loquitur, as a part of the general mode of inferring a fact in issue from another circumstantial fact, is subject to all the principles, the satisfaction of which is essential before an accused can be convicted on the basis of circumstantial evidence alone. These are: Firstly, all the circumstances, including the objective circumstances constituting the accident, from which the inference of guilt is to be drawn, must be firmly established. Secondly, those circumstances must be of a determinative tendency pointing unerringly towards the guilt of the accused. Thirdly, the circumstances should make a chain so complete that they cannot reasonably raise

> any other hypothesis save that of the accused's guilt. That is to say, they should be incompatible with his innocence, and inferentially exclude all reasonable doubt about his guilt."

There cannot, however, be any doubt whatsoever that in the civil appeal the said principle is applicable. It has clearly been held by this Court that the onus of proof would shift on the respondents.

In Nizam Institute of Medical Sciences v. Prasanth S. Dhananka and others, [2009 (7) SCALE 407] this Court held as under :-

> "32. We are also cognizant of the fact that in a case involving medical negligence, once the initial burden has been discharged by the complainant by making out a case of negligence on the part of the hospital or the doctor concerned, the onus then shifts on to the hospital or to the attending doctors and it is for the hospital to satisfy the Court that there was no lack of care or diligence. In Savita Garg (Smt.) v. Director, National Heart Institute it has been observed as under:
>
> > Once an allegation is made that the patient was admitted in a particular hospital and evidence is produced to satisfy that he died because of lack of proper care and negligence, then the burden lies on the hospital to justify that there was no negligence on the part of the treating doctor or hospital. Therefore, in any case, the hospital is in a better position to disclose what care was taken or what medicine was

> administered to the patient. It is the duty of the hospital to satisfy that there was no lack of care or diligence. The hospitals are institutions, people expect better and efficient service, if the hospital fails to discharge their duties through their doctors, being employed on job basis or employed on contract basis, it is the hospital which has to justify and not impleading a particular doctor will not absolve the hospital of its responsibilities."

## C.5. CONTRIBUTORY NEGLIGENCE

The High Court as also the Commission opined that the death of Anuradha took place not because of any negligence on the part of the doctors of AMRI but by reason of interference by Kunal Saha. It was on the insistence of Kuanl Saha that the patient was transferred to Bombay. It has been submitted that it was the infection which developed during transportation which ultimately proved fatal.

Interference by Kunal at AMRI was sought to be proved through Sutapa Chanda, Nursing Superintendant at AMRI, who appeared as DW-1. However, the statement of the said Nursing Superintendent in regard to the alleged interference by Kunal is not borne out from the record. As a matter of fact she had not been able to explain the medicines which were to be administered to her stating**:-**

> "Q.38 (Ld. complainant counsel sows the witness Exbt. 8). What do you understand by this line "Fusys 200 mg. / weekly once"; - 3rd line from the end?
>
> Ans. Regarding this question I like to say all instructions for mediction in Exbt. 8 were carried out by Dr. Kunal Saha but not by my nurses. If I can not understand this instruction I would have made queries and doctor would clear it. But I had no such chance to make queries regarding this."

It is to be noted here that Nursing Superintendent being a professional cannot take this plea. Moreover, the same is not borne out of records at AMRI. Even if we assume this statement to be true, in a professional setting of this nature, these interferences should have been resisted by them. Interference cannot be taken to be an excuse for abdicating one's responsibility especially when an interference could also have been in the nature of suggestion.

Same comments were said to have been made by Dr. Halder while making his statement under Section 313 of the Code of Criminal Procedure. They are admissible in evidence for the said purpose. Similarly the statements made by Dr. Mukherjee and Dr. Halder in their written statements before the National Commission are not backed by any evidence on record. Even otherwise, keeping in view the specific defence raised by

them individually, interference by Kunal, so far as they are concerned, would amount to hearsay evidence and not direct evidence.

Dr. K. Nandy in his evidence stated that he was not allowed to change the dressings on 15th May and 16th May, 1998. However, according to him, he forced his decision to do the dressing on 17th May, 1998 before she was taken away from the hospital.

However, it appears from the AMRI records that the name of Kunal only appears once i.e. when he got Anuradha admitted in the hospital. His name is not borne out from any other record. So far as the statement of Dr. Nandy is concerned, Kunal's explanation is that he did not follow the medical protocol in the matter of dressing. This may or may not be correct.

We may notice that whenever any interference in contrast to the AMRI was attempted to be made by the patient party at Breach Candy Hospital, it had scrupulously been placed on record. Wherever "Dr. Saha" appears in the record, it is evident that the same refers to the elder brother of Kunal, who is a surgeon. However, when there is any discussion with both the brothers, like in the case of Dr. Udwadia, it had been recorded 'both of them'.

It is accepted that the elder brother of Kunal came to Mumbai on 17th May, 1998 itself. He brought with him a new antibiotic named "Quinolone" which was not available in India. He persuaded Dr. Udwadia to administer the said injection. This discussion between them has also been recorded. Some adverse remarks have also been recorded with regard to the conduct of Dr. Saha. Dr. Udwadia has noticed in the records of the Breach Candy Hospital that he tolerated the said conduct on the part of the elder brother of Kunal solely for the patient's sake.

Though some of the suggestions of Dr. Saha did not seem particularly useful to Dr. Udwadia, but those measures which were not harmful to the patient were administered. We, however, may also notice that where Dr. Udwadia thought that there could be some harm to the patient, he did not agree thereto. He, therefore, acted in a professional manner.

We may also place on record that despite such elaborate and careful treatment meted out to Anuradha, her condition had been worsening; Dr. Udwadia even agreed to administer the injection "Quinolone" during her last day as he might have thought that there was no harm in trying the same at that juncture.

Respondents also sought to highlight on the number of antibiotics which are said to have been administered by Kunal to Anuradha while she

was in AMRI contending that the said antibiotics were necessary. Kunal, however, submitted that the said antibiotics were prescribed by the doctors at AMRI and he did not write any prescription. We would, however, assume that the said antibiotics had been administered by Kunal on his own, but it now stands admitted that administration of such antibiotics was necessary.

To conclude, it will be pertinent to note that even if we agree that there was interference by Kunal Saha during the treatment, it in no way diminishes the primary responsibility and default in duty on part of the defendants. In spite of a possibility of him playing an over-anxious role during the medical proceedings, the breach of duty to take basic standard of medical care on the part of defendants is not diluted. To that extent, contributory negligence is not pertinent. It may, however, have some role to play for the purpose of damages.

**C.6. NON-JOINDER OF NECESSARY PARTIES**

Respondents contend that Dr. Kunal had been selective in prosecuting three principal doctors on the criminal side who allegedly treated Anuradha but some more before the Commission. Contending that no reason has been assigned as to why case against Dr. A.K. Ghoshal as also Breach Candy Hospital and doctors treating Anuradha at Bombay from 17th May, 1998 till

28th May, 1998 had been given up, the learned counsel urged that these appeals should be dismissed on that ground alone.

We are afraid that the aforementioned submission cannot be accepted in view of the decision of this Court in Smt. Savita Garg (supra), wherein it has been held:

> " So far as the law with regard to the non-joinder of necessary party under Code of Civil Procedure, Order 1 Rule 9 and Order 1 Rule 10 of the CPC there also even no suit shall fail because of mis-joinder or non-joinder of parties. It can proceed against the persons who are parties before the Court. Even the Court has the power under Order 1 Rule 10(4) to give direction to implead a person who is a necessary party. Therefore, even if after the direction given by the Commission the concerned doctor and the nursing staff who were looking after the deceased A.K. Garg have not been impleaded as opposite parties it can not result in dismissal of the original petition as a whole."

An argument has also been advanced that Anuradha was treated by as many as 16 doctors and, thus, there was no reason as to why only the respondents should have been proceeded against. Proceeding should be initiated both under the criminal law as also the tort law only against those who are specifically found to be guilty of criminal misconduct or medical negligence or deficiency in service and not against all. Apart from making a

general submission, it has not been pointed out as to what difference would have been made if others were also impleaded as parties. The medical records were before the court. The hospital records of both AMRI and Breach Candy were also before it. AMRI records contained 22 pages, records of Breach Candy runs into more than 400 pages. No party had relied on any evidence other than those records as also the oral evidence and documentary evidence brought on record by them. Respondents have also not pointed out as to how treatment by any other doctor has contributed in any manner to the death of Anuradha.

Submissions have also been made at the bar that Kunal issued notices to a large number of persons but withdrew the cases against most of them. It was placed before us that in the first notice there were as many as 26 addresses and in the complaint filed before the National Commission, there were 19 addresses. Withdrawal of cases against some of them, in our opinion, is not of much significance. The Directors of AMRI were impleaded as parties. Cases against them had also been withdrawn and, in our opinion, rightly so as most of them were liable in their personal capacity. Dr. Kunal says that the proceeding against Breach Candy Hospital and doctors treating Anuradha had been withdrawn as the principal grievance against the hospital was that they did not have any burn ward although he

was already informed thereabout. Burn ward was also not there in AMRI. In fact, it was brought on record that no nursing home in Calcutta has a separate burn ward. Absence of burn ward by itself, thus, might not be a contributory factor although existence thereof was highly desirable keeping in view the treatment protocol.

We must bear in mind that negligence is attributed when existing facilities are not availed of. Medical negligence cannot be attributed for not rendering a facility which was not available. In our opinion, if hospitals knowingly fail to provide some amenities that are fundamental for the patients, it would certainly amount to medical malpractice. As it has been held in Smt. Savita Garg (supra), that a hospital not having basic facilities like oxygen cylinders would not be excusable. Therein this Court has opined that even the so-called humanitarian approach of the hospital authorities in no way can be considered to be a factor in denying the compensation for mental agony suffered by the parents. The aforementioned principle applies to this case also in so far as it answers the contentions raised before us that the three senior doctors did not charge any professional fees.

In any event, keeping in view of the said decision, we are of the firm opinion that notices to a large number of persons and withdrawal of cases

against some of them by itself cannot be considered to be a relevant factor for dismissal of these appeals.

## D. CIVIL LIABILITY UNDER TORT LAW AS ALSO UNDER CONSUMER PROTECTION ACT

In this case, we are concerned with the extent of negligence on the part of the doctors, if any, for the purpose of attracting rigours of Section 304A of the Indian Penal Code as also for attracting the liability to pay compensation to the appellant in terms of the provisions of the Consumer Protection Act, 1986. We intend to deal with these questions separately.

It is noteworthy that standard of proof as also culpability requirements under Section 304 –A of Indian Penal Code stands on an altogether different footing. On comparison of the provisions of Penal Code with the thresholds under the Tort Law or the Consumer Protection Act, a foundational principle that the attributes of care and negligence are not similar under Civil and Criminal branches of Medical Negligence law is borne out. An act which may constitute negligence or even rashness under torts may not amount to same under section 304 – A.

Bearing this in mind, we further elaborate on both the questions separately.

## D.1. LAW OF NEGLIGENCE UNDER TORT LAW

Negligence is the breach of a duty caused by the omission to do something which a reasonable man, guided by those considerations which ordinarily regulate the conduct of human affairs would do, or doing something which a prudent and reasonable man would not do. [See Law of Torts, Ratanlal & Dhirajlal Twenty-fourth Edition 2002, at p.441-442]

Negligence means "either subjectively a careless state of mind, or objectively careless conduct. It is not an absolute term but is a relative one; is rather a comparative term. In determining whether negligence exist in a particular case, all the attending and surrounding facts and circumstance have to be taken into account." [See Municipal Corpn. Of Greater Bombay v. Laxman Iyer, (2003) 8 SCC 731, para 6; Adavanced Law Lexicon, P Ramanatha Aiyar, 3rd ed. 2005, p. 3161]

Negligence is strictly nonfeasance and not malfeasance. It is the omission to do what the law requires, or the failure to do anything in a manner prescribed by law. It is the act which can be treated as negligence without any proof as to the surrounding circumstances, because it is in violation of statute or ordinance or is contrary to the dictates of ordinary prudence.

In Bolam v. Friern Hospital Management Committee, [(1957) 2 All ER 118], the law was stated thus:

> "Where you get a situation which involves the use of some special skill or competence, then the test…..is the standard of 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….
>
> [A doctor] is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art….Putting it the other way round, a [doctor] is not negligent, if he [has acted] in accordance with such a practice, merely because there is a body of opinion which [takes] a contrary view."

It has been laid down that an ordinary skilled professional standard of care for determining the liability of medical professional should be followed. (See Maynard v. West Midland Regional Health, Authority, [(1985) 1 All ER 635 (HL)])

Recently in Martin F.D' Souza v. Mohd. Ishfaq, [ (2009) 3 SCC 1], this Court laid down the precautions which doctors/hospitals etc. should have taken, in the following terms :-

> "(a) Current practices, infrastructure, paramedical and other staff, hygiene and sterility should be observed strictly….
>
> (b) No prescription should ordinarily be given without actual examination. The tendency to give prescription over the telephone, except in an acute emergency, should be avoided.
>
> (c) A doctor should not merely go by the version of the patient regarding his symptoms, but should also make his own analysis including tests and investigations where necessary.
>
> (d) A doctor should not experiment unless necessary and even then he should ordinarily get a written consent from the patient.
>
> (e) An expert should be consulted in case of any doubt…."

In fact, the Bolam case in common laws jurisdictions is weakened in recent years by reasons of series of decisions in Australia [Rogers v. Whitaker: (1992) 109 Aus LR 625 and Roenbreg v. Percival 2001 HCA 18]; Canada [Ribl v. Hughes: (1980) 114 DLR 3d 1] and the United States and even in the United Kingdom.

We may refer to Bolitho v. City and Hackney Health Authority, [(1997) 4 All ER 771 (HL)], where the Court got away from yet another aspect of Bolam case. It was observed :-

> " The court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of opinion that the defendant's treatment or diagnosis accorded with sound medical practice. The use of these adjectives – responsible, reasonable and respectable – all show that the court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis. In particular in cases involving, as they so often do, the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable and respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter."

In this regard it would be imperative to notice the views rendered in Jacob Mathew v. State of Punjab, [(2005) 6 SCC 1, where the court came to the conclusions:

(i) Mere deviation from normal professional practice is not necessarily evidence of negligence.

(ii) Mere accident is not evidence of negligence

**(iii)** An error of judgment on the part of a professional is not 7negligence per se.

(iv) Simply because a patient has not favourably responded to a treatment given by a physician or a surgery has failed, the doctor cannot be held liable per se by applying the doctrine of res ipsa loquitor.

RIGHT OF THE PATIENT TO BE INFORMED

The patients by and large are ignorant about the disease or side or adverse affect of a medicine. Ordinarily the patients are to be informed about the admitted risk, if any. If some medicine has some adverse affect or some reaction is anticipated, he should be informed thereabout. It was not done in the instant case.

In Sidaway v. Board of Governors of Bethlem Royal Hospital and the Maudsley Hospital, [ [1985] All ER 643 ], the House of Lords, inter alia held as under :-

> "The decision what degree of disclosure of risks is best calculated to assist a particular patient to make a rational choice as to whether or not to undergo a particular treatment must primarily be a matter of clinical judgment.
>
> An issue whether non-disclosure of a particular risk or cluster of risks in a particular case should be condemned as a breach of the doctor's duty of care is an issue to be decided primarily on the basis of expert medical evidence. In the event of a conflict of evidence the judge will have to

> decide whether a responsible body of medical opinion would have approved of non-disclosure in the case before him.
>
> A judge might in certain circumstances come to the conclusion that disclosure of a particular risk was so obviously necessary to an informed choice on the part of the patient that no reasonably prudent medical man would fail to make it, even in a case where no expert witness in the relevant medical field condemned the non-disclosure as being in conflict with accepted and responsible medical practice."

The law on medical negligence also has to keep up with the advances in the medical science as to treatment as also diagnostics. Doctors increasingly must engage with patients during treatments especially when the line of treatment is a contested one and hazards are involved. Standard of care in such cases will involve the duty to disclose to patients about the risks of serious side effects or about alternative treatments. In the times to come, litigation may be based on the theory of lack of informed consent. A significant number of jurisdictions, however, determine the existence and scope of the doctor's duty to inform based on the information a reasonable patient would find material in deciding whether or not to undergo the proposed therapy. [See Canterbury v. Spence, 464 F.2d 772 (D.C. Cir. 1972), cert. denied, 409 U.S. 1064 (19r72); see also Cobbs v. Grant, 8 Cal. 3d 229, 104 Cal. Rptr. 505, 502 P.2d 1 (1972); Hamiltorn v. Hardy, 37 Colo.

App. 375, 549 P.2d 1099 (1976)]. In this respect, the only reasonable guarantee of a patient's right of bodily integrity and self-determination is for courts to apply a stringent standard of disclosure in conjunction with a presumption of proximate cause. At the same time, a reasonable measure of autonomy for the doctor is also pertinent to be safeguarded from unnecessary interference.

**D.2. TRANSPORTATION**

So far as transportation of Anuradha from Kolkata to Mumbai is concerned, we must place on record that a certificate in that behalf was given by Dr. Baidyanath Halder correctness whereof, except for the words "for better treatment" is not in dispute. Dr. Halder does not contend that the contents of the same are wrong. He merely says that the same was issued at the instance of the patient. The submission of Dr. Halder that he had issued the certificate without seeing the patient cannot be believed. If that be so, such a certificate could have been issued by Dr. Balram Prasad and/or any other doctor. Why he had taken the burden of issuing such a certificate is not explained.

We are of the opinion that a conclusion as to whether the words "for better treatment" have been inserted in the said certificate or not or the same

was done at the instance of Kunal, is wholly unnecessary for our purpose. The only question which arises is as to whether there was any risk of Anuradha developing infection due to exposure during transportation. She was flown to Mumbai by an exclusive chartered flight (air ambulance) of East-West Rescue of Delhi. Kunal had to pay about $ 2000 for the said purpose. Respondents did not suggest that the service provided by the said airlines was of inferior character or sufficient precautions were not taken during transportation. In fact, the condition of Anuradha was so critical that there was no other option but to take her to a better hospital. Her transportation to Mumbai was necessary and was not an act borne out of desperation alone.

We may notice that even a couple of Kunal's friends, who were doctors, came to Mumbai by Jet Airways flight.

It appears that East West Rescue of Delhi, which provided air ambulance, must have taken all necessary precautions. Although lot of literature on the subject relating to the services of the said airlines showing that it is considered to be one of best in the world is available, we refrain from dealing with the same, as it is not necessary.

Dr. Udwadia made a comment that transportation of Anuradha from Kolkata to Mumbai may have exposed her to infection. He, however, added

a proviso thereto – unless better care was taken. There was no reason as to why the proper care was not taken, particularly seeing her condition. There is no evidence on record leading to an opposite conclusion. Dr. Nandy, stated dressing was necessary before transportation. He must have done so keeping in view the necessity of prevention of further infection during flight. At Bombay, Dr. Kulkarni noticed a green patch showing old infection. It must have escaped the notice of even Dr. Nandy. Dr. Kulkarni noticing the same, observed that the patient's condition was worse than he anticipated.

**D.3. LEGITIMATE EXPECTATION**

Kunal approached the best doctors available. He admitted his wife at AMRI on the recommendation of Dr. Mukherjee, evidently, expecting the best possible treatment from the renowned doctors and a renowned hospital. It was not too much for a patient to expect the best treatment from the doctors of the stature of Dr. Mukherjee, Dr. Halder and Dr. Abani Roy Chowdhury. Services of other experts in fields were requisitioned by the Hospital. References were made and the Hospital on the basis of the recommendations made by the doctors themselves consulted the best doctors in their respective fields. Kunal or Anuradha or his relatives never interfered therewith. They did not call any doctor of their choice to the Hospital. In fact, after Dr. A.K. Ghoshal came to know that Anuradha was suffering from

TEN, he suggested a line of treatment which was not adhered to keeping in view the fact that Dr. Halder and hospital authorities were in charge of the case.

The standard of duty to care in medical services may also be inferred after factoring in the position and stature of the doctors concerned as also the hospital; the premium stature of services available to the patient certainly raises a legitimate expectation. We are not oblivious that the source of the said doctrine is in administrative law. A little expansion of the said doctrine having regard to an implied nature of service which is to be rendered, in our opinion, would not be quite out of place.

AMRI makes a representation that it is one of the best hospitals in Calcutta and provides very good medical care to its patients. In fact the learned Senior Counsel appearing on behalf of the respondents, when confronted with the question in regard to maintenance of the nurses register, urged that it is not expected that in AMRI regular daily medical check-up would not have been conducted. We thought so, but the records suggest otherwise. The deficiency in service emanates therefrom. Even in the matter of determining the deficiency in medical service, it is now well-settled that if representation is made by a doctor that he is a specialist and

ultimately it turns out that he is not, deficiency in medical services would be presumed.

We may notice some of the decisions in this behalf.

In Smt. Savita Garg v. The Director, National Heart Institute [2004 (8) SCALE 694 : (2004) 8 SCC 56], this Court opined:

> "It is the common experience that when a patient goes to a private clinic, he goes by the reputation of the clinic and with the hope that proper care will be taken by the Hospital authorities. It is not possible for the patient to know that which doctor will treat him. When a patient is admitted to a private clinic/ hospital it is hospital/ clinic which engages the doctors for treatment. …They charge fee for the services rendered by them and they are supposed to bestow the best care."

**D.4. INDIVIDUAL LIABILITY OF THE DOCTORS**

There cannot be, however, by any doubt or dispute that for establishing medical negligence or deficiency in service, the courts would determine the following:

(i) No guarantee is given by any doctor or surgeon that the patient would be cured.

(ii) The doctor, however, must undertake a fair, reasonable and competent degree of skill, which may not be the highest skill.

(iii) Adoption of one of the modes of treatment, if there are many, and treating the patient with due care and caution would not constitute any negligence.

(iv) Failure to act in accordance with the standard, reasonable, competent medical means at the time would not constitute a negligence. However, a medical practitioner must exercise the reasonable degree of care and skill and knowledge which he possesses. Failure to use due skill in diagnosis with the result that wrong treatment is given would be negligence.

(v) In a complicated case, the court would be slow in contributing negligence on the part of the doctor, if he is performing his duties to be best of his ability.

Bearing in mind the aforementioned principles, the individual liability of the doctors and hospital must be judged.

We enumerate heretobelow the duty of care which ought to have been taken and the deficiency whereof is being complained of in the criminal case

and the civil case, respectively, so far as respondent Nos. 1 to 3 are concerned.

When Dr. Mukherjee examined Anuradha, she had rashes all over her body and this being the case of dermatology, he should have referred her to a dermatologist. Instead, he prescribed "Depomedrol" for the next 3 days on his assumption that it was a case of "vasculitis". The dosage of 120 mg Depomedrol per day is certainly a higher dose in case of a TEN Patient or for that matter any patient suffering from any other bypass of skin disease and the maximum recommended usage by the drug manufacturer has also been exceeded by Dr. Mukherjee. On 11th May, 1998, the further prescription of Depomedrol without diagnosing the nature of the disease is a wrongful act on his part.

According to general practice, long acting steroids are not advisable in any clinical condition, as noticed hereinbefore. However, instead of prescribing to a quick acting steroid, the prescription of a long acting steroid without foreseeing its implications is certainly an act of negligence on his part without exercising any care or caution. As it has been already stated by the Experts who were cross examined and the authorities that have been submitted that the usage of 80-120 mg is not permissible in TEN.

Furthermore, after prescribing a steroid, the effect of immunosuppression caused due to it, ought to have been foreseen. The effect of immunosuppression caused due to the use of steroids has affected the immunity of the patient and Dr. Mukherjee has failed to take note of the said consequences.

After taking over the treatment of the patient and detecting TEN, Dr. Halder ought to have necessarily verified the previous prescription that has been given to the patient. On 12th May, 1998 although 'depomedrol' was stopped, Dr. Halder did not take any remedial measures against the excessive amount of 'depomedrol' that was already stuck in the patient's body and added more fuel to the fire by prescribing a quick acting steroid 'Prednisolone' at 40mg three times daily, which is an excessive dose, considering the fact that a huge amount of "Depomedrol" has been already accumulated in the body.

Life saving 'supportive therapy' including IV fluids/ electrolyte replacement, dressing of skin wounds and close monitoring of infection is mandatory for proper care of TEN patients. Skin(wound) swap and blood tests also ought to be performed regularly to detect the degree of infection. Apart from using the steroids, aggressive supportive therapy that is considered to be rudimentary for TEN patients was not provided by Dr.

Halder. Further 'vital-signs' of a patient such as temperature, pulse, intake-output and blood pressure were not monitored. All these factors are considered to be the very basic necessary amenities to be provided to any patient, who is critically ill. The failure of Dr. Halder to ensure that these factors are monitored regularly is certainly an act of negligence.

Occlusive dressing were carried as a result of which the infection had been increased. Dr Halder's prescription was against the Canadian treatment protocol reference to which we have already made herein before.

It is the duty of the doctors to prevent further spreading of infections. How that is to be done is the doctors concern. Hospitals or nursing homes where a patient is taken for better treatment should not be a place for getting infection.

After coming to know that the patient is suffering from TEN, Dr. Abani Roy Chowdhury ought to have ensured that supportive therapy had been given. He had treated the patient along with Dr. Halder and failed to provide any supportive therapy or advise for providing IV fluids or other supplements that is a necessity for the patient who was critically ill.

As regards, individual liability of the respondent Nos 4, 5 and 6 is concerned, we may notice the same hereunder.

As regards AMRI, it may be noticed:

(i) Vital parameters of Anuradha were not examined between 11.05.1998 to 16.05.1998 (Body Temperature, Respiration Rate, pulse, BP and urine input and output)

(ii) I.V. Fuid not administered. (I.V. fluid administration is absolutely necessary in the first 48 hours of treating TEN)

As regards, Dr. Balaram Prasad, Respondent No. 5, it may be noticed:

(i) Most Doctors refrain from using steroids at the later stage of the disease – due to the fear of Sepsis, yet he added more steroids in the form of quick – acting "Prednisolone" at 40g three times a day.

(ii) He stood as second fiddle to the treatment and failed to apply his own mind.

(iii) No doctor has the right to use the drug beyond the maximum recommended dose.

So far as the judgment of the Commission is concerned, it was clearly wrong in opining that there was no negligence on the part of the hospital or the doctors. We are, however, of the opinion, keeping in view the fact that Dr. Kaushik Nandy has done whatever was possible to be done and his line of treatment meets with the treatment protocol of one of the experts, viz. Prof. Jean Claude Roujeau although there may be otherwise difference of opinion, that he cannot be held to be guilty of negligence.

**D.5. CONCLUSION**

We remit the case back to the Commission only for the purpose of determination of quantum of compensation.

The principles of determining compensation are well-known. We may place on record a few of them.

In Oriental Insurance Company Limited v. Jashuben and Others [(2008) 4 SCC 162], this Court held:

> "28. We, therefore, are of the opinion that what would have been the income of the deceased on the date of retirement was not a relevant factor in the light of peculiar facts of this case and, thus, the approach of the Tribunal and the High Court must be held to be incorrect. It is impermissible in law to take into consideration the effect of revision in scale of pay w.e.f. 1.1.1997 or what would have been the scale of pay in 2002.

> 29. The loss of dependency, in our opinion, should be calculated on the basis as if the basic pay of the deceased been Rs. 3295/- X 2 = Rs. 6,590/-, thereto should be added 18.5% dearness allowance which comes to Rs. 1219/-, child education allowance for two children @ Rs. 240/- X 2 = Rs. 480 and child bus fair Rs. 160 X 2 = Rs. 320/- should have been added which comes to Rs. 8,609/-.
>
> 30. From the aforementioned figure 1/3rd should be deducted. After deduction, the amount of income comes to Rs. 5,738/- per month [Rs. 8609/- - Rs. 2871/-] and the amount of compensation should be determined by adopting the multiplier of 13, which comes to Rs. 8,95,128/-
>
> 31. In the present case, the High Court itself has applied the multiplier of 13. We are of the opinion that no interference therewith is warranted. We furthermore do not intend to interfere with the rate of interest in the facts and circumstance of the case."

Indisputably, grant of compensation involving an accident is within the realm of law of torts. It is based on the principle of *restitution in integrum.* The said principle provides that a person entitled to damages should, as nearly as possible, get that sum of money which would put him in the same position as he would have been if he had not sustained the wrong. [See Livingstone v. Rawyards Coal Co. [ (1880) 5 AC 25 ].

When a death occurs the loss accruing to the dependent must be taken into account; the balance of loss and gain to him must be ascertained ; the position of each dependent in each case may have to be considered separately [ See Davis v. Powell Duffrya Associated Collieries Ltd. [ (1942) AC 601 ]. The said principle has been applied by this Court in Gobald Motor Service Ltd., Allahabad v. R.M.K. Veluswami, [AIR 1962 SC 1 ].

Loss of wife to a husband may always be truly compensated by way of mandatory compensation. How one would do it has been baffling the court for a long time. For compensating a husband for loss of his wife, therefore, courts consider the loss of income to the family. It may not be difficult to do when she had been earning. Even otherwise a wife's contribution to the family in terms of money can always be worked out. Every housewife makes contribution to his family. It is capable of being measured on monetary terms although emotional aspect of it cannot be. It depends upon her educational qualification, her own upbringing, status, husband's income, etc.

This Court, we may notice, has laid down certain norms for grant of compensation for the death of members of family including the loss of child

in some of its decisions. [See Lata Wadhwa v. State of Bihar (2001) 8 SCC 197 and R.K. Malik and Anr. v. Kiran Pal & Ors. 2009 (8) SCALE 451]

In R.D. Hattangadi v. Pest Control (India) (P) Ltd. [AIR 1995 SC 755], this Court observed:

> "Broadly speaking while fixing an amount of compensation payable to a victim of an accident, the damages have to be assessed separately as pecuniary damages and special damages. Pecuniary damages are those which the victim has actually incurred and which are capable of being calculated in terms of money; whereas non-pecuniary damages are those which are incapable of being assessed by arithmetical calculations. In order to appreciate two concepts pecuniary damages may include expenses incurred by the claimant: (i) medical attendance; (ii) loss of earning of profit up to the date of trial; (iii) other material loss. So far non-pecuniary damages are concerned, they may include (i) damages for mental and physical shock, pain and suffering, already suffered or likely to be suffered in future; (ii) damages to compensate for the loss of amenities of life which may include a variety of matters i.e. on account of injury the claimant may not be able to walk, run or sit; (iii) damages for the loss of expectation of life, i.e., on account of injury the normal longevity of the person concerned is shortened; (iv) inconvenience, hardship, discomfort, disappointment, frustration and mental stress in life."

The Commission must, therefore, while arriving at the adequate compensation bear in mind all these relevant facts and circumstances.

## E. ASSESSING CRIMINAL CULPABILITY UNDER SECTION 304-A

### E.1. CRIMINAL NEGLIGENCE UNDER SECTION 304-A

Criminal Medical Negligence is governed by Section 304A of the Indian Penal Code. Section 304-A of the Indian Penal Code reads as under:-

> "304-A. Causing death by negligence.- Whoever causes the death of any person by doing any rash or negligent act not amounting to culpable homicide, shall be punished with imprisonment of either description for a term which may extend to two years, or with fine, or with both."

Essential ingredients of Section 304-A are as under:-

(i) Death of a person

(ii) Death was caused by accused during any rash or negligence act.

(iii) Act does not amount to culpable homicide.

And to prove negligence under Criminal Law, the prosecution must prove:

(i) The existence of duty.

(ii) A breach of the duty causing death.

(iii) The breach of the duty must be characterized as gross negligence.

[See R. v. Prentice and R v. Adomako: [1993] 4 All ER 935]

The question in the instant case would be whether the Respondents are guilty of criminal negligence. Criminal negligence is the failure to exercise duty with reasonable and proper care and employing precautions guarding against injury to the public generally or to any individual in particular.

It is, however, well settled that so far as the negligence alleged to have been caused by medical practitioner is concerned, to constitute negligence, simple lack of care or an error of judgment is not sufficient. Negligence must be of a gross or a very high degree to amount to Criminal Negligence.

Medical science is a complex science. Before an inference of medical negligence is drawn, the court must hold not only existence of negligence but also omission or commission on his part upon going into the depth of the working of the professional as also the nature of the job. The cause of death should be direct or proximate. A distinction must be borne in mind between civil action and the criminal action.

The jurisprudential concept of negligence differs in civil and criminal law. What may be negligence in civil law may not necessarily be negligence in criminal law. For negligence to amount to an offence the element of mens rea must be shown to exist. For an act to amount to criminal negligence, the degree of negligence should be much high degree. A negligence which is not of such a high degree may provide a ground for action in civil law but cannot form the basis for prosecution. To prosecute a medical professional for negligence under criminal law it must be shown that the accused did something or failed to do something which in the given facts and circumstances no medical professional in his ordinary senses and prudence would have done or failed to do.

SHIFTING OF BLAME

It is also of some great significance that both in the criminal as also the civil cases, the concerned doctors took recourse to the blame game. Some of them tried to shirk their individual responsibilities. We may in this behalf notice the following:

(i) In response to the notice of Dr. Kunal, Dr. Mukherjee says that Depomedrol had not been administered at all. When confronted

with his prescription, he suggested that the reply was not prepared on his instructions, but on the instruction of AMRI.

**(ii)** Dr. Mukherjee, thus, sought to disown his prescription at the first instance. So far as his prescription dated 11th May, 1998 is concerned, according to him, because he left Calcutta for attending an international conference, the prescription issued by him became non-operative and, thus, he sought to shift the blame on Dr. Halder.

(iii) Dr. Mukherjee and Dr. Halder have shifted the blame to Dr. Prasad and other doctors. Whereas Dr. Prasad counter-charged the senior doctors including the respondent No. 2 stating:

> "Prof. B.N. Halder (Respondent No. 2) was so much attached with the day to day treatment of patient Anuradha that he never found any deficiency in overall management at AMRI so much so that he had himself given a certificate that her condition was very much fit enough to travel to Mumbai…"

In answer to a question as to whether Dr. Halder had given specific direction to him for control of day to day medicine to Anuradha, he stated:

> "…this was done under the guidance of Dr. Sukumar Mukherjee (Respondent No. 1), Dr. B.N. Halder (Respondent No. 2) and Dr. Abani Roychowdhury (Respondent No. 3)"

He furthermore stated that those three senior doctors primarily decided the treatment regimen for Anuradha at AMRI.

(iv) Dr. Kaushik Nandy had also stated that three senior doctors were incharge of Anuradha's treatment.

(v) AMRI states that the drugs had been administered and nursing care had been given as per the directions of the doctors.

(vi) Respondent Nos. 5 and 6, therefore, did not own any individual responsibility on themselves although they were independent Physicians with Post Graduate medical qualifications.

In 'Errors, Medicine and the Law', Cambridge University Press, p.14., the authors, Alan Merry and Alexander McCall Smith, 2001 ed., stated:

> "Many incidents involve a contribution from more than one person, and this case is an example. It illustrates the tendency to blame the last identifiable element in the claim of causation – the person holding the 'smoking gun'. A more comprehensive approach would identify the relative contributions of the other failures in the system, including failures in the conduct of other individuals…"

In R v. Yogasa Karan [1990] 1 NZLR 399, the New Zealand Court opined that the hospital is in a better position to disclose what care was taken

or what medicine was administered to the patient. It is the duty of the hospital to satisfy that there was no lack of care or diligence. The hospitals are institutions, people expect better and efficient service, if the hospital fails to discharge their duties through their doctors, being employed on job basis or employed on contract basis, it is the hospital which has to justify and not impleading a particular doctor will not absolve the hospital of its responsibilities. [See also Errors, Medicine and the Law, Alan Merry and Alexander McCall Smith, 2001 ed., Cambridge University Press, p.12]

It is generally expected that very senior doctors would behave responsibly, and they were entitled to take any defence which is available to them but they should not resort to mudslinging. This being a case where both sides being doctors, fair dealings were expected from them.

CUMULATIVE EFFECT OF NEGLIGENCE

A patient would feel the deficiency in service having regard to the cumulative effect of negligence of all concerned. Negligence on the part of each of the treating doctors as also the hospital may have been contributing factors to the ultimate death of the patient. But, then in a case of this nature, the court must deal with the consequences the patient faced keeping in view the cumulative effect.

In the instant case, negligent action has been noticed with respect to more than one respondent. A cumulative incidence, therefore, has led to the death of the patient. It is to be noted that doctrine of cumulative effect is not available in criminal law. The complexities involved in the instant case as also differing nature of negligence exercised by various actors, make it very difficult to distil individual extent of negligence with respect to each of the respondent. In such a scenario finding of medical negligence under section 304-A cannot be objectively determined.

**E.2. CONCLUSION**

. In view of our discussions made hereinbefore, we are of the opinion that for the death of Anuradha although Dr. Mukherjee, Dr. Halder, Dr. Abani Roy Chowdhury, AMRI, Dr. B. Prasad were negligent, the extent thereof and keeping in view our observations made hereinbefore, it cannot be said that they should be held guilty for commission of an offence under Section 304-A of the Indian Penal Code. We furthermore in a case of this nature do not intend to exercise our discretionary jurisdiction under Article 136 of the Constitution of India having regard to the fact that a judgment of acquittal has been recorded by the Calcutta High Court.

**F. OBSERVATIONS OF THE CALCUTTA HIGH COURT**

We must express our agony in placing on record that the Calcutta High Court in its judgment has made certain observations which apart from being not borne out from the records, are also otherwise highly undesirable.

Some of the conclusions arrived at by the High Court are not based on the findings emerging from the records. These conclusions are as produced as under:

> "28…On 24.5.1998, it was noted "wounds were healing well, epidermal islands have appeared over palms, soles and trunk ..... no obvious Pseudomonas Colony like before". All these noting in the record of Breach Candy Hospital indicate that her skin had started healing and undoubtedly, such healing was outcome of effective treatment. This betterment of skin lesion in the instant case could have been due to timely and effective treatment, undoubtedly with steroids. This may indicate the benefit of treatment at Calcutta…

It was furthermore stated:

> "32. In this connection it is also to be mentioned that the death certificate alone cannot rule out the possibility of accidental suicidal or homicidal cause of the death. A post-mortem examination alone could rule out the possibility of these three kinds of death….On the other hand, the improvement of Anuradha as noticed before 25.5.1998 indirectly supports the argument that the treatment at Calcutta was at best not wrongly directed."

….

> "119…But in the present case, it indicates that there was no fixed treatment, and no faith was reposed on any of the accused doctors and over-jealousness of the patient party practically brought the untimely death of a young lady.

The High Court observed that Anuradha died because of interference of Kunal. Such an observation was made on the basis of some representations although his name did not appear in the records of AMRI. It was stated:

> "124. At the close, it is to be pointed out that Dr. Kunal Saha did not repose faith on any institution as can be ascertained from his conduct discussed hereinabove in details. He also failed to take the investigating agency of this country into confidence and in paragraph 25 of the complaint, it was noted --"that the accused persons are highly influential and are likely to interfere with investigation and as such, complainant would be left with no other alternative than to institute the complaint before the highest magistracy of the Sessions Division of 24-Paraganas (South)". It is rightly contended by the learned counsel appearing on behalf of the accused doctors that such an action may lead to two conclusions :--
>
> (i) The complainant has no confidence on the police investigation of this country, or,
>
> (ii) The police investigation could unveil some untold facts or circumstances leading to the untimely death of Anuradha.

> Be that as it may, by filing a complaint for the purpose of proving the rash and negligent act against the three specialized doctors, the complainant party intentionally took upon themselves a heavy burden of proving the case which they actually failed to discharge. So it was claimed to be an uneven battle, which was declared by the complainant party without being aware of the law on the subject and the consequences. It is needless to mention that now-a-days there is an attempt amongst the patient party to lodge complaint against the attending doctors for the purpose of their punishment. On several occasions patient party also ransacked the hospitals or chambers of the doctors and mishandled them on the plea of negligence to duty. In this way the doctors have been suffering from fear psychosis."

We must also express our great dissatisfaction when the Calcutta High Court stated:

> "121. But it is sufficiently clear that a man of the medical field now residing at United States with family after acquiring citizenship of that country has challenged the conduct and integrity of the three Professors. In this connection, I deem it proper to quote a remark of Lord Denning MR in White House v. Jordan (supra);
>
> "..... Take heed of what has happened in the United States. 'Medical malpractice' cases there are very worrying, especially as they are tried by juries who have sympathy for the patient and none for the doctor who is insured. The damages are colossal. The doctors insure but the premiums become very high ; and these have to be passed on in fees to the patients. Experienced practitioners

> are none to have refused to treat patients for fear of being accused of negligence. Young men are even deterred from entering the profession because of the risks involved. In the interests of all, we must avoid such consequences in England. Not only must we avoid excessive damages. We must say and say firmly, that in a professional man, an error of judgment is not negligent .....".

Further the statement made by the High Court that the transfer certificate was forged by the patient party is absolutely erroneous, as Dr. Anil Kumar Gupta deposed before the trial court that he saw the transfer certificate at AMRI's office and the words "for better treatment" were written by Dr.Balaram Prasad in his presence and these words were written by Dr.Prasad, who told it would be easier for them to transport the patient.

In a case of this nature, Kunal would have expected sympathy and not a spate of irresponsible accusation from the High Court.

## G. SUMMARY

For the reasons aforementioned, the criminal appeals are dismissed. As regards the civil appeal, the matter is remitted to the National Commission for determining the compensation with a request to dispose of the matter as expeditiously as possible and preferably within a period of six

months from the date of receipt of a copy of this judgment. Civil Appeal is disposed of accordingly.

We, keeping in view the stand taken and conduct of AMRI and Dr. Mukherjee, direct that costs of Rs. 5,00,000/- and Rs. 1,00,000/- would payable by AMRI and Dr. Mukherjee respectively.

We further direct that if any foreign experts are to be examined it shall be done only through video conferencing and at the cost of respondents.

…….J.
[S.B. Sinha]

..…….J.
[Deepak Verma]

New Delhi;
August 07, 2009