2-Judge Bench
2019
Dec. 16

(2020) 6 Supreme Court Cases 501

(BEFORE UDAY U. LALIT AND INDU MALHOTRA, JJ.)

Civil Appeal No. 6619 of 2016†

MAHARAJA AGRASEN HOSPITAL AND OTHERS .. Appellants;

Versus

MASTER RISHABH SHARMA AND OTHERS .. Respondents.

With

Civil Appeal No. 9461 of 2019‡

POOJA SHARMA AND OTHERS .. Appellants;

Versus

MAHARAJA AGRASEN HOSPITAL AND OTHERS .. Respondents.

Civil Appeals No. 6619 of 2016 with No. 9461 of 2019, decided on December 16, 2019

A. **Consumer Protection — Services — Medical practitioners/services — Degree of skill and care required by medical practitioner — Principles summarised**

B. **Consumer Protection — Services — Medical practitioners/services — Medical negligence — Determination of — Burden of proof is on complainant to establish medical negligence — Cause of action arises after damage has been caused — Injury caused to victim should be sufficiently proximate to breach of duty by medical practitioner — He would be liable only when his conduct falls below the standards of a reasonably competent practitioner in his field — Applicable principles explained in detail**

— Principle of law laid down in *Bolam*, (1957) 1 WLR 582 — Re-examination of — In the context of the changed jurisprudential thinking on the efficacy of the *Bolam* test, reiterated, the time has come for Supreme Court to reconsider the parameters set down in the *Bolam* test as a guide to decide cases on medical negligence — This is true especially in view of Art. 21 of the Constitution which encompasses within its guarantee, a right to medical treatment and medical care — The standard of care as enunciated in *Bolam* must evolve in consonance with its subsequent interpretation adopted by English and Indian courts — Thus, held, where expert opinion is not capable of withstanding logical analysis, the court is not bound to accept it and such opinion can be rejected as not reasonable or responsible — In present case, the National Commission was justified in rejecting the expert report as it was unreliable (*see* Shortnote *F*)

† Arising from the Judgment and Order in *Rishabh Sharma* v. *Rama Sharma* (National Consumer Disputes Redressal Commission, New Delhi, Consumer Complaint No. 119 of 2007, dt. 10-5-2016)

‡ Arising out of Diary No. 15393 of 2019

— Evidence Act, 1872 — S. 45 — Consumer Forums — Practice and Procedure — Expert evidence — Medical and Health Law — Medical Negligence — Tort Law — Negligence — Medical negligence — Constitution of India — Art. 21 — Medical negligence claims — Manner of adjudication of — Standard of care — Principles to be in consonance with right to health and proper medical treatment being guaranteed as part of right to life under Art. 21

Held :

Medical negligence is the breach of a duty of care by an act of omission or commission by a medical professional of ordinary prudence. Actionable medical negligence is the neglect in exercising a reasonable degree of skill and knowledge to the patient, to whom he owes a duty of care, which has resulted in injury to such person. The standard to be applied for adjudging whether the medical professional charged has been negligent or not, in the performance of his duty, would be that of an ordinary competent person exercising ordinary skill in the profession. The law requires neither the very highest nor a very low degree of care and competence to adjudge whether the medical professional has been negligent in the treatment of the patient. (Para 12.4.3)

Laxman Balkrishna Joshi v. *Trimbak Bapu Godbole*, (1969) 1 SCR 206 : AIR 1969 SC 128; *Kusum Sharma* v. *Batra Hospital*, (2010) 3 SCC 480 : (2010) 1 SCC (Civ) 747 : (2010) 2 SCC (Cri) 1127, *relied on*

Medical negligence comprises of the following constituents:

(*1*) a legal duty to exercise due care on the part of the medical professional;

(*2*) failure to inform the patient of the risks involved;

(*3*) the patient suffers damage as a consequence of the undisclosed risk by the medical professional;

(*4*) if the risk had been disclosed, the patient would have avoided the injury;

(*5*) breach of the said duty would give rise to an actionable claim of negligence. (Para 12.4.1)

The cause of action for negligence arises only when damage occurs, since damage is a necessary ingredient of this tort. In a complaint of medical negligence, the burden is on the complainant to prove breach of duty, injury and causation. The injury must be sufficiently proximate to the medical practitioner's breach of duty. In the absence of evidence to the contrary adduced by the opposite party, an inference of causation may be drawn even though positive or scientific proof is lacking. (Para 12.4.2)

Postgraduate Institute of Medical Education & Research v. *Jaspal Singh*, (2009) 7 SCC 330 : (2009) 3 SCC (Civ) 114 : (2009) 3 SCC (Cri) 399, *relied on*

A person who holds himself out as ready to give medical advice or treatment impliedly undertakes that he is possessed of skill and knowledge for the purpose. Such a person, whether he is a registered medical practitioner or not, who is consulted by a patient, owes him certain duties, namely, a duty of care in deciding whether to undertake the case; a duty of care in deciding what treatment to give; and a duty of care in his administration of that treatment. A breach of any of these duties will support an action for negligence by the patient. To establish liability on that basis it must be shown (*1*) that there is a usual and normal practice; (*2*)

that the defendant has not adopted it; and (*3*) that the course in fact adopted is one no professional man of ordinary skill would have taken had he been acting with ordinary care. (Para 12.4.4)

Halsbury's Laws of England, 3rd Edn., Vol. 26, pp. 17-18; 4th Edn., Vol. 30, para 35., *referred to*

A medical practitioner would be liable only where his conduct falls below the standards of a reasonably competent practitioner in his field. (Para 12.4.5)

Postgraduate Institute of Medical Education & Research v. *Jaspal Singh*, (2009) 7 SCC 330 : (2009) 3 SCC (Civ) 114 : (2009) 3 SCC (Cri) 399, *relied on*

Hucks v. *Cole*, (1968) 118 New LJ 469 (CA), *approved*

The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill; it is well-established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art. (Para 12.4.6)

Bolam v. *Friern Hospital Management Committee*, (1957) 1 WLR 582 : (1957) 2 All ER 118, *considered*

It is enough for the doctor to show that the standard of care and the skill exercised by him was that of an ordinary competent medical practitioner exercising an ordinary degree of professional skill. (Para 12.4.7)

Bolam v. *Friern Hospital Management Committee*, (1957) 1 WLR 582 : (1957) 2 All ER 118, *considered*

A professional man should command the corpus of knowledge which forms part of the professional equipment of the ordinary member of his profession. He should not lag behind other ordinary assiduous and intelligent members of his profession in the knowledge of new advances, discoveries and developments in his field. He should have such an awareness as an ordinarily competent practitioner would have of the deficiencies in his knowledge and the limitations on his skill. He should be alert to the hazards and risks in any professional task he undertakes to the extent that other ordinarily competent members of the profession would be alert. He must bring to any professional task he undertakes no less expertise, skill and care than other ordinarily competent members of his profession would bring, but need bring no more. The standard is that of the reasonable average. The law does not require of a professional man that he be a paragon combining the qualities of polymath and prophet. (Para 12.4.8)

Eckersley v. *Binnie*, (1988) 18 Con LR 1 (CA); *Jacob Mathew* v. *State of Punjab*, (2005) 6 SCC 1 : 2005 SCC (Cri) 1369; *S.K. Jhunjhunwala* v. *Dhanwanti Kaur*, (2019) 2 SCC 282 : (2019) 1 SCC (Civ) 620, *referred to*

Bolam v. *Friern Hospital Management Committee*, (1957) 1 WLR 582 : (1957) 2 All ER 118, *cited*

A medical professional should be alert to the hazards and risks in any professional task he undertakes to the extent that other ordinarily competent members of the profession would be alert. He must bring to any professional task he undertakes reasonable skill that other ordinarily competent members of his profession would bring. (Para 12.4.9)

The law on medical negligence was summed up in *Jacob Mathew*, (2005) 6 SCC 1, as follows:

> (*1*) Negligence is the breach of a duty caused by 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. This definition of negligence, holds good. Negligence becomes actionable on account of injury resulting from the act or omission amounting to negligence attributable to the person sued. The essential components of negligence are three: "duty", "breach" and "resulting damage".
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> (*2*) Negligence in the context of the medical profession necessarily calls for a treatment with a difference. To infer rashness or negligence on the part of a professional, in particular a doctor, additional considerations apply. A case of occupational negligence is different from one of professional negligence. A simple lack of care, an error of judgment or an accident, is not proof of negligence on the part of a medical professional. So long as a doctor follows a practice acceptable to the medical profession of that day, he cannot be held liable for negligence merely because a better alternative course or method of treatment was also available or simply because a more skilled doctor would not have chosen to follow or resort to that practice or procedure which the accused followed. When it comes to the failure of taking precautions, what has to be seen is whether those precautions were taken which the ordinary experience of men has found to be sufficient; a failure to use special or extraordinary precautions which might have prevented the particular happening cannot be the standard for judging the alleged negligence. So also, the standard of care, while assessing the practice as adopted, is judged in the light of knowledge available at the time of the incident, and not at the date of trial. Similarly, when the charge of negligence arises out of failure to use some particular equipment, the charge would fail if the equipment was not generally available at that particular time (that is, the time of the incident) at which it is suggested it should have been used.
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> (*3*) A professional may be held liable for negligence on one of the two findings: either he was not possessed of the requisite skill which he professed to have possessed, or, he did not exercise, with reasonable competence in the given case, the skill which he did possess. The standard to be applied for judging, whether the person charged has been negligent or not, would be that of an ordinary competent person exercising ordinary skill in that profession. It is not possible for every professional to possess the highest level of expertise or skills in that branch which he practices. A highly skilled professional may be possessed of better qualities, but that cannot be made the basis or the yardstick for judging the performance of the professional proceeded against on indictment of negligence.
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> (*4*) Though it was held in *Jacob Mathew*, (2005) 6 SCC 1, that the test for determining medical negligence as laid down in *Bolam*, (1957) 1 WLR 582 would hold good in its applicability in India, however, in recent years, the *Bolam* test has been discarded by the courts. 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. 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 or 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. (Paras 12.4.10 and 12.4.11)

Bolitho v. *City & Hackney Health Authority*, 1998 AC 232 : (1997) 3 WLR 1151 : (1997) 4 All ER 771 (HL); *Jacob Mathew* v. *State of Punjab*, (2005) 6 SCC 1 : 2005 SCC (Cri) 1369, *relied on*

Bolam v. *Friern Hospital Management Committee*, (1957) 1 WLR 582 : (1957) 2 All ER 118; *Maynard* v. *West Midlands Regional Health Authority*, (1984) 1 WLR 634 (HL), *held, limited*

In some cases, it cannot be demonstrated to the Judge's satisfaction that the body of opinion relied upon is reasonable or responsible. In the vast majority of cases the fact that distinguished experts in the field are of a particular opinion will demonstrate the reasonableness of that opinion. In particular, where there are questions of assessment of the relative risks and benefits of adopting a particular medical practice, a reasonable view necessarily presupposes that the relative risks and benefits have been weighed by the experts in forming their opinions. But if, in a rare case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the Judge is entitled to hold that the body of opinion is not reasonable or responsible. (Para 12.4.12)

Bolitho v. *City & Hackney Health Authority*, 1998 AC 232 : (1997) 3 WLR 1151 : (1997) 4 All ER 771 (HL), *relied on*

The law imposes on a medical practitioner a duty to exercise reasonable care and skill in the provision of professional advice and treatment. That duty is a single comprehensive duty covering all the ways in which a doctor is called upon to exercise his skill and judgment; it extends to the examination, diagnosis and treatment of the patient and the provision of information. (Para 12.4.13)

Rogers v. *Whitaker*, (1992) 109 Aus LR 625 : 1992 HCA 58, *relied on*

Sidaway v. *Board of Governors of the Bethlem Royal Hospital & the Maudsley Hospital*, 1985 AC 871 : (1985) 2 WLR 480 : 1985 UKHL 1, *cited*

The standard of care to be observed by a person with some special skill or competence is that of the ordinary skilled person exercising and professing to have that special skill. But, that standard is not determined solely or even primarily by reference to the practice followed or supported by a responsible body of opinion in the relevant profession or trade. Even in the sphere of diagnosis and treatment, the heartland of the skilled medical practitioner, the *Bolam* principle has not always been applied. Further, and more importantly, particularly in the field of non-disclosure of risk and the provision of advice and information, the *Bolam* principle has been discarded and, instead, the courts have adopted the principle that, while evidence of acceptable medical practice is a useful guide for the courts, it is for the courts to adjudicate on what is the appropriate standard of care after giving weight to "the paramount consideration that a person is entitled to make his own decisions about his life". (Para 12.4.13)

Cook v. *Cook*, 1986 HCA 73 : (1986) 162 CLR 376; *Papatonakis* v. *Australian Telecommunications Commission*, 1985 HCA 3 : (1985) 156 CLR 7; *Weber* v. *Land Agents Board*, (1986) 40 SASR 312; *Lewis* v. *Tressider Andrews Associates (P) Ltd.*, (1987) 2 Qd R 533; *Florida Hotels (P) Ltd.* v. *Mayo*, 1965 HCA 26 : (1965) 113 CLR 588; *Albrighton* v. *Royal Prince Alfred Hospital*, (1980) 2 NSWLR 542; *E* v. *Australian Red Cross Society*,

1991 FCA 20 : (1991) 99 ALR 601; *Bolam* v. *Friern Hospital Management Committee*, (1957) 1 WLR 582 : (1957) 2 All ER 118, *cited*

In the law of negligence, this approach entails a duty on the part of doctors to take reasonable care to ensure that a patient is aware of material risks of injury that are inherent in treatment. This can be understood, within the traditional framework of negligence, as a duty of care to avoid exposing a person to a risk of injury which she would otherwise have avoided, but it is also the counterpart of the patient's entitlement to decide whether or not to incur that risk. The existence of that entitlement, and the fact that its exercise does not depend exclusively on medical considerations, are important. They point to a fundamental distinction between, on the one hand, the doctor's role when considering possible investigatory or treatment options and, on the other, her role in discussing with the patient any recommended treatment and possible alternatives, and the risks of injury which may be involved. (Para 12.4.14)

Montgomery v. *Lanarkshire Health Board*, 2015 AC 1430 : (2015) 2 WLR 768 : 2015 UKSC 11, *relied on*

An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken. The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it. (Para 12.4.14)

Rogers v. *Whitaker*, (1992) 109 Aus LR 625 : 1992 HCA 58; *Sidaway* v. *Board of Governors of the Bethlem Royal Hospital & the Maudsley Hospital*, 1985 AC 871 : (1985) 2 WLR 480 : 1985 UKHL 1; *Pearce* v. *United Bristol Healthcare NHS Trust*, 1999 PIQR P53 (CA), *cited*

It has been found that the inherent danger in the *Bolam* test is that if the courts defer too readily to expert evidence medical standards would obviously decline. Michael Jones in his treatise on *Medical Negligence* criticised the *Bolam* test as it opts for the lowest common denominator. The author noted that opinion was gaining ground in England that the *Bolam* test should be restricted to those cases where an adverse result follows a course of treatment which has been intentional and has been shown to benefit other patients previously. This should not be extended to certain types of medical accidents merely on the basis of how common they are. It is felt "to do this would set us on the slippery slope of excusing carelessness when it happens often enough". (Para 12.4.15)

V. Kishan Rao v. *Nikhil Super Speciality Hospital*, (2010) 5 SCC 513 : (2010) 2 SCC (Civ) 460, *relied on*

Even though the *Bolam* test "has not been uprooted" it has come under some criticism as has been noted in Jackson & Powell on *Professional Negligence*: that there is an argument to the effect that the *Bolam* test is inconsistent with the right to life unless the domestic courts construe that the requirement to take reasonable care is equivalent with the requirement of making adequate provision for medical care. In the context of such jurisprudential thinking in England, time has come for the Supreme Court also to reconsider the parameters set down in the *Bolam* test

as a guide to decide cases on medical negligence and specially in view of Article 21 of our Constitution which encompasses within its guarantee, a right to medical treatment and medical care. (Para 12.4.15)

The standard of care as enunciated in *Bolam* must evolve in consonance with its subsequent interpretation adopted by English and Indian courts. (Para 12.4.16)

Arun Kumar Manglik v. *Chirayu Health & Medicare (P) Ltd.*, (2019) 7 SCC 401 : (2019) 3 SCC (Civ) 647, *relied on*

Bolam v. *Friern Hospital Management Committee*, (1957) 1 WLR 582 : (1957) 2 All ER 118, *held, limited*

C. **Consumer Protection — Services — Medical practitioners/services — Medical negligence — Retinopathy of Prematurity (ROP) — Examination of — It is mandatory to be examined for babies with weight less than 1500 gms and gestational age of less than 32 weeks — Reasons for such examination, explained — Omission to conduct ROP under such circumstances amounts to deficiency in service — Various aspects relating to ROP discussed by referring to different medical literature**

— On facts held, appellants possessed the skills and owed a duty of care to the patient — They ought to have followed standard protocol for screening ROP — They neither advised nor guided about possible occurrence of ROP — Lack of required care constitutes deficiency in service — Holding appellants, including hospital, guilty of deficiency in service, compensation awarded to respondents — Modalities for disbursement of compensation — Set out — Medical and Health Law — Medical Negligence — Tort Law — Negligence — Medical negligence — Consumer Protection Act, 1986, Ss. 2(g), 2(o) and 21

D. **Consumer Protection — Services — Medical practitioners/services — Medical negligence — Vicarious liability — Liability of hospital for negligence of doctors engaged or empanelled by it — Tort Law — Vicarious Liability**

E. **Tort Law — Compensation/Damages — Award of, for medical negligence — Within realm of Tort law — Measure for award of compensation i.e. principle of restitutio in integrum, explained**

Respondent 2 Complainant 2 was under ante-natal care of Respondent 4. She had to undergo Caesarean section and Respondent 1 Complainant 1 (baby) was born pre-term. The case was referred to Appellant 1. Respondent 1 Complainant 1 stayed with Appellant 1 for four weeks. There was no advise to carry out the mandatory checkup of Retinopathy of Prematurity (ROP) in discharge slip. When Respondent 1 Complainant 1 was brought in for first follow-up visit, Appellants 2 and 3 examined the baby. There was no advise for Retinopathy of Prematurity checkup. When the baby was brought for second follow-up visit, a doctor of Appellant 1 examined and recommended a test but Retinopathy of Prematurity checkup was not advised.

After few months, Respondent 2 Complainant 2 noticed abnormal visual response from the baby. She asked for medical records of the baby to have his follow up treatment done. But records were not made available.

During examination of the baby in eye hospital, it was diagnosed that the baby had Retinopathy of Prematurity Stage 5 in both eyes resulting in total retinal detachment. After some more examinations in different hospitals, it was confirmed that it was case of Retinopathy of Prematurity Stage 5.

A legal notice was issued to provide entire in-patient medical records of the baby in compliance with the Indian Medical Council (Professional Conduct, Etiquettes and Ethics) Regulations, 2002. However, records were not provided by Appellant 1. A complaint was filed before the Delhi Medical Council for direction to Appellant 1. At that stage, the medical records of the baby were supplied to Respondent 2 Complainant 2. She noticed that medical records mentioned that Retinopathy of Prematurity checkup was conducted by Appellant 4. However, no such examination was conducted. Later, there was correspondence between Respondent 2 Complainant 2 and Appellant 1.

Respondents 1 to 3 Complainants 1 to 3 filed a complaint under Section 21 of the Consumer Protection Act, 1986 before the National Commission claiming compensation of Rs 1,30,25,000 on ground of medical negligence and deficiency in service on part of the appellants.

During these proceedings expert opinion was obtained from AIIMS. A report was submitted that babies who are born at 32 weeks' gestation or less, should have their eyes examined at 3-4 weeks' age and more frequent checkups to be done later. It was submitted that Appellant 4 examined the baby at 24 days of age as per established protocol. If screening does not reveal any Retinopathy of Prematurity then tests should be conducted after 2 weeks. It was also mentioned that there was no record that baby was brought after 2 weeks of discharge when subsequent progression could be assessed.

Based on materials available, the National Commission concluded that no Retinopathy of Prematurity examination was conducted by Appellant 4. As a result the baby became blind for life. Holding the appellants guilty of medical negligence and deficiency in service, compensation of: (*i*) Rs 53,00,000 was awarded to Respondent 1 Complainant 1 (baby); (*ii*) Rs 10,00,000 to Respondent 2 Complainant 2 to take care of blind baby throughout her life; (*iii*) Rs 1,00,000 was awarded towards costs. It was ordered for disbursement of money and manner in which money had to be deposited. Hence, this appeal by the appellants. However, the respondents also preferred an appeal for enhancement.

While dismissing the appeal preferred by the Hospital and the doctors, and allowing the appeal preferred by the complainants for enhancement, the Supreme Court

Held :

Retinopathy of Prematurity (ROP) is one of the major emerging causes of childhood blindness. A premature baby is not born with ROP. At the time of birth, particularly in the case of premature babies, the retina is immature, which is natural at this stage. It is the post-natal developments in the retinal vessels which could lead to ROP. (Para 12.2)

As per medical literature, all infants with a birth weight of less than 1500 gm, or gestational age of less than 32 weeks, are required to be mandatorily screened

for ROP, which usually takes about 4 to 5 weeks to be diagnosed. The routine screening should begin no later than 4 weeks after birth, and possibly even earlier for infants at higher risk (2 to 3 weeks). The standard of care is to be judged in the light of the protocols and standard procedures prevailing on the date of birth, and not on the date of trial. (Para 12.2.1)

Nizam's Institute of Medical Sciences v. *Prasanth S. Dhananka*, (2009) 6 SCC 1 : (2009) 2 SCC (Civ) 688; *Jacob Mathew* v. *State of Punjab*, (2005) 6 SCC 1 : 2005 SCC (Cri) 1369, *relied on*

There are several compelling reasons to have a screening programme for ROP. Firstly, the premature child is not born with ROP and retinal disease is not present at birth. Each prematurely born child has a potential for normal vision, even if the retina is immature at birth. Screening for ROP aims to identify those infants who have reached or have the potential to reach threshold ROP, which if untreated, may cause blindness or visual impairment. This has medico-legal implications. There are indefensible legal repercussions should an infant develop ROP and retinal detachment, but had not received eye examination. Secondly, the grief and the personal tragedy for the family is tremendous, besides the economic burden of such childhood blindness. The aim of screening premature babies for ROP is to detect all treatable neonates, with minimal expense of time and resources. This also aims at not screening those babies who are unlikely to get a severe form of ROP. Early recognition of ROP by screening provides an opportunity for effective treatment. The criteria for screening babies are based on two critical factors — the birth weight and the gestational age. (Para 12.2.2)

Subhadra Jalali, MS; Raj Anand, MS; Harsh Kumar, MD; Mangat R Dogra, MS; Rajvardhan Azad, MD, FRCS (Ed.); Lingam Gopal, MS, "Programme Planning and Screening Strategy in Retinopathy of Prematurity", Indian J Ophthalmol 2003 (March 2003), Vol. 51, pp. 89-99, *referred to*

A well-organised screening strategy and timely intervention can to a large extent prevent blindness due to ROP. Extensive clinical trials and publications have established that among other factors, gestation period and low birth weight are critical in the pathophysiology of ROP. If detected early and treated with peripheral retinal cryopexy or laser, ROP blindness can be prevented to some extent. Once the case crosses Stage 3, in very few cases can the sight be saved even by extensive vitreoretinal surgery. (Para 12.2.3)

It is said that prematurity is one of the most common causes of blindness and is caused by an initial constriction and then rapid growth of blood vessels in the retina. When the blood vessels leak, they cause scarring. These scars can later shrink and pull on the retina, sometimes detaching it. The disease advances in severity through five stages — 1, 2, 3, 4 and 5 (5 being the terminal stage). Medical literature suggests that Stage 3 can be treated by laser or cryotherapy treatment in order to eliminate the abnormal vessels. Even in Stage 4, in some cases, the central retina or macula remains intact thereby keeping intact the central vision. When the disease is allowed to progress to Stage 5, there is a total detachment and the retina becomes funnel shaped leading to blindness. There is ample medical literature on the subject. It is, however, not necessary to refer all of it. Some material relevant to the need for checkup for ROP for an infant is — "All infants with a birth weight less than 1500 gm or gestational age less than 32 weeks are required to be screened

for ROP." It is a visually devastative disease that often can be treated successfully if it is diagnosed in time. (Para 12.2.5)

AIIMS Report dated 21-8-2007, *referred to*

V. Krishna Kumar v. *State of T.N.*, OP No. 57 of 1998, order dated 27-5-2009 (NCDRC), *cited*

ROP starts developing 2 to 4 weeks after birth when it is mandatory to do the first screening of the child. As per the report of AIIMS "it may not be possible to exactly predict which premature baby will develop ROP and to what extent and why". This would necessitate the need for a checkup in all such cases. (Para 12.2.7)

V. Krishnakumar v. *State of T.N.*, (2015) 9 SCC 388 : (2015) 4 SCC (Civ) 546, *relied on*

It is clear from the medical literature that ROP is a visually progressive disease, which can be treated successfully if it is diagnosed on time. ROP advances through 5 stages. Medical literature suggests that Stage 3 can be treated by laser or cryotherapy treatment in order to eliminate the abnormal vessels. Even at Stage 4, in some cases, the central retina or macula remains intact thereby keeping intact the central vision. When the disease progresses to Stage 5, there is a total detachment, and the retina becomes funnel shaped, leading to blindness. (Para 12.2.8)

After careful perusal of the original medical records of Appellant 1 Hospital, which were provided in a sealed cover to the Court, it is found that there is an entry at p. 100 of the medical records dated 25-4-2005 recorded at 9.00 a.m. At the bottom of p. 102 of the medical records, there is another entry dated 26-4-2005.The said noting is signed by *S* — Appellant 4. There is, however, no time mentioned against this noting. A visual examination of the original medical records/treatment sheet shows that this entry is not recorded in the same sequence as all previous and subsequent notings. The entries recorded at pp. 100 and 102 have been made at the bottom of the page. The date "26/4" is mentioned in a different column, unlike the other entries made before and after this entry. There is no time of the ophthalmological examination by Appellant 4 *S* on 26-4-2005 mentioned in the record, unlike all other notings by other doctors, who have examined the patient, where the time is clearly recorded. (Paras 12.2.9 and 12.2.10)

On the next page i.e. p. 103 of the medical record, it is mentioned as "Day 28" i.e. 26-4-2005 on the top of the page. The first entry on that date is recorded at 10.30 a.m. This would indicate that the baby was not examined prior to 10.30 a.m. by any doctor. (Para 12.2.11)

There is no contemporaneous record to corroborate that ROP screening was done by Appellant 4 *S* on 26-4-2005. The nurses' daily record or treatment sheet do not mention that the dilation of the pupils of the baby were carried out by administration of cyclopentolate (0.5%) and phenylephrine (2.5%) drops to conduct test of ROP. (Para 12.2.12)

It was orally enquired from the counsel appearing on behalf of Appellant 4 *S* about the approximate time at which the ROP checkup was done by him on 26-4-2005. The counsel was unable to specify the time at which the baby was examined by him. (Para 12.2.13)

Respondent 1 Complainant 1 (baby) was discharged on 29-4-2005. The complainants were provided with a discharge slip. The discharge slip does not contain any advice for a mandatory follow-up for ROP. Rather, the discharge slip only advised the complainant to bring Respondent 1 Complainant 1 for a review to the Paediatrics OPD on Wednesday or Saturday at 4 p.m. (Para 12.2.14)

The original medical records produced by Appellant 1 Hospital were seen, and it was found that on both occasions, i.e. 4-5-2005 and 13-7-2005, the complainants went correctly to the Paediatrics Unit of the General OPD. Hence, the contention of the appellants is liable to be rejected as being completely baseless. (Para 12.2.16)

Respondent 2 Complainant 2 took the baby (Respondent 1 Complainant 1) for a follow-up checkup post-discharge to the Paediatrics-III Department on two occasions i.e. 4-5-2005 and 13-7-2005. The baby was examined by Appellants 2 and 3 on 4-5-2005. In the treatment sheet, there is no recommendation to have ROP test done, nor was the patient advised to come back after two weeks. (Para 12.2.17)

Respondent 2 Complainant 2 took the baby for a further follow-up on 13-7-2005 to the Paediatrics-III Department. The baby was examined by Dr Manoj on behalf of Appellant 2. The medical record even on this date does not mention any advice for an ROP test. The attending doctor only advised that a BERA test be done. It is thus abundantly clear that the baby was rightly taken to the Paediatrics Unit of the General OPD Clinic at the chronological age of 4 to 5 weeks, when the onset of ROP could have been detected. However, there was no advice given by the treating doctors i.e. Appellants 2 and 3 — the Consultant Paediatricians, nor Appellant 4 Ophthalmologist to conduct the ROP test. (Para 12.2.18)

ROP was neither advised, nor carried out at all by Appellant 1 Hospital, or Appellant 4 *S*, the Senior Ophthalmologist, throughout the period of hospitalisation of the baby, or even after discharge. The baby was born in the 32nd gestational week, and was 1.49 kg at birth. As per standard protocol, the ROP screening ought to have been done between 3-4 weeks from birth. The baby remained admitted for 27 days in Appellant 1 Hospital from 2-4-2005 to 29-4-2005. There is no justification whatsoever why the mandatory screening of ROP was not done for the baby, while he was under the direct care and supervision of the appellants. (Para 12.2.19)

The complainants have discharged the initial burden of proof by making out a case of clear negligence on the part of Appellant 1 Hospital and the paediatric doctors under whose care the baby was admitted, as also Appellant 4 *S*, the Senior Ophthalmologist attached to Appellant 1 Hospital. All appellants failed to satisfy the Court that ROP tests were conducted at any point of time, or that the complainants were even advised to get the ROP test done. (Para 12.3.4)

Nizam's Institute of Medical Sciences v. *Prasanth S. Dhananka*, (2009) 6 SCC 1 : (2009) 2 SCC (Civ) 688; *Savita Garg* v. *National Heart Institute*, (2004) 8 SCC 56, *relied on*

The findings of the National Commission of gross negligence by Appellants 2 to 4 Doctors, and deficiency of service by Appellant 1 Hospital are affirmed. (Para 12.2.20)

Appellants 2 and 3 viz. *G* and *N*, the Consultant Paediatricians, undoubtedly possessed the skill and qualifications of a Paediatrician, and the baby was placed under their direct care and treatment from birth till he was 3½ months old. They owed a duty of care to the baby and his parents. Appellant 4 *S*, the Senior Consultant Ophthalmologist, who was engaged by Appellant 1 Hospital, and was the specialist in the Ophthalmology Department, ought to have followed the standard protocol for screening Respondent 1 Complainant 1 for ROP, which is prescribed at the chronological age of 3 to 4 weeks after birth. (Para 12.4.17)

Appellants 1 to 3 are liable for medical negligence since at no stage were the parents of Respondent 1 Complainant 1 either advised or guided about the possibility of occurrence of ROP in a premature baby, nor was the baby examined by Appellant 4, the Ophthalmologist as per standard protocol. The doctors ought to have been fully aware of the high chances of occurrence of ROP in a pre-term baby. The lack of care constitutes a gross deficiency in service. After discharge on 29-4-2005, the baby was brought on 4-5-2005 at the chronological age of 5 weeks. Even on this date, no ROP test was either advised or conducted. The baby was brought for a further follow-up checkup on 13-7-2005, by which time the baby was 3½ months old. Even on this visit, the appellants did not advise or guide Respondent 2 Complainant 2 to have the ROP test conducted. (Para 12.4.18)

After reviewing the medical literature setting out the contemporaneous standards and established protocols on ROP, the reasonable standard of care for a premature baby, mandates screening and checking up for ROP. It is a medically accepted position that ROP is a reversible disease, if diagnosed up to Stage 3. Had the ROP test been conducted by the appellants, there would have been timely detection of the onset of ROP, which at that stage would have been reversible. On account of the negligence of Appellants 2 to 4, the disease remained undiagnosed. It came to be diagnosed on 3-12-2005, when the baby was 8 months old, by Shroff Charity Eye Hospital. By this time, the ROP had reached Stage 5, when it becomes irreversible leading to total blindness of Respondent 1 Complainant 1 (baby). (Para 12.4.19)

The findings of the National Commission to hold that Appellant 1 Hospital, Appellants 2 and 3 — the Paediatricians, and Appellant 4 *S*, the Senior Ophthalmologist, owed a legal duty of care to Respondents 1 and 2 Complainants 1 and 2 are affirmed. The failure to inform Respondent 2 Complainant 2 (the mother of baby) of the necessity to have the ROP test conducted in the case of a pre-term baby, and the high risk involved which could lead to total blindness, was a breach of duty. Furthermore, the failure to carry out the ROP test, which is mandated by standard protocol, while the baby was under their direct care and supervision from birth till he was 3½ months old, amounted to gross negligence by the doctors, and deficiency of service by Appellant 1 Hospital. The consequential damage caused to the baby by not having conducted the mandatory ROP test, which led to the total blindness of the baby, has given rise to an actionable claim of negligence. (Para 12.4.20)

It is well established that a hospital is vicariously liable for the acts of negligence committed by the doctors engaged or empanelled to provide medical care. It is common experience that when a patient goes to a hospital, he/she goes there on account of the reputation of the hospital, and with the hope that due and

proper care will be taken by the hospital authorities. 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 the acts of commission or omission on behalf of their doctors. (Para 12.4.21)

Savita Garg v. *National Heart Institute*, (2004) 8 SCC 56; *Balram Prasad* v. *Kunal Saha*, (2014) 1 SCC 384 : (2014) 1 SCC (Civ) 327; *Achutrao Haribhau Khodwa* v. *State of Maharashtra*, (1996) 2 SCC 634; *V. Krishnakumar* v. *State of T.N.*, (2015) 9 SCC 388 : (2015) 4 SCC (Civ) 546, *relied on*

Accordingly, Appellant 1 Hospital is held to be vicariously liable for the acts of omission and commission committed by Appellants 2 to 4. All the appellants are held as being jointly and severally liable to pay compensation to the complainants. (Para 12.4.22)

Having affirmed the findings recorded by the National Commission on the question of medical negligence and deficiency in service by the appellants, the issue whether the compensation awarded by the National Commission was just and reasonable is required to be determined. The complainants had claimed Rs 1,30,25,000 as compensation before the National Commission. The National Commission vide the impugned judgment awarded a total sum of Rs 64,00,000 to the complainants along with interest. (Para 12.5.1)

Rishabh Sharma v. *Rama Sharma*, 2016 SCC OnLine NCDRC 2726, *cited*

The Supreme Court vide order dated 6-11-2019 directed the appellants to release a sum of Rs 5,00,000 (Rupees five lakhs) in favour of Respondent 2 Complainant 2 from the amount lying deposited by Appellant 1 Hospital in the Court. It was further directed Respondent 2 Complainant 2 to file an affidavit regarding the education received by Respondent 1, and the level of proficiency he had attained. (Para 12.5.2)

Maharaja Agrasen Hospital v. *Rishabh Sharma*, 2019 SCC OnLine SC 1698, *cited*

The grant of compensation to remedy the wrong of medical negligence is within the realm of law of tort. It is based on the principle of *restitutio in integrum*. The said principle provides that a person is entitled to damages which 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. (Para 12.5.4)

Livingstone v. *Rawyards Coal Co.*, (1880) LR 5 AC 25 (HL); *Malay Kumar Ganguly* v. *Sukumar Mukherjee*, (2009) 9 SCC 221 : (2009) 3 SCC (Civ) 663 : (2010) 2 SCC (Cri) 299; *V. Krishnakumar* v. *State of T.N.*, (2015) 9 SCC 388 : (2015) 4 SCC (Civ) 546; *Balram Prasad* v. *Kunal Saha*, (2014) 1 SCC 384 : (2014) 1 SCC (Civ) 327, *relied on*

Having regard to the finding that the medical negligence in the instant case occurred in 2005, and the litigation has been pending before the Supreme Court for over 3 years, coupled with the fact that the additional monthly expenses such as the care of an attendant/nurse, educational expenses of the patient in a special school, assistive devices, etc. have not been taken into account, it would serve the ends of justice if the compensation awarded by the National Commission is enhanced, by a further lump sum amount of Rs 12,00,000 (Rupees twelve lakhs). Directions issued for utilisation of compensation for welfare of Respondent 1 Complainant 1. (Paras 12.5.5 and 12.7 to 12.9)

Rishabh Sharma v. *Rama Sharma*, 2016 SCC OnLine NCDRC 2726, *affirmed* and *modified*

Maharaja Agrasen Hospital v. *Rishabh Sharma*, 2016 SCC OnLine SC 1860; *Maharaja Agrasen Hospital* v. *Rishabh Sharma*, 2016 SCC OnLine SC 1862, *cited*

F. **Evidence Act, 1872 — S. 45 — Expert evidence — Admissibility and Ambit of — Principles summarised — On facts held, rejection of report of AIIMS as an expert on subject-matter was valid, as it was based on interpolation of entries and was fallacious — Consumer Protection — Services — Medical practitioners/services — Expert evidence**

Held :

It is well settled that a court is not bound by the evidence of an expert, which is advisory in nature. The court must derive its own conclusions after carefully sifting through the medical records, and whether the standard protocol was followed in the treatment of the patient. The duty of an expert witness is to furnish the court with the necessary scientific criteria for testing the accuracy of the conclusions, so as to enable the court to form an independent opinion by the application of this criteria to the facts proved by the evidence of the case. Whether such evidence could be accepted or how much weight should be attached to it is for the court to decide. (Para 12.3.2)

Ramesh Chandra Agrawal v. *Regency Hospital Ltd.*, (2009) 9 SCC 709 : (2009) 3 SCC (Civ) 840; *State of H.P.* v. *Jai Lal*, (1999) 7 SCC 280 : 1999 SCC (Cri) 1184; *Malay Kumar Ganguly* v. *Sukumar Mukherjee*, (2009) 9 SCC 221 : (2009) 3 SCC (Civ) 663 : (2010) 2 SCC (Cri) 299; *V. Kishan Rao* v. *Nikhil Super Speciality Hospital*, (2010) 5 SCC 513 : (2010) 2 SCC (Civ) 460, *relied on*

A perusal of the AIIMS Report dated 11-5-2012 shows that it was premised on the alleged entry recorded by Appellant 4 *S* on 26-4-2005, which records that ROP test was conducted, and no ROP was detected. A finding had already been recorded that the entry made in the treatment sheet (at pp. 100 and 102 of the original medical records) seems to be an interpolation done subsequently to cover up the failure of Appellant 1 Hospital and the Doctors to advise or conduct the mandatory ROP checkup and follow-up protocol. The second point contained in the AIIMS Report that the baby was not taken to the Paediatrics OPD is wholly fallacious. The medical records were seen, and it was found that the baby was, in fact, taken to the Paediatrics Unit of the General OPD. Hence, the basis of the Report is misconceived, and cannot be relied upon. The view taken by the National Commission in disregarding the opinion of the Medical Board constituted by AIIMS is accepted. (Paras 12.3.1 and 12.3.3)

[**Ed.**: *See also* Shortnote *B* on manner in which the *Bolam test* is to be applied and freedom of Judge or Consumer Forum to reject expert opinion in case it is found to be unreliable.]

G. **Medical and Health Law — Medical Practice and Practitioners — Indian Medical Council (Professional Conduct, Etiquettes and Ethics) Regulations, 2002 — Regns. 1.3.2, 7 and 8 — Delay in supply of records — Regulations have statutory force and are binding on medical professionals — Maintenance of medical records of patients is integral part of medical profession — Failure to provide medical records of patient within 72 hrs of request amounts to professional misconduct liable for disciplinary action and punishment**

— On facts held, withholding of medical records for more than 2 yrs after request was made amounted to professional misconduct and deficiency in service on part of Hospital and its management — Consumer Protection — Services — Medical practitioners/services — Medical negligence — Indian Medical Council Act, 1956, Ss. 20-A and 33(m) (Paras 12.1 to 12.8.1)

Federation of Obstetrics & Gynaecological Societies of India v. *Union of India*, (2019) 6 SCC 283, *relied on*

G-D/63483/CV

Advocates who appeared in this case :

Gaurav Goel, Sidharth Arora, Harshit Goel, Sameer Shrivastava (with Ms Pooja Sharma and Master Rishabh Sharma), Gautam Narayan, Neeraj Kr. Gupta, A.K. Sharma, Anjani Kumar, Ranjeet Kr. Singh, Anil Kumar and Ms Manisha Ambwani, Advocates) for the appearing parties.

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The Judgment of the Court was delivered by

INDU MALHOTRA, J.— The present civil appeals arise out of a complaint of medical negligence made by Respondents 1 to 3, the complainants against Appellant 1 Hospital and Appellants 2 to 4, the paediatricians and ophthalmologist doctors working with Appellant 1 Hospital, and Respondent 4, the gynaecologist, before the National Consumer Disputes Redressal Commission (hereinafter referred to as "the National Commission").

2. The National Commission vide judgment and order dated 10-5-2016[1] ("the impugned judgment") allowed the consumer complaint, and held Appellant 1 Hospital, and Appellants 2 to 4 doctors guilty of medical negligence, since they failed to carry out the mandatory checkup of Retinopathy

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of Prematurity ("ROP") on Respondent 1, Master Rishabh, who was a pre-term baby, which led to his total blindness. Insofar as Respondent 4 Dr Rama Sharma, the Gynaecologist is concerned, who had delivered the baby, she was exonerated by the National Commission, and has not been pressed before this Court.

3. Aggrieved by the impugned judgment[1] passed by the National Commission, Appellant 1 Maharaja Agrasen Hospital, a super speciality hospital, Appellant 2 Dr G.S. Kochhar and Appellant 3 Dr Naveen Jain, the Consultant Paediatricians working for Appellant 1 Hospital, and Appellant 4 Dr S.N. Jha, the Senior Consultant Ophthalmologist working for Appellant 1 Hospital have filed Civil Appeal No. 6619 of 2016.

4. Respondent 1, Master Rishab Sharma, is the child-patient, who was Complainant 1 before the National Commission, and was represented by his widowed mother Pooja Sharma, Respondent 2/Complainant 2. Respondent 3 is the elder brother of Respondent 1. The complainants have filed Civil Appeal No. 9461 of 2019 (Diary No. 15393 of 2019) before this Court for further enhancement of the compensation awarded by the National Commission.

5. The background facts in which the present civil appeals have been filed are as under:

5.1. Respondent 2 Pooja Sharma Complainant 2 was under the ante-natal care of Respondent 4 Dr Rama Sharma at Sharma Medical Centre since September 2005.

5.2. On 2-4-2005, at about 5.30 p.m., Respondent 2 had to undergo a caesarean section in view of the condition of placenta previa. The baby Respondent 1 was born pre-term at 32 weeks' gestation, with a weight of 1.49 kg at the time of birth.

5.3. On the same day, at about 8.30 p.m., Respondent 4 Dr Rama Sharma, the Gynaecologist referred the case for intensive care to Maharaja Agrasen Hospital Appellant 1. At the time of admission, the general condition of the baby was poor, and was diagnosed as "32 weeks pre-term AGA with HMD". The baby was treated in the neo-natal ICU of the Paediatrics Unit and was put on ventilatory support, and surfactant injections were administered gradually.

5.4. Respondent 1 baby stayed in Appellant 1 Hospital for almost 4 weeks, and was discharged on 29-4-2005, which was 27 days after birth. The discharge slip issued by Appellant 1 Hospital to the complainants reads as follows:

"Maharaja Agrasen Hospital
Punjabi Bagh, New Delhi-110026, Ph. 25106645 to 54
Discharge slip
Hospital No. 505404. Ward: NICU Deptt./Unit: Paed-III.
Name: B/O. Pooja Sharma Age/Sex NB/M.
Date of Admission: 2-4-2005 at 8.30 p.m.
Date of Discharge: 29-4-2005

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Diagnosis: PT (32) with HMD with Neonatal Hyperbil with B/L Pneumothorax Fungal Septicaemia.

Condition at time of discharge: Satisfactory.

Consultants: Dr G.S. Kochar/Dr N. Jain

DOB: 2-4-2005.

Sex: Male.

Birth weight: 1.49 kg.

Weight at discharge: 1.56 kg.

Mode: Emergency LSCS for placenta previa.

Follow-up advice:

- Syp. Taxim O 1 ml BD × 5 d.
- Syp. Osteocalcium TDS.
- Drops Visyneral Z 0.3 ml OD.
- Drop Vitcofol 5 drops OD.
- Drop Evion 5 drops OD.
- To review in Pead. OPD on Wed/Sat 4 p.m.
- Refer back to Rama Nursing Home (Sharma Medical Centre)

sd-

Consultant Medical Officer"

5.5. There is no advice to the complainants to have the ROP test carried out on the baby, who was born prematurely, in the discharge slip. Post discharge, Respondent 2 complainant brought the baby for a follow-up checkup on 4-5-2005 to the Paediatrics Unit of the General OPD of Appellant 1 Hospital, when the baby was 4 weeks and 4 days old. The baby was examined by the Consultant Paediatricians, Dr G.S. Kochhar and Dr Naveen Jain/Appellants 2 and 3. As per the medical records, Respondent 1 baby was found to be stable, and Respondent 2 complainant was advised to continue breast feeding along with supplements. It is pertinent to note that there was no advice or recommendation for ROP checkup on this date in the medical records produced by Appellant 1 Hospital.

5.6. On 13-7-2005, Respondent 2 complainant brought the baby for a second follow-up visit when he was over 3 months old to the Paediatrics Unit of the General OPD of Appellant 1 Hospital. Respondent 1 baby was examined by Dr Manoj on behalf of Dr G.S. Kochhar. Dr Manoj advised the complainants for the BERA scan/test to be conducted. It is pertinent to note that there was no advice for ROP checkup given even on this visit.

5.7. Respondent 2 complainant submits that sometime in November 2005, she noticed abnormal visual responses in Respondent 1 baby. The complainant asked for the medical records of the baby to have his follow-up treatment done. The medical records were, however, not made available by Appellant 1 Hospital.

5.8. On 23-11-2005, Respondent 2 complainant took the baby to Nayantara Eye Clinic, Delhi where an ultrasound (B. Scan) was conducted. It was advised that eye ointment and eye drops be administered to the baby.

5.9. On 3-12-2005, the baby was taken by Respondent 2 complainant to Shroff Charity Eye Hospital, Delhi for further examination where the ultrasound (B. Scan) was conducted. Shroff Charity Eye Hospital diagnosed that the baby had ROP Stage 5 in both eyes, which is a case of total retinal detachment.

5.10. Respondent 2 complainant approached Respondent 4 Dr Rama Sharma, the Gynaecologist of Sharma Medical Centre to explain how the medical condition of Respondent 1 baby had remained undiagnosed. Dr Rama Sharma shifted the blame to the appellants.

5.11. On 7-12-2005, Respondent 2 complainant took the baby to Appellant 1 Hospital in the private OPD consultation. Dr Sanjay Bhavan, Ophthalmologist examined Respondent 1 baby. The case was referred to Dr Lingam Gopal of Shankara Netralaya at Chennai for an urgent appointment.

5.12. On 7-1-2006, Respondent 1 baby was taken by his mother Respondent 2 complainant to Dr Rajendra Prasad Centre for Ophthalmic Sciences at AIIMS, New Delhi for OPD Consultation. After examination, it was confirmed that it was a case of ROP Stage 5.

5.13. On 24-2-2007, Respondent 2 complainant was constrained to issue a legal notice to Appellant 1 Hospital to provide the entire in-patient medical records of the baby in compliance with Regulation 1.3.2 of the Indian Medical Council (Professional Conduct, Etiquettes and Ethics) Regulations, 2002 ("the IMC Regulations").

5.14. Appellants 1 to 3 failed to provide the in-patient medical records to the complainant despite the issuance of legal notice.

5.15. Respondent 2 complainant then filed a complaint with the Delhi Medical Council for a direction to Appellant 1 Hospital to provide the complete in-patient medical records pertaining to the baby.

5.16. Eventually, Appellant 1 Hospital provided a copy of the medical records of the baby along with the case summary on 14-6-2007 after more than 2 years of discharge from Appellant 1 Hospital.

5.17. Respondent 2 complainant contends that when she received these records, she was shocked to find that the medical records mentioned an alleged ROP checkup was conducted on 26-4-2005 by Appellant 4 Dr S.N. Jha. Respondent 2 complainant contends that no ROP examination was conducted by Appellant 4 Dr S.N. Jha.

5.18. On 4-8-2007, Respondent 2 complainant addressed a letter to the Medical Superintendent of Appellant 1 Hospital. The relevant extract of the said letter is reproduced hereinbelow for ready reference:

"Under the above enclosure we have received photocopies of some medical record (uncertified) along with a case summary dated 13-6-2007.

The said summary states that on 26-4-2007 ROP examination on our baby was conducted in the Ophthalmological unit of your hospital and review examination after two weeks was also advised.

We are rather intrigued by this observation as it does not find mention anywhere in the discharge summary nor is there any follow-up advise.

Since both of us do not recollect any such examination conducted in our presence or review advise and the said medical record is also totally silent about it, kindly provide us with the entire record of the Ophthalmological unit, name of the Paediatric Ophthalmologist who had conducted the ROP examination and his written report dated 26-4-2006." (emphasis supplied)

5.19. Appellant 1 Hospital replied to the letter on 24-8-2007, wherein it was stated that:

"As per standard neonatal protocol, ophthalmological checkup was requested on 25-4-2005 to rule out ROP.

The ophthalmological examination was done in the Nursery on 26-4-2005 morning by Dr S.N. Jha, Senior Consultant Ophthalmologist. The written report of the Ophthalmological unit is stated on p. 102 of the case record." (emphasis supplied)

5.20. On 19-11-2007, Respondents 1 to 3 filed a consumer complaint under Section 21(*a*)(*i*) of the Consumer Protection Act, 1986 before the National Commission [Consumer Case No. 119 of 2007] claiming compensation of Rs 1,30,25,000 alleging medical negligence and deficiency in service on the part of Appellants 1 to 4, and Respondent 4 the Gynaecologist, for compensation for the permanent physical disability, mental agony, and social stigma, deprivation of normal human life, companionship, torture and harassment, etc.

5.21. The Delhi Medical Council vide order dated 14-12-2007 issued a warning to Appellant 1 Hospital for the delay in supplying the medical records of Respondent 1 baby to the complainant.

5.22. The National Commission vide order dated 29-2-2012 directed the Medical Board, AIIMS to give an expert opinion in the matter.

5.23. The Medical Board of AIIMS submitted its report dated 11-5-2012 to the National Commission. The report states that as per standard guidelines (National Neonatology Forum), new born babies who are born at 32 weeks' gestation or less, should have their eyes examined at 3-4 weeks of age and more frequent checkups to be done thereafter. Appellant 4 Dr S.N. Jha examined the baby at 24 days of age in accordance with established protocol. If ROP screening does not reveal any ROP, then repeat examination should be performed after 2 weeks. The report goes on to say that after discharge, the baby was brought twice to the General OPD of Appellant 1 Hospital. There is no record to show that the baby was brought after 2 weeks of discharge to the

Paediatrics OPD clinic when subsequent progression could have been assessed and treated on time.

6. The National Commission vide its judgment and order dated 10-5-2016[1] (Bench comprising of Presiding Member J.M. Malik J. and Dr S.M. Kantikar, a qualified doctor) held as under:

6.1. The National Commission was not convinced that the ROP screening was done by OP No. 5/Appellant 4 on Respondent 1 baby. The progress sheet was devoid of any details about the ROP examination, the method and instruments used, drugs (midrates/tropicamide)/anaesthesia used during ROP testing. The Ophthalmologist has not mentioned any details of the dilation of the pupils, and the findings by indirect ophthalmoscope, and the intra-ocular or extra retinal findings. The standard ROP screening protocol was not followed. The nurses' daily records from 25-4-2005 to 27-4-2005 does not show that any ROP examination was done by OP No. 5/Appellant 4.

6.2. The AIIMS report did not comment about the details of the ROP screening and the follow-up findings.

6.3. The National Commission held that the sequence of events leading to ROP usually takes about 4 to 5 weeks, except in a small sub-set of premature infants who develop rush disease in 2 to 3 weeks. The routine screenings should begin at no later than 4 weeks after birth, and possibly even earlier for infants at higher risk (2 to 3 weeks). It is strongly recommended that one session of retinal screening be carried before day 30 of the life of any premature baby. The examination should be done with the dilation of the pupil with tropicamide 0.5% to 1% with phenylapinephrine 2.5%.

6.4. The National Commission came to the conclusion that OP No. 5/ Appellant 4 did not conduct the ROP screening on the baby. ROP screening is a team-work of the Paediatrician, Ophthalmologist and the NICU nurse. There is no medical documentation of the ROP screening procedural details. OP No. 5 should have performed the retinal examination with binocular indirect ophthalmoscope on dilation of the pupil with scleral depression to ascertain avascular zone at the periphery of the retina. The National Commission found that nothing was forthcoming from p. 102 of the medical records. It appears to be a bare visual examination done by OP No. 5 in haste to cover up the case. The National Commission was of the considered view that neither the ROP screening was performed, nor was any advice for follow-up of ROP given to Respondent 2 complainant/mother.

6.5. The National Commission held that Respondent 1, Master Rishabh had been rendered blind for life, which could never really be compensated in monetary terms. The baby had lost his father during the pendency of proceedings in 2013. Respondent 2 complainant had been pursuing the consumer complaint single-handedly for almost a decade.

1 *Rishabh Sharma* v. *Rama Sharma*, 2016 SCC OnLine NCDRC 2726

6.6. The National Commission awarded an amount of Rs 53,00,000 to Respondent 1 baby by applying the average inflationary principle at a conservative rate of 1% p.a., keeping in mind the fluctuations over the next 59 years. The National Commission awarded an amount of Rs 10,00,000 to Respondent 2 complainant/mother who would have to take care of the blind child throughout her life. A further amount of Rs 1,00,000 was awarded towards costs of litigation. The National Commission held OPs Nos. 2 to 5/Appellants 1 to 4 to be jointly and severally liable to pay the total amount of Rs 64,00,000 within 2 months of the order. The entire amount would carry interest @ 9% p.a.

6.7. Out of the total compensation awarded, Rs 50,00,000 would be kept in a fixed deposit with a nationalised bank till Respondent 1 attained the age of majority. The periodic interest on the deposit would be paid to Respondent 2 complainant/mother till the child attained the age of majority. The remaining amount of Rs 14,00,000 would be released to Respondent 2 complainant.

7. Aggrieved by the impugned Judgment[1] passed by the National Commission, CA No. 6619 of 2016 was filed by the Hospital and the doctors before this Court. The complainants have filed Civil Appeal No. 9461 of 2019 (Diary No. 15393 of 2019) before this Court for enhancement of compensation. This Court vide interim order dated 29-7-2016[2] ordered stay of the operation of the impugned Judgment[1], subject to Appellant 1 Hospital depositing 50% of the amount awarded by the National Commission in this Court within 6 weeks.

8. On 7-9-2016, Appellant 1 Hospital deposited an amount of Rs 32,00,000 in this Court. This Court vide order dated 7-11-2016[3], directed the amount to be kept in a fixed deposit with UCO Bank, which was renewed from time to time. The fixed deposit is due to mature on 17-2-2020.

9. We have heard the learned counsel for all the parties and perused the original medical records, pleadings and written submissions filed by the parties.

10. The learned counsel for the appellants viz. the Hospital and doctors inter alia submitted that:

10.1. Respondent 1 baby was pre-term (32 weeks) with signs of HMD, and was admitted in Appellant 1 Hospital on 2-4-2005 in a critical condition with little chance of survival. The baby was admitted in the neo-natal ICU, and had to be immediately placed on ventilatory support for 10 days. As per standard protocol, regular investigations and arterial blood gas (ABG) analysis were performed. Blood component therapy was given. The critical condition of the baby and possible neuro-development, visual and hearing sequel was informed to the parents. The baby was given utmost care and attention by the doctors of Appellant 1 Hospital.

1 *Rishabh Sharma* v. *Rama Sharma*, 2016 SCC OnLine NCDRC 2726
2 *Maharaja Agrasen Hospital* v. *Rishabh Sharma*, 2016 SCC OnLine SC 1860
3 *Maharaja Agrasen Hospital* v. *Rishabh Sharma*, 2016 SCC OnLine SC 1862

10.2. As per protocol, ophthalmological examination was advised on 25-4-2005 to rule out ROP, as recorded at p. 100 of the medical records. Appellant 4 Dr S.N. Jha, the Senior Ophthalmologist conducted the ROP test on 26-4-2005, who found no ROP in Respondent 1 baby, as recorded by Appellant 4 in his handwriting at p. 102 of the medical records. It was submitted that Appellant 4 had advised a further review/checkup after 2 weeks in the speciality OPD on Wednesday/Saturday between 4 p.m. to 6 p.m. The parents of Respondent 1 baby were explained all the problems which may develop in a premature baby.

10.3. As per the Discharge Summary at p. 109 of the medical records, the complainants were advised to bring Respondent 1 baby for a ROP and BERA checkup to the speciality OPD on Wednesday/Saturday at 4 p.m.

10.4. Respondent 2 complainant brought the baby to the General OPD of Appellant 1 Hospital on 4-5-2005 after 8 days of the first ROP checkup, and not after 2 weeks as advised. Thereafter, the baby was brought on 13-7-2005, which was after 2 months again to the General OPD.

10.5. The appellants relied on the report of the Medical Board constituted by AIIMS, which had vide their report dated 11-5-2012 held that the baby was not brought to the Paediatrics OPD Clinic on Wednesdays or Saturdays at 4 p.m. after two weeks of discharge, when subsequent progression of ROP could have been assessed and treated on time.

10.6. Appellant 4/OP No. 5, Dr S.N. Jha, a Senior Ophthalmologist was engaged with Appellant 1 Hospital from 1997 to 2010. It was submitted on his behalf that on 25-4-2005, the Paediatrics Department of Appellant 1 Hospital had requisitioned him to perform the ROP examination. Appellant 4 submits that ROP was duly conducted by him on 26-4-2005. His finding is recorded at p. 102 of the medical records, wherein he has recorded that he did not find any evidence of ROP at that stage. It was further submitted that it was not required to record the method of dilation of the pupil and use of indirect ophthalmoscope. The standard medical literature establishes that ROP manifests itself after 4 weeks of post-natal age. In view thereof, the finding of Appellant 4, who examined the baby only on 26-4-2005 i.e. when the baby was 24 days' old, there was no evidence of ROP, cannot be faulted.

10.7. It was further submitted that the only requirement for conducting an ROP examination is a chemical solution of tropicamide and phenylephrine to dilate the eyes, which was available in the nursery, and an indirect ophthalmoscope, which is available with all ophthalmologists. who have specialised in the care of retina, and are competent to carry ROP examination. It was submitted that Appellant 4 was not required to record the procedure for conducting the ROP examination, which is merely the retinal examination of the baby by use of an indirect ophthalmoscope after dilation of the pupils.

10.8. Appellant 4 Dr S.N. Jha was not consulted on the two subsequent visits by Respondent 2 complainant with the baby on 4-5-2005 and 13-7-2005

in the Ophthalmology Department, even though he would have been available in the speciality OPD on Wednesdays/Saturdays at 4 p.m.

11. The learned counsel for the complainants, Respondents 1 to 3 (Appellants 1 to 3 in Civil Appeal No. 9461 of 2019/Diary No. 15393 of 2019), inter alia submitted that Respondent 1 baby has become permanently blind on account of the gross medical negligence by the Hospital, and the three specialist doctors i.e two consultant Paediatricians, and the Ophthalmologist, for the following reasons:

11.1. Appellants 1 to 4 did not at any stage conduct the ROP examination of the baby, who was a premature baby, nor was the family ever informed about the high risk of ROP in a premature baby, and the necessity for regular checkups.

11.2. Appellant 1 Hospital had deliberately withheld the medical records for over two years after discharge. At the time of discharge on 29-4-2005, the complainants were provided with a discharge slip, which did not disclose any instructions advising that the infant be brought for ROP examination (the discharge slip in para 5.4 above). In this discharge slip, there is no advice of ROP having been conducted, or follow-up of ROP, nor was the risk of ROP explained by Appellants 2 and 3 to Respondent 2 complainant.

11.3. The complainants have strongly contended that parts of the medical records, which were provided after 2 years in 2007, had been fabricated and interpolated as an afterthought to escape liability. It was submitted that a bare perusal of the noting dated 26-4-2005 made in the medical record by Appellant 4 Ophthalmologist, shows that is merely a scribble, and is illegible. The complainants have strongly refuted the case of the appellants that the ROP was conducted by Appellant 4 on 26-4-2005.

11.4. The complainants have supported their submission on the basis of: (*i*) the progress sheets, which contain no details of the ROP examination; (*ii*) there is no mention of the ROP examination in the nurses' daily record; (*iii*) ROP exam is conducted with the help of dilation by using cyclopentolate (0.5%) and phenylephrine (2.5%) drops to be applied 2 to 3 times, about 10-15 minutes apart. There is no record with respect to the administration of these medicines to the baby; (*iv*) there is no mention of the ROP test in the discharge slip of 29-4-2005.

11.5. The complainants contended that if the standard protocol had been carried out by the doctors, the ROP would have been detected at an early stage, and could have been cured, since it is medically known to be reversible at the early stages. On account of the negligence of Appellants 1 to 4, the ROP was discovered only at Stage 5, by Shroff Charity Eye Hospital, when the baby was 8 months old. By this time, the ROP became irreversible, and resulted in total blindness of Respondent 1 baby.

11.6. It was further urged that the quantum of compensation awarded by the National Commission was grossly inadequate and insufficient. The National Commission failed to take into account variables such as the

additional educational expenses in special schools, transportation costs, costs of purchasing, maintaining and upgrading visual aid/assistive devices, costs of permanent nursing/attendant care and miscellaneous medical expenses. It was further contended that the average rate of inflation taken by the National Commission i.e. a conservative rate of 1% p.a. for the next 59 years, was grossly undervalued. The complainants sought enhancement of the compensation to the extent of Rs 9,87,84,000.

12. ***Discussion and Analysis***

12.1. ***Inordinate delay in supply of medical records***: We find that there was an inordinate delay of over 2 years in making the medical records of Respondent 1, Master Rishabh available to Respondent 2 complainant. Regulation 1.3.2 of the IMC Regulations casts a statutory obligation upon every doctor/hospital to provide medical records within 72 hours of the request being made by the patient.

12.1.1. The Medical Council of India has framed the IMC Regulations with the previous approval of the Central Government, in exercise of the powers conferred by Section 20-A read with Section 33(*m*) of the Indian Medical Council Act, 1956. The IMC Regulations came into force on their publication in the Gazette of India on 6-4-2002, and have statutory force.

12.1.2. Regulation 1.3.2 of the Indian Medical Council (Professional Conduct, Etiquettes and Ethics) Regulations, 2002 provides as under:

> "**1.3.** ***Maintenance of medical records***:
>
> **1.3.1.** Every physician shall maintain the medical records pertaining to his/her indoor patients for a period of 3 years from the date of commencement of the treatment in a standard pro forma laid down by the Medical Council of India and attached as Appendix 3.
>
> **1.3.2.** *If any request is made for medical records either by the patients/ authorised attendant or legal authorities involved, the same may be duly acknowledged and documents shall be issued within the period of 72 hours.*
>
> **1.3.3.** A registered medical practitioner shall maintain a Register of Medical Certificates giving full details of certificates issued. When issuing a medical certificate he/she shall always enter the identification marks of the patient and keep a copy of the certificate. He/She shall not omit to record the signature and/or thumb mark, address and at least one identification mark of the patient on the medical certificates or report. The medical certificate shall be prepared as in Appendix 2.
>
> **1.3.4.** Efforts shall be made to computerise medical records for quick retrieval." (emphasis supplied)

12.1.3. As per Regulation 7, if the doctor refuses or fails to provide the medical records within 72 hours when the patient or his/her authorised representative makes a request as per Regulation 1.3.2, the said act of commission or omission would constitute professional misconduct rendering

him/her liable for disciplinary action and punishment under Regulation 8. Regulations 7 and 8 provide as follows:

"**7.** ***Misconduct.***—The following acts of commission or omission on the part of a physician shall constitute professional misconduct rendering him/her liable for disciplinary action.

7.1. ***Violation of the Regulations.***— If he/she commits any violation of these Regulations.

7.2. If he/she does not maintain the medical records of his/her indoor patients for a period of three years as per Regulation 1.3 and refuses to provide the same within 72 hours when the patient or his/her authorised representative makes a request for it as per Regulation 1.3.2.

* * *

8. ***Punishment and Disciplinary Action***

8.1. It must be clearly understood that the instances of offences and of professional misconduct which are given above do not constitute and are not intended to constitute a complete list of the infamous acts which call for disciplinary action, and that by issuing this notice the Medical Council of India and or State Medical Councils are in no way precluded from considering and dealing with any other form of professional misconduct on the part of a registered practitioner. Circumstances may and do arise from time to time in relation to which there may occur questions of professional misconduct which do not come within any of these categories. Every care should be taken that the code is not violated in letter or spirit. In such instances as in all others, the Medical Council of India and/or State Medical Councils have to consider and decide upon the facts brought before the Medical Council of India and/or State Medical Councils.

8.2. It is made clear that any complaint with regard to professional misconduct can be brought before the appropriate Medical Council for disciplinary action. Upon receipt of any complaint of professional misconduct, the appropriate Medical Council would hold an enquiry and give opportunity to the registered medical practitioner to be heard in person or by pleader. If the medical practitioner is found to be guilty of committing professional misconduct, the appropriate Medical Council may award such punishment as deemed necessary or may direct the removal altogether or for a specified period, from the register of the name of the delinquent registered practitioner. Deletion from the Register shall be widely publicised in the local press as well as in the publications of different Medical Associations/Societies/Bodies.

8.3. In case the punishment of removal from the register is for a limited period, the appropriate Council may also direct that the name so removed shall be restored in the register after the expiry of the period for which the name was ordered to be removed.

8.4. Decision on complaint against delinquent physician shall be taken within a time-limit of 6 months.

8.5. During the pendency of the complaint the appropriate Council may restrain the physician from performing the procedure or practice which is under scrutiny.

8.6. Professional incompetence shall be judged by peer group as per guidelines prescribed by Medical Council of India."

12.1.4. The IMC Regulations framed by the Medical Council of India are binding on all medical professionals, who are under a statutory obligation to provide medical records to the patients or their attendants. All hospitals, whether government or private are liable to maintain the medical records, and provide the same to patient or their attendants within 72 hours of the request.

12.1.5. The Delhi Medical Council vide Circular No. DMC/DHS/F.5/2/2009 dated 15-5-2009 casts a statutory obligation on all registered medical practitioners and hospitals/nursing homes to strictly adhere to Regulation 1.3.2 of the IMC Regulations. The failure to comply with the same would constitute professional misconduct and entail disciplinary action.

12.1.6. This Court in *Federation of Obstetrics & Gynaecological Societies of India* v. *Union of India*[4] held that: (SCC p. 322, para 58)

> "*58.* ... considering the nature of services rendered by medical professionals, proper maintenance of records is an integral part of the medical services."

12.1.7. Respondent 2 complainant submitted that she had made several requests for being provided the in-patient records for further evaluation/examination of the baby, which was not made available to her for over 2 years after his discharge in April 2005 from Appellant 1 Hospital. Respondent 2 complainant had to run from one hospital to another so as to ascertain why her son had abnormal visual responses. Despite repeated requests, the medical records were withheld by the Hospital. Respondent 2 complainant had a legal notice issued on 24-2-2007 to Appellant 1 Hospital requesting for the entire in-patient medical record of her child, and made a complaint to the Delhi Medical Council. Appellant 1 Hospital eventually provided the medical record on 14-6-2007.

12.1.8. The Delhi Medical Council vide order dated 14-12-2007 issued a warning to Appellant 1 Hospital for the delay in supplying the medical records of Respondent 1 to the complainant. We find that withholding the medical records of Respondent 1, who was a premature baby, for a period of over 2 years, would constitute grave professional misconduct under Regulation 7, apart from being a gross deficiency in service on the part of Appellant 1 Hospital and its management.

4 (2019) 6 SCC 283

12.2. ***Failure to diagnose Retinopathy of Prematurity (ROP)***: Retinopathy of Prematurity (ROP) is one of the major emerging causes of childhood blindness. A premature baby is not born with ROP. At the time of birth, particularly in the case of premature babies, the retina is immature, which is natural at this stage. It is the post-natal developments in the retinal vessels which could lead to ROP.

12.2.1. As per medical literature, all infants with a birth weight of less than 1500 gm, or gestational age of less than 32 weeks, are required to be mandatorily screened for ROP, which usually takes about 4 to 5 weeks to be diagnosed. The routine screening should begin no later than 4 weeks after birth, and possibly even earlier for infants at higher risk (2 to 3 weeks). The standard of care is to be judged in the light of the protocols and standard procedures prevailing on the date of birth, and not on the date of trial.[5]

12.2.2. In "Programme Planning and Screening Strategy in Retinopathy of Prematurity"[6], published in March 2003 co-authored by Drs Subhadra Jalali, MS; Raj Anand, MS; Harsh Kumar, MD; Mangat R. Dogra, MS; Rajvardhan Azad, MD, FRCS (Ed.); Lingam Gopal, MS have opined that:

> "There are several compelling reasons to have a screening programme for ROP. *Firstly, the premature child is not born with ROP and retinal disease is not present at birth. Each prematurely born child has a potential for normal vision, even if the retina is immature at birth. Screening for ROP aims to identify those infants who have reached or have the potential to reach threshold ROP, which if untreated, may cause blindness or visual impairment. This has medico-legal implications. There are indefensible legal repercussions should an infant develop ROP and retinal detachment, but had not received eye examination. Secondly, the grief and the personal tragedy for the family is tremendous, besides the economic burden of such childhood blindness. The aim of screening premature babies for ROP is to detect all treatable neonates, with minimal expense of time and resources. This also aims at not screening those babies who are unlikely to get a severe form of ROP. Early recognition of ROP by screening provides an opportunity for effective treatment.... The criteria for screening babies are based on two critical factors — the birth weight and the gestational age.*" (emphasis supplied)

12.2.3. A well-organised screening strategy and timely intervention can to a large extent prevent blindness due to ROP. Extensive clinical trials and

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5 *Nizam's Institute of Medical Sciences* v. *Prasanth S. Dhananka*, (2009) 6 SCC 1 : (2009) 2 SCC (Civ) 688; *Jacob Mathew* v. *State of Punjab*, (2005) 6 SCC 1 : 2005 SCC (Cri) 1369

6 Subhadra Jalali, MS; Raj Anand, MS; Harsh Kumar, MD; Mangat R. Dogra, MS; Rajvardhan Azad, MD, FRCS (Ed.); Lingam Gopal, MS, "Programme Planning and Screening Strategy in Retinopathy of Prematurity", Indian J Ophthalmol 2003 (March 2003), Vol. 51, pp. 89-99.

publications[7] have established that among other factors, gestation period and low birth weight are critical in the pathophysiology of ROP. If detected early and treated with peripheral retinal cryopexy or laser, ROP blindness can be prevented to some extent.[8] Once the case crosses Stage 3, in very few cases can the sight be saved even by extensive vitreoretinal surgery.[9]

12.2.4. This Court considered this issue in a similar case in *V. Krishnakumar* v. *State of T.N.*[10] In that case, a premature female baby was born in the 29th week of pregnancy. The infant weighed only 1.25 kg at birth. The doctors failed to examine the baby for ROP, or advise the parents that the baby was required to be seen by a paediatric ophthalmologist since there was a possibility of occurrence of ROP, so as to avert permanent blindness. The discharge summary neither disclosed a warning to the infant's parents of the possibility that the infant might develop ROP for which certain precautions must be taken, nor any signs that the doctors were themselves cautious of the dangers of development of ROP. The doctors attempted to cover up their gross negligence of not having examined the infant for the onset of ROP, which is a standard precaution for a well-known condition in such a case.

12.2.5. This Court in *V. Krishnakumar*[10] after reviewing and analysing the medical literature on ROP, observed that the problem occurs in infants who are prematurely born, and who have been administered oxygen and blood transfusion upon birth. If detected during early stages, it can be prevented. In paras 4-6 of the judgment, this Court held that: (*V. Krishnakumar case*[10], SCC pp. 395-96)

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7 Palmer EA, Flynn JT, Hardy RJ, Phleps DL, Phillips CL, Schaffer DB, Incidence and early course of retinopathy of prematurity. Ophthalmology 1991;98:1628-40; *Fielder AR, Shaw DF, Robinson J, Ng YK*, Natural history of retinopathy of prematurity: A prospective study. Eye 1992;6:233-42; STOP-ROP Multicentre Study Group. Supplemental therapeutic oxygen for pre-threshold retinopathy of prematurity (STOP-ROP), a randomised controlled trial: Primary outcomes. Paediatrics 2000;150:295-10. Cryotherapy for Retinopathy of Prematurity Cooperative Group. Multicentre trial of cryotherapy for retinopathy of prematurity-Three-month outcome. Arch Ophthalmol 1990;108:195-40.

8 Cryotherapy for Retinopathy of Prematurity Cooperative Group. Multicentre trial of cryotherapy for retinopathy of prematurity-Three-month outcome, Arch Ophthalmol 1990;108:195-40 ; Cryotherapy for Retinopathy of Prematurity Cooperative Group. Multicentre trial of cryotherapy for retinopathy of prematurity-3½ years outcome for both structure and function, Arch Ophthalmol 1993;111:339-44. Tsisis T, Tasman W, Mcnamara JA, Brown G, Vander J. Diode laser photocoagulation for retinopathy of prematurity, Trans Am Ophthal Soc 1997;95:231-36.; Despande DA, Chaturvedi M, Gopal L, Ramachandram S, Shanmugasundaram R. Treatment of threshold retinopathy of prematurity, Indian J Ophthalmol 1998;46:1519.

9 Cherry TA, Lambert SR, Capone-A Jr. Electroretinographic findings in stage V retinopathy of prematurity after retinal reattachment, Retina 1995;15:21-24; Noorily SW, Small K, Juan E de, Machemar R. Scleral bucking surgery for stage 4B retinopathy of prematurity, Ophthalmology 1992;99:263-68.

10 (2015) 9 SCC 388 : (2015) 4 SCC (Civ) 546

"*4. … It is said that prematurity is one of the most common causes of blindness and is caused by an initial constriction and then rapid growth of blood vessels in the retina. When the blood vessels leak, they cause scarring. These scars can later shrink and pull on the retina, sometimes detaching it. The disease advances in severity through five stages — 1, 2, 3, 4 and 5 (5 being the terminal stage). Medical literature suggests that Stage 3 can be treated by Laser or Cryotherapy treatment in order to eliminate the abnormal vessels. Even in Stage 4, in some cases, the central retina or macula remains intact thereby keeping intact the central vision. When the disease is allowed to progress to Stage 5, there is a total detachment and the retina becomes funnel shaped leading to blindness. There is ample medical literature on the subject. It is, however, not necessary to refer all of it. Some material relevant to the need for checkup for ROP for an infant is*:

'*All infants with a birth weight less than 1500 gm or gestational age less than 32 weeks are required to be screened for ROP.*'[11]

* * *

5. It is undisputed that the relationship of birth weight and gestational age to ROP as reproduced in NCDRC's order[12] is as follows:

'*Most ROP is seen in very low birth weight infants, and the incidence is inversely related to birth weight and gestational age. About 70-80% of infants with birth weight less than 1000 gm show acute changes, whereas above 1500 gm birth weight the frequency falls to less than 10%.*'

6. … It is further observed that ROP is a visually devastative disease that often can be treated successfully if it is diagnosed in time." (emphasis supplied)

12.2.6. This Court relied upon a report dated 21-8-2007 of the All India Institute of Medical Sciences, New Delhi comprising of five members, of which, four were ophthalmological specialists. The Board opined as under: (*V. Krishnakumar case*[10], SCC p. 397, para 11)

"*11. … 'A premature infant is not born with Retinopathy of Prematurity (ROP), the retina though immature is normal for this age. The ROP usually starts developing 2-4 weeks after birth when it is mandatory to do the first screening of the child. The current guidelines are to examine and screen the babies with birth weight<1500 gm and <32 weeks' gestational age, starting at 31 weeks' post-conceptional age (PCA) or 4 weeks after birth, whichever is later. Around a decade ago, the guidelines in general were the*

11 AIIMS Report dated 21-8-2007.
12 *V. Krishna Kumar* v. *State of T.N.*, OP No. 57 of 1998, order dated 27-5-2009 (NCDRC)
10 *V. Krishnakumar* v. *State of T.N.*, (2015) 9 SCC 388 : (2015) 4 SCC (Civ) 546

same and the premature babies were first examined at 31-33 weeks post-conceptional age or 2-6 weeks after birth.

There is a general agreement on these above guidelines on a national and international level. The attached annexure explains some authoritative resources and guidelines published in national and international literature especially over the last decade.

However, in spite of ongoing interest world over in screening and management of ROP and advancing knowledge, it may not be possible to exactly predict which premature baby will develop ROP and to what extent and why." (emphasis supplied)

12.2.7. On a review of the literature on ROP, the Supreme Court in *V. Krishnakumar*[10] set out the screening guidelines as follows: (SCC p. 397, para 11)

"*Year*	*Source*	*First screening*	*Who to screen*
2006	American Academy of Paediatrics et al.	31 weeks PCA or 4 weeks after birth, whichever is later.	<1500 gm birth weight or <32 weeks GA or higher.
2003	Jalali S et al. Indian J Ophthalmology	31 weeks PCA or 3-4 weeks after birth, whichever is earlier.	<1500 gm birth weight or <32 weeks GA or higher.
2003	Azad et al. JIMA	32 weeks PCA or 4-5 weeks after birth, whichever is earlier.	<1500 gm birth weight or <32 weeks GA or higher.
2002	Aggarwal R et al. Indian J. Paediatrics	32 weeks PCA or 4-6 weeks after birth, whichever is earlier.	<1500 gm birth weight or <32 weeks GA.
1997	American Academy of Paediatrics et al.	31-33 weeks PCA or 4-6 weeks after birth.	<1500 gm birth weight or <28 weeks GA or higher.
1996	Maheshwari R et al. National Med. J. India	32 weeks PCA or 2 weeks after birth, whichever is earlier.	<1500 gm birth weight or <35 weeks GA or 02>24 hrs.
1988	Cryotherapy ROP Group	4-6 weeks after birth.	<1250 gm birth weight."

This Court observed that ROP starts developing 2 to 4 weeks after birth when it is mandatory to do the first screening of the child. As per the report of AIIMS "it may not be possible to exactly predict which premature baby will develop ROP and to what extent and why". This would necessitate the need for a checkup in all such cases.

12.2.8. It is clear from the above medical literature that ROP is a visually progressive disease, which can be treated successfully if it is diagnosed on time. ROP advances through 5 stages. Medical literature suggests that Stage 3 can be treated by laser or cryotherapy treatment in order to eliminate the abnormal

10 *V. Krishnakumar* v. *State of T.N.*, (2015) 9 SCC 388 : (2015) 4 SCC (Civ) 546

vessels. Even at Stage 4, in some cases, the central retina or macula remains intact thereby keeping intact the central vision. When the disease progresses to Stage 5, there is a total detachment, and the retina becomes funnel shaped, leading to blindness.

12.2.9. We have carefully perused the original medical records of Appellant 1 Hospital, which were provided in a sealed cover to the Court. We find that there is an entry at p. 100 of the medical records dated 25-4-2005 recorded at 9.00 a.m. which reads as under:

"25-4-2005

9 a.m.	Stable Wt: 1.56 kg Accepting cup feeds S/E — NAD D19 of Inj Amphocan
Plan for Discharge tomorrow	*Adv:* *– Breast feeds* *– Cont. rest* *– ROP Check-Up (Dr Jha)"*

(emphasis supplied)

12.2.10. At the bottom of p. 102 of the medical records, there is another entry dated 26-4-2005, which reads as under:

"26/4 by Dr SNJ
No ROP
Review, 2 weeks."

The said noting is signed by Dr S.N. Jha, Appellant 4. There is, however, no time mentioned against this noting. A visual examination of the original medical records/treatment sheet shows that this entry is not recorded in the same sequence as all previous and subsequent notings. The entries recorded at pp. 100 and 102 have been made at the bottom of the page. The date "26/4" is mentioned in a different column, unlike the other entries made before and after this entry. There is no time of the ophthalmological examination by Appellant 4 Dr S.N. Jha on 26-4-2005 mentioned in the record, unlike all other notings by other doctors, who have examined the patient, where the time is clearly recorded.

12.2.11. On the next page i.e. p. 103 of the medical record, it is mentioned as "Day 28" i.e. 26-4-2005 on the top of the page. The first entry on that date is recorded at 10.30 a.m. This would indicate that the baby was not examined prior to 10.30 a.m. by any doctor.

12.2.12. There is no contemporaneous record to corroborate that ROP screening was done by Appellant 4 on 26-4-2005. The nurses' daily record or treatment sheet do not mention that the dilation of the pupils of the baby

were carried out by administration of cyclopentolate (0.5%) and phenylephrine (2.5%) drops to conduct test of ROP.

12.2.13. We had orally enquired from the learned counsel appearing on behalf of Appellant 4 Dr S.N. Jha about the approximate time at which the ROP checkup was done by him on 26-4-2005. The counsel was unable to specify the time at which the baby was examined by him.

12.2.14. Respondent 1 baby was discharged on 29-4-2005. The complainants were provided with a discharge slip. The discharge slip does not contain any advice for a mandatory follow-up for ROP. Rather, the discharge slip only advised the complainant to bring Respondent 1 for a review to the Paediatrics OPD on Wednesday or Saturday at 4 p.m.

12.2.15. The counsel for the Hospital and the doctors contended that post-discharge, Respondent 2 complainant did not bring the baby to the speciality Paediatric OPD for a checkup as advised in the discharge summary.

12.2.16. We have seen the original medical records produced by Appellant 1 Hospital, and find that on both occasions i.e. 4-5-2005 and 13-7-2005, the complainants went correctly to the Paediatrics Unit of the General OPD. Hence, the contention of the appellants is liable to be rejected as being completely baseless.

12.2.17. The complainant took the baby for a follow-up checkup post-discharge to the Paediatrics-III Department on two occasions i.e. 4-5-2005 and 13-7-2005. The baby was examined by Appellants 2 and 3 on 4-5-2005. In the treatment sheet, there is no recommendation to have ROP test done, nor was the patient advised to come back after two weeks. The noting on 4-5-2005 is extracted hereinbelow for ready reference:

"Maharaja Agrasen Hospital
Punjabi Bagh, New Delhi — 26
Ph. 252266465 to 54 (10 lines)
General OPD Prescription

MAH No.: 0505404 Date: 4-5-2005
Deptt./Unit …Paediatrics-III Wed, Sat…9.00 to 11.00
Consultants: Dr G.S. Kochhar/Dr Naveen Jain
B/O Pooja Sharma Age/Sex 1 Mths
Male.
Wt 1.65 kg

FUC 32 weeks pre-term AGA with HMD
with bilateral pneumothorax
with fungal septicaemia.

Baby stable.

Adv.

– Breast feeds.
– Continue supplements.

Signature Dr Naveen Jain."

12.2.18. The complainant took the baby for a further follow-up on 13-7-2005 to the Paediatrics-III Department. The baby was examined by Dr Manoj on behalf of Appellant 2. The medical record even on this date does not mention any advice for an ROP test. The attending doctor only advised that a BERA test be done. The noting on 13-7-2005 is reproduced hereinbelow for ready reference:

"Maharaja Agrasen Hospital
Punjabi Bagh, New Delhi — 26
Ph. 252266465 to 54 (10 lines)
General OPD Prescription

MAH No.: 05052879 Date 13-7-2005
Deptt.: Paediatrics-III Wed, Sat...9.00 to 11.00
Consultants: Dr G.S. Kochhar/Dr Naveen Jain
Rishabh Sharma Age/Sex 4 Mths Male.
B/O Pooja Sharma
Wt 4 kg
Dr Manoj Advice — BERA test
Calcirol sachet (3)
Visyneral-Z drops 8 drops daily.
RB tone drop 5 drops.
Syp. Lactocal 1/2 tsf.

Dr G.S. Kochhar (Signature)"

It is thus abundantly clear that the baby was rightly taken to the Paediatrics Unit of the General OPD Clinic at the chronological age of 4 to 5 weeks, when the onset of ROP could have been detected. However, there was no advice given by the treating doctors i.e. Appellants 2 and 3, the Consultant Paediatricians, nor Appellant 4, Ophthalmologist to conduct the ROP test.

12.2.19. We find that the ROP was neither advised, nor carried out at all by Appellant 1 Hospital, or Appellant 4 Dr S.N. Jha, the Senior Ophthalmologist, throughout the period of hospitalisation of the baby, or even after discharge. The baby was born in the 32nd gestational week, and was 1.49 kg at birth. As per standard protocol, the ROP screening ought to have been done between 3-4 weeks from birth. The baby remained admitted for 27 days in the Hospital from 2-4-2005 to 29-4-2005. There is no justification whatsoever why the mandatory screening of ROP was not done for the baby, while he was under the direct care and supervision of the appellants.

12.2.20. We affirm the findings of the National Commission of gross negligence by Appellants 2 to 4 doctors, and deficiency of service by Appellant 1 Hospital.

12.3. ***Report of the Medical Board constituted by AIIMS***

12.3.1. A perusal of the AIIMS Report dated 11-5-2012 shows that it was premised on the alleged entry recorded by Appellant 4 Dr S.N. Jha on 26-4-2005, which records that ROP test was conducted, and no ROP was detected. We have already recorded a finding that the entry made in the treatment sheet (at pp. 100 and 102 of the original medical records) seems to be an interpolation done subsequently to cover up the failure of the Hospital and the doctors to advise or conduct the mandatory ROP checkup and follow-up protocol. The second point contained in the AIIMS Report that the baby was not taken to the Paediatrics OPD is wholly fallacious. We have seen the medical records, and find that the baby was, in fact, taken to the Paediatrics Unit of the General OPD. Hence, the basis of the Report is misconceived, and cannot be relied upon.

12.3.2. It is well settled that a court is not bound by the evidence of an expert, which is advisory in nature. The court must derive its own conclusions after carefully sifting through the medical records, and whether the standard protocol was followed in the treatment of the patient. The duty of an expert witness is to furnish the court with the necessary scientific criteria for testing the accuracy of the conclusions, so as to enable the court to form an independent opinion by the application of this criteria to the facts proved by the evidence of the case.[13] Whether such evidence could be accepted or how much weight should be attached to it is for the court to decide.[14]

12.3.3. We accept the view taken by the National Commission in disregarding the opinion of the Medical Board constituted by AIIMS.

12.3.4. The complainants have discharged the initial burden of proof[15] by making out a case of clear negligence on the part of Appellant 1 Hospital and the Paediatric doctors under whose care the baby was admitted, as also Appellant 4 Dr S.N. Jha, the Senior Ophthalmologist attached to Appellant 1 Hospital. Appellant 1 Hospital and Appellants 2-4 doctors have failed to satisfy the Court that ROP tests were conducted at any point of time, or that the complainants were even advised to get the ROP test done.

12.4. ***Medical Negligence and Duty of Care***

12.4.1. Medical negligence comprises of the following constituents:

(*1*) A legal duty to exercise due care on the part of the medical professional;

(*2*) failure to inform the patient of the risks involved;

(*3*) the patient suffers damage as a consequence of the undisclosed risk by the medical professional;

(*4*) if the risk had been disclosed, the patient would have avoided the injury;

13 *Ramesh Chandra Agrawal* v. *Regency Hospital Ltd.*, (2009) 9 SCC 709 : (2009) 3 SCC (Civ) 840; *State of H.P.* v. *Jai Lal*, (1999) 7 SCC 280 : 1999 SCC (Cri) 1184

14 *Malay Kumar Ganguly* v. *Sukumar Mukherjee*, (2009) 9 SCC 221 : (2009) 3 SCC (Civ) 663 : (2010) 2 SCC (Cri) 299; *V. Kishan Rao* v. *Nikhil Super Speciality Hospital*, (2010) 5 SCC 513 : (2010) 2 SCC (Civ) 460

15 *Nizam's Institute of Medical Sciences* v. *Prasanth S. Dhananka*, (2009) 6 SCC 1 : (2009) 2 SCC (Civ) 688; *Savita Garg* v. *National Heart Institute*, (2004) 8 SCC 56

(*5*) breach of the said duty would give rise to an actionable claim of negligence.

12.4.2. The cause of action for negligence arises only when damage occurs, since damage is a necessary ingredient of this tort. In a complaint of medical negligence, the burden is on the complainant to prove breach of duty, injury and causation. The injury must be sufficiently proximate to the medical practitioner's breach of duty. In the absence of evidence to the contrary adduced by the opposite party, an inference of causation may be drawn even though positive or scientific proof is lacking.[16]

12.4.3. Medical negligence is the breach of a duty of care by an act of omission or commission by a medical professional of ordinary prudence. Actionable medical negligence is the neglect in exercising a reasonable degree of skill and knowledge to the patient, to whom he owes a duty of care, which has resulted in injury to such person. The standard to be applied for adjudging whether the medical professional charged has been negligent or not, in the performance of his duty, would be that of an ordinary competent person exercising ordinary skill in the profession. The law requires neither the very highest nor a very low degree of care and competence to adjudge whether the medical professional has been negligent in the treatment of the patient.[17]

12.4.4. The degree of skill and care required by a medical practitioner stated in *Halsbury's Laws of England*[18] is as follows:

> "22. *Negligence: Duties owed to patient.* A person who holds himself out as ready to give medical advice or treatment impliedly undertakes that he is possessed of skill and knowledge for the purpose. *Such a person, whether he is a registered medical practitioner or not, who is consulted by a patient, owes him certain duties, namely, a duty of care in deciding whether to undertake the case; a duty of care in deciding what treatment to give; and a duty of care in his administration of that treatment. A breach of any of these duties will support an action for negligence by the patient.*"
>
> "35. *Degree of skill and care required.*—... *To establish liability on that basis it must be shown (1) that there is a usual and normal practice; (2) that the defendant has not adopted it; and (3) that the course in fact adopted is one no professional man of ordinary skill would have taken had he been acting with ordinary care.*" (emphasis supplied)

12.4.5. Lord Denning, in *Hucks* v. *Cole*[19], held that a medical practitioner would be liable only where his conduct falls below the standards of a reasonably competent practitioner in his field.

16 *Postgraduate Institute of Medical Education & Research* v. *Jaspal Singh*, (2009) 7 SCC 330 : (2009) 3 SCC (Civ) 114 : (2009) 3 SCC (Cri) 399

17 *Laxman Balkrishna Joshi* v. *Trimbak Bapu Godbole*, (1969) 1 SCR 206 : AIR 1969 SC 128; *Kusum Sharma* v. *Batra Hospital*, (2010) 3 SCC 480 : (2010) 1 SCC (Civ) 747 : (2010) 2 SCC (Cri) 1127

18 3rd Edn., Vol. 26, pp. 17-18; 4th Edn., Vol. 30, para 35.

19 (1968) 118 New LJ 469 (CA); followed in *Postgraduate Institute of Medical Education & Research* v. *Jaspal Singh*, (2009) 7 SCC 330 : (2009) 3 SCC (Civ) 114 : (2009) 3 SCC (Cri) 399

12.4.6. In earlier judgments, this Court referred to the Bolam test laid down in *Bolam* v. *Friern Hospital Management Committee*[20]. In this case, the doctor treating the patient suffering from mental illness was held not to be guilty of medical negligence by the Queen's Bench Division for failure to administer muscle-relaxant drugs and using physical restraint in the course of electro-convulsive therapy. McNair, J., in his opinion, explained the law in the following words (*Bolam*[20], WLR at p. 586):

> "... where you get a situation which involves the use of some special skill or competence, then the test as to whether there has been negligence or not is not the test of the man on the top of a Clapham omnibus, because he has not got this special skill. *The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill; it is well-established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art.*" (emphasis supplied)

12.4.7. The ratio of the *Bolam case*[20] is that it is enough for the doctor to show that the standard of care and the skill exercised by him was that of an ordinary competent medical practitioner exercising an ordinary degree of professional skill. McNair, J., held that (*Bolam*[20], WLR at p. 587):

> "... he [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."

12.4.8. In the subsequent judgment rendered in *Eckersley* v. *Binnie*[21], Bingham, L.J. explained the *Bolam*[20] test in the following words: (Con LR p. 79)

> "From these general statements it follows that a professional man should command the corpus of knowledge which forms part of the professional equipment of the ordinary member of his profession. He should not lag behind other ordinary assiduous and intelligent members of his profession in the knowledge of new advances, discoveries and developments in his field. *He should have such an awareness as an ordinarily competent practitioner would have of the deficiencies in his knowledge and the limitations on his skill. He should be alert to the hazards and risks in any professional task he undertakes to the extent that other ordinarily competent members of the profession would be alert. He must bring to any professional task he undertakes no less expertise, skill and care than other ordinarily competent members of his profession would bring, but need bring no more. The standard is that of the reasonable average.* The law does not require of a professional man that he be a paragon

20 (1957) 1 WLR 582 : (1957) 2 All ER 118

21 (1988) 18 Con LR 1 (CA); followed in *Jacob Mathew* v. *State of Punjab*, (2005) 6 SCC 1 : 2005 SCC (Cri) 1369; *S.K. Jhunjhunwala* v. *Dhanwanti Kaur*, (2019) 2 SCC 282 : (2019) 1 SCC (Civ) 620

combining the qualities of polymath and prophet. (Charlesworth & Percy, ibid., para 8.04)" (emphasis supplied)

12.4.9. A medical professional should be alert to the hazards and risks in any professional task he undertakes to the extent that other ordinarily competent members of the profession would be alert. He must bring to any professional task he undertakes reasonable skill that other ordinarily competent members of his profession would bring.

12.4.10. This Court followed the *Bolam*[20] test in *Jacob Mathew* v. *State of Punjab*[22] wherein it was held that the *Bolam*[20] test has been widely accepted as decisive of the standard of care required by medical practitioners, and it is invariably cited with approval before the courts in India, and applied as a touchstone to test the pleas of medical negligence. The Court summed up the law on medical negligence in the following words: (*Jacob Mathew case*[22], SCC pp. 32-33, para 48)

"*48.* ... (1) Negligence is the breach of a duty caused by 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. The definition of negligence as given in *Law of Torts*, Ratanlal & Dhirajlal (edited by Justice G.P. Singh), referred to hereinabove, holds good. Negligence becomes actionable on account of injury resulting from the act or omission amounting to negligence attributable to the person sued. The essential components of negligence are three: "duty", "breach" and "resulting damage".

(2) Negligence in the context of the medical profession necessarily calls for a treatment with a difference. To infer rashness or negligence on the part of a professional, in particular a doctor, additional considerations apply. A case of occupational negligence is different from one of professional negligence. A simple lack of care, an error of judgment or an accident, is not proof of negligence on the part of a medical professional. *So long as a doctor follows a practice acceptable to the medical profession of that day, he cannot be held liable for negligence merely because a better alternative course or method of treatment was also available or simply because a more skilled doctor would not have chosen to follow or resort to that practice or procedure which the accused followed. When it comes to the failure of taking precautions, what has to be seen is whether those precautions were taken which the ordinary experience of men has found to be sufficient; a failure to use special or extraordinary precautions which might have prevented the particular happening cannot be the standard for judging the alleged negligence. So also, the standard of care, while assessing the practice as adopted, is judged in the light of knowledge available at the time of the incident, and not at the date of*

20 *Bolam* v. *Friern Hospital Management Committee*, (1957) 1 WLR 582 : (1957) 2 All ER 118
22 (2005) 6 SCC 1 : 2005 SCC (Cri) 1369

trial. Similarly, when the charge of negligence arises out of failure to use some particular equipment, the charge would fail if the equipment was not generally available at that particular time (that is, the time of the incident) at which it is suggested it should have been used.

(3) *A professional may be held liable for negligence on one of the two findings: either he was not possessed of the requisite skill which he professed to have possessed, or, he did not exercise, with reasonable competence in the given case, the skill which he did possess. The standard to be applied for judging, whether the person charged has been negligent or not, would be that of an ordinary competent person exercising ordinary skill in that profession. It is not possible for every professional to possess the highest level of expertise or skills in that branch which he practices. A highly skilled professional may be possessed of better qualities, but that cannot be made the basis or the yardstick for judging the performance of the professional proceeded against on indictment of negligence.*

(4) *The test for determining medical negligence as laid down in Bolam case*[20] *holds good in its applicability in India*." (emphasis supplied)

12.4.11. In recent years, the *Bolam*[20] test has been discarded by the courts in England. In *Bolitho* v. *City & Hackney Health Authority*[23], a five-Judge Bench of the House of Lords ruled that (*Bolitho*[23] AC pp. 241 G-H and 242 A-B):

"*... 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*. In *Bolam case*[20], WLR at pp. 583, 587 itself, McNair, J. stated that the defendant had to have acted in accordance with the practice accepted as proper by a "*responsible* body of medical men". Later, he referred to "a standard of practice recognised as proper by a competent *reasonable* body of opinion". Again, in the passage which I have cited from *Maynard case*[24], WLR at p. 639, Lord Scarman refers to a "respectable" body of professional opinion. 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 or 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*." (emphasis supplied and in original)

20 *Bolam* v. *Friern Hospital Management Committee*, (1957) 1 WLR 582 : (1957) 2 All ER 118
23 1998 AC 232 : (1997) 3 WLR 1151 : (1997) 4 All ER 771 (HL)
24 *Maynard* v. *West Midlands Regional Health Authority*, (1984) 1 WLR 634 (HL)

12.4.12. Lord Browne-Wilkinson, in *Bolitho case*[23] speaking for the Bench, in his opinion stated that despite a body of professional opinion approving the doctor's conduct, a doctor can be held liable for negligence, if it is demonstrated that the professional opinion is not capable of withstanding logical analysis (*Bolitho*[23], AC at p. 243 A-C):

> "*These decisions demonstrate that in cases of diagnosis and treatment there are cases where, despite a body of professional opinion sanctioning the defendant's conduct, the defendant can properly be held liable for negligence (I am not here considering questions of disclosure of risk).* In my judgment that is because, in some cases, it cannot be demonstrated to the Judge's satisfaction that the body of opinion relied upon is reasonable or responsible. In the vast majority of cases the fact that distinguished experts in the field are of a particular opinion will demonstrate the reasonableness of that opinion. In particular, where there are questions of assessment of the relative risks and benefits of adopting a particular medical practice, a reasonable view necessarily presupposes that the relative risks and benefits have been weighed by the experts in forming their opinions. *But if, in a rare case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the Judge is entitled to hold that the body of opinion is not reasonable or responsible.*" (emphasis supplied)

12.4.13. A five-Judge Bench of the Australian High Court in *Rogers* v. *Whitaker*[25] identified the basic flaw involved in approaching the standard of duty of care of a doctor as laid down in *Bolam*[20], and held that:

> "*5.* ... The law imposes on a medical practitioner a duty to exercise reasonable care and skill in the provision of professional advice and treatment. *That duty is a "single comprehensive duty covering all the ways in which a doctor is called upon to exercise his skill and judgment*"[26]; *it extends to the examination, diagnosis and treatment of the patient and the provision of information.*"
>
> * * *
>
> "*12.* In Australia, it has been accepted that the standard of care to be observed by a person with some special skill or competence is that of the ordinary skilled person exercising and professing to have that special skill.[27] But, that standard is not determined solely or even primarily by reference to the practice followed or supported by a responsible body

23 *Bolitho* v. *City & Hackney Health Authority*, 1998 AC 232 : (1997) 3 WLR 1151 : (1997) 4 All ER 771 (HL)

25 (1992) 109 Aus LR 625 : 1992 HCA 58

20 *Bolam* v. *Friern Hospital Management Committee*, (1957) 1 WLR 582 : (1957) 2 All ER 118

26 *Sidaway* v. *Board of Governors of the Bethlem Royal Hospital & the Maudsley Hospital*, 1985 AC 871 : (1985) 2 WLR 480 : 1985 UKHL 1

27 *Cook* v. *Cook*, 1986 HCA 73 : (1986) 162 CLR 376, at pp. 383-384; *Papatonakis* v. *Australian Telecommunications Commission*, 1985 HCA 3 : (1985) 156 CLR 7, at p. 36; *Weber* v. *Land Agents Board*, (1986) 40 SASR 312, at p. 316; *Lewis* v. *Tressider Andrews Associates (P) Ltd.* (1987) 2 Qd R 533

of opinion in the relevant profession or trade.[28] *Even in the sphere of diagnosis and treatment, the heartland of the skilled medical practitioner, the Bolam*[20] *principle has not always been applied.*[29] *Further, and more importantly, particularly in the field of non-disclosure of risk and the provision of advice and information, the Bolam*[20] *principle has been discarded and, instead, the courts have adopted the principle that, while evidence of acceptable medical practice is a useful guide for the courts, it is for the courts to adjudicate on what is the appropriate standard of care after giving weight to "the paramount consideration that a person is entitled to make his own decisions about his life".*" (emphasis supplied)

12.4.14. A seven-Judge Bench of the U.K. Supreme Court in a more recent judgment delivered in *Montgomery* v. *Lanarkshire Health Board*[30] traced the changes in the jurisprudence of medical negligence in England, and held that (at AC p. 1459, para 75) "patients are now widely regarded as persons holding rights, rather than as the passive recipients of the care of the medical profession". The Supreme Court noted that the courts have tacitly ceased to apply the *Bolam*[20] test in relation to the advice given by the doctor to their patients. The Court summed up the law on medical negligence in the following words: (*Montgomery case*[30], AC pp. 1461 H-1462 A-B & 1463 B-D, paras 82 & 87)

"*82.* In the law of negligence, this approach entails a duty on the part of doctors to take reasonable care to ensure that a patient is aware of material risks of injury that are inherent in treatment. *This can be understood, within the traditional framework of negligence, as a duty of care to avoid exposing a person to a risk of injury which she would otherwise have avoided, but it is also the counterpart of the patient's entitlement to decide whether or not to incur that risk.* The existence of that entitlement, and the fact that its exercise does not depend exclusively on medical considerations, are important. They point to a fundamental distinction between, on the one hand, the doctor's role when considering possible investigatory or treatment options and, on the other, her role in discussing with the patient any recommended treatment and possible alternatives, and the risks of injury which may be involved.

* * *

87. The correct position, in relation to the risks of injury involved in treatment, can now be seen to be substantially that adopted in *Sidaway*[26] by Lord Scarman, and by Lord Woolf MR in *Pearce*[31], subject to the

28 *Florida Hotels (P) Ltd.* v. *Mayo*, 1965 HCA 26 : (1965) 113 CLR 588
20 *Bolam* v. *Friern Hospital Management Committee*, (1957) 1 WLR 582 : (1957) 2 All ER 118
29 *Albrighton* v. *Royal Prince Alfred Hospital*, (1980) 2 NSWLR 542; *E* v. *Australian Red Cross Society*, 1991 FCA 20 : (1991) 99 ALR 601
30 2015 AC 1430 : (2015) 2 WLR 768 : 2015 UKSC 11
26 *Sidaway* v. *Board of Governors of the Bethlem Royal Hospital & the Maudsley Hospital*, 1985 AC 871 : (1985) 2 WLR 480 : 1985 UKHL 1
31 *Pearce* v. *United Bristol Healthcare NHS Trust*, 1999 PIQR P53 (CA)

refinement made by the High Court of Australia in *Rogers* v. *Whitaker*[25], which we have discussed at paras 77-73. *An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken. The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it.*" (emphasis supplied)

12.4.15. This Court in *V. Kishan Rao* v. *Nikhil Super Speciality Hospital*[32] has opined that the *Bolam*[20] test requires reconsideration. A.K. Ganguly, J. speaking for this Court, observed that: (*V. Kishan Rao case*[32], SCC pp. 523-34, paras 23 & 25-26)

"*23. Even though Bolam*[20] *test was accepted by this Court as providing the standard norms in cases of medical negligence, in the country of its origin, it is questioned on various grounds.* It has been found that the inherent danger in *Bolam*[20] test is that if the courts defer too readily to expert evidence medical standards would obviously decline. Michael Jones in his treatise on *Medical Negligence* (Sweet and Maxwell), 4th Edn., 2008 criticised the *Bolam*[20] test as it opts for the lowest common denominator. The learned author noted that opinion was gaining ground in England that *Bolam*[20] test should be restricted to those cases where an adverse result follows a course of treatment which has been intentional and has been shown to benefit other patients previously. This should not be extended to certain types of medical accidents merely on the basis of how common they are. It is felt 'to do this would set us on the slippery slope of excusing carelessness when it happens often enough' (*see* Michael Jones on *Medical Negligence*, para 3-039 at p. 246).

* * *

25. Even though Bolam[20] *test "has not been uprooted" it has come under some criticism as has been noted in Jackson & Powell on Professional Negligence (Sweet and Maxwell), 5th Edn., 2002. The learned authors have noted (see para 7-047 at p. 200 in Professional Negligence) that there is an argument to the effect that Bolam*[20] *test is inconsistent with the right to life unless the domestic courts construe that the requirement to take reasonable care is equivalent with the requirement of making adequate provision for medical care. In the context of such jurisprudential thinking in England, time has come for this Court also to reconsider the parameters*

25 (1992) 109 Aus LR 625 : 1992 HCA 58
32 (2010) 5 SCC 513 : (2010) 2 SCC (Civ) 460
20 *Bolam* v. *Friern Hospital Management Committee*, (1957) 1 WLR 582 : (1957) 2 All ER 118

set down in Bolam[20] *test as a guide to decide cases on medical negligence and specially in view of Article 21 of our Constitution which encompasses within its guarantee, a right to medical treatment and medical care.*

26. In England, Bolam[20] *test is now considered merely a 'rule of practice or of evidence. It is not a rule of law' (see para 1.60 in Clinical Negligence by Michael Powers QC, Nigel Harris and Anthony Barton, 4th Edn., Tottel Publishing). However, as in the larger Bench of this Court in Jacob Mathew* v. *State of Punjab*[22]*, Lahoti, C.J. has accepted Bolam*[20] *test as correctly laying down the standards for judging cases of medical negligence, we follow the same and refuse to depart from it.*" (emphasis supplied)

12.4.16. More recently, this Court in *Arun Kumar Manglik* v. *Chirayu Health & Medicare (P) Ltd.*[33] has held that the standard of care as enunciated in *Bolam*[20] must evolve in consonance with its subsequent interpretation adopted by English and Indian courts.

12.4.17. Applying the aforesaid principles to the facts of the present case, Appellants 2 and 3 viz. Dr G.S. Kochhar and Dr Naveen Jain, the Consultant Paediatricians, undoubtedly possessed the skill and qualifications of a Paediatrician, and the baby was placed under their direct care and treatment from birth till he was 3½ months old. They owed a duty of care to the baby and his parents. Appellant 4 Dr S.N. Jha, the Senior Consultant Ophthalmologist, who was engaged by Appellant 1 Hospital, and was the specialist in the Ophthalmology Department, ought to have followed the standard protocol for screening Respondent 1 baby for ROP, which is prescribed at the chronological age of 3 to 4 weeks after birth.

12.4.18. Appellants 1 to 3 are liable for medical negligence since at no stage were the parents of Complainant 1 either advised or guided about the possibility of occurrence of ROP in a premature baby, nor was the baby examined by Appellant 4 Ophthalmologist as per standard protocol. The doctors ought to have been fully aware of the high chances of occurrence of ROP in a pre-term baby. The lack of care constitutes a gross deficiency in service. After discharge on 29-4-2005, the baby was brought on 4-5-2005 at the chronological age of 5 weeks. Even on this date, no ROP test was either advised or conducted. The baby was brought for a further follow-up checkup on 13-7-2005, by which time the baby was 3½ months old. Even on this visit, the appellants did not advise or guide Respondent 2 complainant to have the ROP test conducted.

12.4.19. After reviewing the medical literature setting out the contemporaneous standards and established protocols on ROP, the reasonable standard of care for a premature baby, mandates screening and checking up for ROP. It is a medically accepted position that ROP is a reversible disease, if diagnosed up to Stage 3. Had the ROP test been conducted by the appellants,

20 *Bolam* v. *Friern Hospital Management Committee*, (1957) 1 WLR 582 : (1957) 2 All ER 118
22 (2005) 6 SCC 1 : 2005 SCC (Cri) 1369
33 (2019) 7 SCC 401 : (2019) 3 SCC (Civ) 647

there would have been timely detection of the onset of ROP, which at that stage would have been reversible. On account of the negligence of Appellants 2 to 4, the disease remained undiagnosed. It came to be diagnosed on 3-12-2005, when the baby was 8 months old, by Shroff Charity Eye Hospital. By this time, the ROP had reached Stage 5, when it becomes irreversible leading to total blindness of Respondent 1 baby.

12.4.20. We affirm the findings of the National Commission to hold that Appellant 1 Hospital, Appellants 2 and 3 — the Paediatricians, and Appellant 4 Dr S.N. Jha, the Senior Ophthalmologist, owed a legal duty of care to the complainants/Respondents 1 and 2. The failure to inform Respondent 2 mother of the necessity to have the ROP test conducted in the case of a pre-term baby, and the high risk involved which could lead to total blindness, was a breach of duty. Furthermore, the failure to carry out the ROP test, which is mandated by standard protocol, while the baby was under their direct care and supervision from birth till he was 3½ months old, amounted to gross negligence by the doctors, and deficiency of service by the Hospital. The consequential damage caused to the baby by not having conducted the mandatory ROP test, which led to the total blindness of the baby, has given rise to an actionable claim of negligence.

12.4.21. It is well established that a hospital is vicariously liable for the acts of negligence committed by the doctors engaged or empanelled to provide medical care.[34] It is common experience that when a patient goes to a hospital, he/she goes there on account of the reputation of the hospital, and with the hope that due and proper care will be taken by the hospital authorities.[35] 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 the acts of commission or omission on behalf of their doctors.[35]

12.4.22. Accordingly, we hold Appellant 1 Hospital to be vicariously liable for the acts of omission and commission committed by Appellants 2 to 4. We hold all the appellants as being jointly and severally liable to pay compensation to the complainants.

12.5. ***Compensation***

12.5.1. Having affirmed the findings recorded by the National Commission on the question of medical negligence and deficiency in service by the appellants, the issue whether the compensation awarded by the National Commission was just and reasonable is required to be determined. The complainants had claimed Rs 1,30,25,000 as compensation before the National Commission. The National Commission vide the impugned judgment[1] awarded a total sum of Rs 64,00,000 to the complainants along with interest.

34 *Savita Garg* v. *National Heart Institute*, (2004) 8 SCC 56; *Balram Prasad* v. *Kunal Saha*, (2014) 1 SCC 384 : (2014) 1 SCC (Civ) 327; *Achutrao Haribhau Khodwa* v. *State of Maharashtra*, (1996) 2 SCC 634; *V. Krishnakumar* v. *State of T.N.*, (2015) 9 SCC 388 : (2015) 4 SCC (Civ) 546

35 *Savita Garg* v. *National Heart Institute*, (2004) 8 SCC 56

1 *Rishabh Sharma* v. *Rama Sharma*, 2016 SCC OnLine NCDRC 2726

12.5.2. This Court vide order dated 6-11-2019[36] directed the appellants to release a sum of Rs 5,00,000 (Rupees five lakhs) in favour of Respondent 2 complainant from the amount lying deposited by Appellant 1 Hospital in the Court. This Court further directed the complainant Respondent 2 to file an affidavit regarding the education received by Respondent 1, and the level of proficiency he had attained.

12.5.3. Accordingly, Respondent 2 complainant has stated on affidavit that Respondent 1, who is now 14 years old, was studying in a Government Senior Secondary School for Blind Boys, Kingsway Camp from 2013 to 2017, and barely received education for 4 years, up to 5th standard. Respondent 1 was forced to leave school since Respondent 2 complainant was unable to bear his educational, co-curricular and transportation expenses. The father of Respondent 1, who was working as a security guard with the Municipal Corporation of Delhi, had expired in 2013. Respondent 2 complainant stated that she is currently employed as a part-time receptionist since 2017, and earns Rs 5500 per month as salary, and receives Rs 2500 per month under the Delhi Vidhwa Pension Yojna. She further stated that Respondent 1 received Rs 2500 per month under the Delhi Government's Scheme for Subsistence Allowance to Persons with Special Needs.

12.5.4. The grant of compensation to remedy the wrong of medical negligence is within the realm of law of torts. It is based on the principle of *restitutio in integrum*. The said principle provides that a person is entitled to damages which 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.[37]

12.5.5. In our considered view, having regard to the finding that the medical negligence in the instant case occurred in 2005, and the litigation has been pending before this Court for over 3 years, coupled with the fact that the additional monthly expenses such as the care of an attendant/nurse, educational expenses of the patient in a special school, assistive devices, etc. have not been taken into account, it would serve the ends of justice if the compensation awarded by the National Commission is enhanced, by a further lump sum amount of Rs 12,00,000 (Rupees twelve lakhs).

12.6. In conclusion, we pass the following directions to secure the interest and welfare of Respondent 1. These directions are being passed to ensure that the compensation received is utilised for the welfare of Respondent 1, to enable him to acquire suitable education and equip him to become self-reliant.

12.7. We direct that the compensation of Rs 76,00,000 awarded to Respondent 1, Master Rishabh Sharma s/o Mrs Pooja Sharma (in CA No. 6619 of 2016), be utilised in the following manner:

36 *Maharaja Agrasen Hospital* v. *Rishabh Sharma*, 2019 SCC OnLine SC 1698

37 *Livingstone* v. *Rawyards Coal Co.*, (1880) LR 5 AC 25 (HL); followed in *Malay Kumar Ganguly* v. *Sukumar Mukherjee*, (2009) 9 SCC 221 : (2009) 3 SCC (Civ) 663 : (2010) 2 SCC (Cri) 299 and *V. Krishnakumar* v. *State of T.N.*, (2015) 9 SCC 388 : (2015) 4 SCC (Civ) 546; *Balram Prasad* v. *Kunal Saha*, (2014) 1 SCC 384 : (2014) 1 SCC (Civ) 327

12.7.1. Rs 60,00,000 (Rupees sixty lakhs only) is allocated exclusively for Respondent 1, Master Rishabh Sharma for his education, welfare, and sustenance;

12.7.2. Rs 15,00,000 (Rupees fifteen lakhs only) is allocated to Mrs Pooja Sharma, the mother of Master Rishabh Sharma, as his care-giver, after deduction of an amount of Rs 5,00,000 already disbursed to her.

12.7.3. Rs 1,00,000 (Rupees one lakh only) is awarded towards litigation costs, payable to Mr Jai Dehadrai, Advocate and Mr Sidharth Arora, Advocate, who have represented the complainants on a pro bono basis (as stated by them) in this Court.

12.8. The amount of Rs 60,00,000 awarded to Master Rishabh Sharma shall be disbursed in the following manner:

12.8.1. Rs 50,00,000 be deposited in a five years' Post Office Time Deposit Scheme in the name of Master Rishabh Sharma with Mrs Pooja Sharma as his natural guardian. Let five deposits in multiples of Rs 10,00,000 each be made. The deposits shall be opened in the post office savings bank account of the Supreme Court Post Office, New Delhi. The account shall be operated by Mrs Pooja Sharma under the supervision of the Registrar concerned of this Court.

12.8.2. The aforesaid five deposits aggregating to Rs 50,00,000 will fetch Master Rishabh Sharma an annual interest income of Rs 3,85,000, which will be credited into a savings account with the post office. Out of the said sum, Rs 1,50,000 shall be invested annually in a 15-year Public Provident Fund ("PPF") Account to be opened in the name of Master Rishabh Sharma with UCO Bank, Supreme Court, Tilak Marg, New Delhi. These yearly investments, going by the provisions of the Income Tax Act, 1961, will be tax free.

12.8.3. After having invested Rs 1,50,000 every year in a PPF account, the rest of the yearly income amounting to Rs 2,35,000 p.a. (from and out of Rs 3,85,000) which is equivalent to about Rs 20,000 per month, shall be utilised by Respondent 2 Mrs Pooja Sharma for the education and upbringing of Respondent 1.

12.8.4. Rs 4,50,000 shall be deposited in a five-year Post Office Monthly Income Scheme Account ("MIS Account") with the Supreme Post Office in the name of Master Rishabh Sharma so that it will give him monthly interest of 7.6% p.a., that is to say Rs 2850 per month, which shall be utilised by Mrs Pooja Sharma primarily for the upbringing of Respondent 1.

12.8.5. The balance of Rs 5,50,000 from the amount deposited by the appellants, shall be invested in a five-year fixed deposit account ("FD Account") to be opened with UCO Bank, Supreme Court, Tilak Marg, New Delhi in the name of Master Rishabh Sharma. The interest accruing therefrom may be utilised by Mrs Pooja Sharma in such manner as is deemed appropriate.

12.8.6. These investments will ensure an annual income of approximately Rs 4,50,000. With the investment of Rs 1,50,000 in a PPF Account, which will be tax free, as the annual income of Rs 3,00,000 will be within the permissible tax exemption limit of Rs 3,00,000 plus Rs 75,000 (disability allowance under Section 80-U of the Income Tax Act, 1961).

12.8.7. All these deposits on maturity shall be re-invested by Respondent 2 Pooja Sharma with the concurrence of the Registrar concerned of this Court on such terms, which will fetch a high rate of interest, and preserve the corpus for the benefit of Respondent 1. At no stage, will Respondent 2 be permitted to withdraw any amount from these deposits without the permission of the Registrar concerned.

12.9. We direct the Registrar concerned of this Court to be associated with Respondent 2 — the mother of Master Rishabh Sharma, in giving effect to the directions issued hereinabove.

13. Accordingly, we allow Civil Appeal No. 9461 of 2019 (Diary No. 15393 of 2019) filed by the complainants.

14. Civil Appeal No. 6619 of 2016 filed by the Hospital and the doctors is dismissed. Appellants 1 to 4 in Civil Appeal No. 6619 of 2016 are directed to deposit the balance amount of Rs 44,00,000 in this Court within a further period of 12 weeks from today.

15. An affidavit of compliance with respect to the deposit of compensation be filed by the appellants before this Court.

16. We have been informed by the Registry of this Court that the amount of Rs 32,00,000, which was deposited by the appellants pursuant to order dated 29-7-2016[2] of this Court, and kept in a fixed deposit with UCO Bank, has accrued an interest of about Rs 3,80,954. We direct that this interest amount be made over to Mrs Pooja Sharma, the mother and care-giver, for the welfare and education of Master Rishabh Sharma, for the current year.

17. The original medical records be returned by the Registry to the counsel for Appellant 1 Hospital.

18. Pending applications, if any, are accordingly disposed of. Ordered accordingly.

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2 *Maharaja Agrasen Hospital* v. *Rishabh Sharma*, 2016 SCC OnLine SC 1860