Consumer Disputes Redressal Commission
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Dr. Kunal Saha Represented By Sri ... vs Dr. Sukumar Mukherjee And Ors. on 1 June, 2006
Equivalent citations: III (2006) CPJ 142 NC
Bench: M Shah, K G Member, R Rao
ORDER

M.B. Shah, J. (President)

1. Whether the Courts or the Consumer Fora can sit in appeal against the decision taken by the expert doctors with regard to administration of a particular dose of medicine? Answer would be - No. It is to be judged in the light of particular circumstance of each case. Jurisdiction of the Consumer Fora would be limited in case of apparent deficiency in prescribing dose of medicine, i.e. in cases where Doctors have not taken reasonable degree of care in prescribing a particular dose of medicine. Reasonable care is to be judged on the basis of the skill and knowledge expected from such practitioner.

2. Claim in the complaint is in Crores i.e. Rs. 77,76,73,500/- (Rupees Seventy Seven Crores Seventy Six Lakhs Seventy Three Thousand and Five Hundred) - Rare. Disease suffered by the wife of the Complainant was also - Rare - TEN (Toxic Epidermal Necrolysis) which affects only 1 or 1.3 persons, out of 10 lakhs. Diagnosis of such disease is difficult and not simple and depends upon expertise of the medical practitioner, particularly, a Dermatologist. In such a case, can a patient or his relative expect from the medical practitioner that the patient in all cases should be cured. Medical literature states that mortality rate is 25% to 70% and there is no exact treatment for such disease. Obvious reply in such cases is, everything is uncertain and no guarantee can be given by anyone on the earth that treatment would cure the patient.

Complaint:

3. It is the say of the complainant, Dr. Kunal Saha, that he had left United States of America along with his wife on 24.3.1998 enroute Calcutta stopping at Mumbai. They arrived at Calcutta on 1.4.1998. On arrival at Calcutta, Dr. Saha found that Mrs. Anuradha Saha (his wife) had developed a sore throat with some palpable neck glands and, on 3.4.1998, he found that she had also developed a low-grade temperature. She was treated by him, as he is a trained medical man (M.D., Ph.D).

4. On 17.4.1998, Mrs. Anuradha developed high-grade fever with upper respiratory tract infection. On 25.4.1998, her fever increased with skin rash and enlarged neck glands (lymph nodes). On 26.4.1998, the complainant contacted Dr. Sukumar Mukherjee (OP-1) and requested him to examine the patient at his residence. After examination, Dr. Mukherjee suggested:

a) a host of pathological tests including haematology, i.e., blood examination ;

b) Bio-chemistry including liver and kidney functions, immunology, i.e., determination of anti-bodies and other relevant examinations; and

c) Virology, i.e., determining the presence of viruses for ascertaining the causes of the fever.

5. No other treatment was prescribed on the said date. Dr. Mukherjee informed Dr. Saha that he would be leaving India on 12.5.1998 for U.S.A. where he was to participate in an International Medical Conference.

6. Thereafter, on 7.5.1998 (after about two weeks), the complainant contacted Dr. Mukherjee and informed him that after showing some improvement, the condition of his wife had further deteriorated and the skin rash and fever were back. He, therefore, requested Dr. Mukherjee to examine her. On that, Dr. Mukherjee requested Dr. Saha to bring his wife to his chambers. Mrs. Anuradha walked into the clinic late in the evening

on 7.5.1998.

7. When Dr. Mukherjee was examining Mrs. Anuradha, the complainant informed him that on 6.5.1998, they had been for a Chinese meal after which there was worsening of the skin rash. After examining her, Dr. Mukherjee's diagnosis was that she was suffering from Angio-neurotic Oedema with Allergic Vasculitis - challenge to Chinese Food +ve. At that point of time, there were no blisters, no target lesion, no mucosal involvement. He, therefore, advised administration of 'Depomedrol' injections 80 mg. (IM) twice a day for a period of 3 days. This was based on blood reports with eosinephilia and mild leucocycosis.

8. Undisputedly, between 7.5.1998 and 11.5.1998, the complainant consulted 2 dermatologists, namely, Dr. A.K. Ghoshal and Dr. S. Ghosh. Both of them diagnosed Mrs. Anuradha as a case of Vasculitis. On 11.5.1998, the complainant again telephoned Dr. Mukherjee and informed him that his wife's condition was not improving. The skin rash was persisting along with fever and palpable neck glands. At that time, Dr. Mukherjee recommended that she be hospitalized. Hence, the complainant admitted Mrs. Anuradha in the Advanced Medical and Research Institute (hereinafter referred to as AMRI Hospital - OP-4). In the hospital, she was under the care of Dr. Balram Prasad (OP-5), a Consultant Physician (a classmate of the complainant, as contended).

9. On 11.5.1998 at 2.15 PM, Dr. Mukherjee examined Mrs. Anuradha on a reference being made by Dr. Prasad. He made an endorsement on the bed-head ticket as under:

Date & Time Progress notes Treatment 11/5/98

2-15 pm Maculo Papular Bullous lesion? Allergy to Exogenous toxin and

Unlikely to be SLE/Allied disorder

Adv

Wysolone 50 mg once daily x 1week

40 mg daily x 1 week

30 mg daily x 1 week

Inj. 'Depomedrol' 80 mg IM twice daily x 2 days Then 40 mg IM twice x days

Omez 20 mg BD

Baycip 500 mg twice daily

Pepsigard liquid 1 tsf 4 times daily x 1 week Limcee 500mg twice daily

Atarax 25 mg twice daily

O To Consult Dermatologist

May, I request Dr. Abani Roy Chouwdhury, MD. to see her

Repeat : HC, TC/ DC ESR CRP SGPT, Urea, Creatinine, Total Protein, Uric Acid platelets, AN factor, DS-DNA, Complement.

Eye check up Opthalmologist

Dr. B. Prasad please arrange eye, dermatological check up Bed to change ripple bed

Daily fluid intake 2 litres / a day

To puncture blister and send fluid to School of Tropical Medicine, Virology Dept.

10. Undisputedly, thereafter, Dr. Mukherjee has neither examined Mrs. Anuradha nor given any treatment and he has departed to U.S.A.

11. In the evening hours on 11.5.1998, at the request of the complainant and Dr. Balaram Prasad, Dr. A.K. Ghoshal - a Consultant Dermatologist, examined Mrs. Anuradha at about 4.30 pm and after examining he diagnosed that Mrs. Anuradha was suffering from Toxic Epidermal Necrolysis [TEN]. The same is recorded in the bed-head ticket. The relevant portion is as under:

Case Seen by Dr. A.K. Ghoshal:

11.5.1998:

Toxic Epidermal Necrolysis.

Separation of large sheets of skin from back and limbs, many small/ large bulla on limbs. Dusky red areas of vasculitis almost all over the body. Mild conjunctivitis. Erosive lesions on tongue and buccal mucosali.

Adv.Maintain fluid and electrolyte balance.

Maintain maximum asepsis.

Continue same medicines.

Soframycin cream to apply on rash areas only

Capsule Zevit - 1 Cap daily

To be reviewed later.

It is to be stated that Dr. Ghoshal also directed to continue the same medicines as prescribed by Dr. Mukherjee.

12. On 12.5.1998, Prof. Dr. Abani Roy Chowdhury (OP-3) - a Consultant Physician, was requested by Dr. Balaram Prosad to examine Mrs. Anuradha. Dr. Balaram's notes is as under:

Treatment sheet:

Name : Mrs. Anuradha Roy Saha visiting Doctor :Dr. B. Prasad Bad No. 430 Serial No. 738 DATE & TIME PROGRESS NOTES TREATMENT 12/5/

May I request Prof. Abani Roy Choudhury to kindly examine her and give your valuable opinion.

Refd to Dr. Soven Bhattacharya for Eye Checkup Blood for Eletrolytes and as suggested by Prof. Sukumar Mukherjee.

Skin biopsy for histopathology Dr. N. Iqbal.

Prof. B. Halder has kindly agreed to examine this patient today. Sd/ - Dr. B. Prasad

13. On the same day, i.e. on 12.5.1998, Dr. Baidyanath Halder (OP-2) - a Consultant Dermatologist examined Anuradha and opined that she was suffering from 'Stevens & Johnson Syndrome' and recommended continuation of treatment as recommended by Dr. Mukherjee. His consultation record is a sunder:

CONSULTATION RECORD

Name: Age: Sex: Mar. Status: Service Ward: M.R.D. Occupation Referred by Dr. ... to Dr. Suven Bhattacharjee (Requesting Doctor) (Consultant & Specialist) Nature of Investigation : (CT Process) Date: 12.5.98 Thanks for Referral

Steven Jhonson's

C/o. Redness of Eye with discharge

Reservations: O/E: Both Eyes: Conjunctival Congestion and a. No obvious corneal or Conjunctival Ulcer

b. No Symptoms at present.

Adv: 1) Tear Plus Eye drop - 5 times/day Both Eyes i. DEXACORT-N Eye ointment 2 lw/dy both by

Remarks/Clinical Inspection:

To repeat if any pain increases or watering increases Sd/- Illegible

Consultant's signature

CONSULTATION RECORD

Name: Age: Sex: Mar. Status: Service: Ward: M.R.D. Occupation : Referred by Dr. BALARAM PRASAD to Dr. Prof. B. HALDER (Requesting Doctor) (Consultant & Specialist) Nature of investigation : (CT Process) Date : May I request Prof. B. Halder to examine this patient & Adv. Sd/ - B.M.

Observations : Toxic Epidermal Necrolysis (? Drug) Avoid Erythema + blisters + Eye - NAD + Lungs NAD XXX

Local anesthetic Prednisolone 40 mg x 000

Neomycin Zinetac 150 0 0

Soframycin omez 20 0 0

Menabol 1 bd 0 0

Father Potchlor 2 tsp after lunch Diabitic MV - 0 -

Imp Claribid 250 mg 1 tab bdpc 0 0 Electrolyte Vit B Complex (USP) 0

Balance Egg white/Protinex/complan / threptin High Cal biscuit

Nutrition Betadine / piodine lotion / oint / tube Prevent corfisone kemecetine eye ont. Secondary Fusfo 200 mg/weekly once

Infection Benadryl sys 2 tsp. " " (three times 2 tsp.) Shelcal 1 tab (500) mg)

Remarks / Clinical Inspection:

This is Dr. B.N. Halder's hand written prescription at AMRI Consultant's Sig.

TREATMENT SHEET

Name: Mrs. Anuradha Roy Saha Visiting Doctor: Dr. B. Prasad Bed No. 430 Serial No. 738 Date & Progress Notes Treatment Time

13/5

Adv.

1. E.C.G. 12 lead

2. Ryle's tube feeding S.O.S

3. Refd. To Dr. K. Nandy (consultant plastic surgeon)

4. Cold food preferably.

Refd. To Dr. Purnima Chatterjee

For Gynae Check up

a. Refd. To Dr. K. Ahmed (ENT)

Osteocalcium syrup

K-gard.

Sd/- Dr. B. Prasad

CONSULTANT RECORD

Name: Age: Sex: Mr. Status: Service Ward: M.R.D. Occupation:

Referred by Dr. to Dr. Kaushik Nandy (Requesting Doctor) (Consultant & Specialist) Nature of investigation: (CT Process) Date: 13.05.98

14. Examination of the anas of Skin affected show new area involving the whole of the back and buttocks plus other areas in the upper arm and thigh adding upto perhaps 25 - 30% of BSA.

Plan: Occlusive Jelonet & guage pad dressing of backs

Rest left exposed

Patient to place buttocks on guage pads will review patient

Sd/- Kaushik Nandy

CONSULTATION RECORD

Name : Age: Sex: Mr. Status:

Referred by Dr. to Dr.

(Requesting Doctor) (Consultant & Specialist) Nature of investigation: (CT Process) Date: 13.5.98 Extensive skin blisters all over body more on back. Inspection: Vulval (labiamargins)blisters some ruptured blisters seen compartment of vagina.

Once vaginal swab taken from vagina just above introitus sent for bacteria smear & culture.

ADV. Treatment should be continued as per

Advise of Physician & Dermatologist.

Sd/- Purnima Chatterjee

CONSULTANT RECORD

Name: Age: Sex: Mr. Status: Service Ward: M.R.D. Occupation:

Referred by Dr. B. Prasad to Dr. Prof.K. Ahmed (Requesting Doctor) (Consultant & Specialist) Nature of investigation: (CT Process) Date: Thank you for the referral

Drug Eryptions

Odonphagia

Maculo Papular rash/blister around gums lips

Palate/buccal mucosa

Observations:

Adv.

Xylocaine Viscus - before meal

Kenalog in orobase apply locally twice daily

Sucral suspensin 2-3 tsf three thrice daily before meal Remarks/Clinical Inspection:

Sd/- illegible

Consultant's signature

TREATMENT SHEET

Name: Mrs. Anuradha Roy Saha Visiting Doctor : Dr. Kaushik Nandy Bed No. 430 Serial No. 738 Date & Progress Notes Treatment Time

14/5/98

5:50 p.m. Dressing change

Yesterday dressing have made the wound more

Comfortable.

There are more extensive areas of the legs which Are Mepithetralcsing.

Sd/-

Kaushik Nandy

15/5/98

Prognosis: Poor

Patient is still having temp & rash.

Chest (v) Heart (v)

To continue as adv. By Prof: Sukumar Mookherjee & Dr. A.R. Chowdhury

Sd/- Dr. B. Prasad

TREATMENT SHEET

Name: Mrs. A.R. Saha Visiting Doctor :

Bed No. 430 Serial No. Date & Progress Notes Treatment Time

16/5

May I request ICCU R.M.O. FOR I/V cannulation if required I/V fluid: 5% dextrose charged with + M.V.I.

6 hrly

ISO lyte M

Sd/- Dr. B. Prasad

I am taking my patient at my own risk

Sd/- Illegible

17.5.98

It is pointed out that between 13.5.1998 and 16.5.1998, Mrs. Anuradha was examined by the following Consultants :

1) Dr. K.Nandy - A Plastic Surgeon ;

2) Dr. Purnima Chatterjee - A gynaecologist ;

3) Dr. K.Ahmed - An ENT Surgeon ;

4) Dr. S.Bhattacharjee ; and

5) Dr. N.Iqbal - General Surgeon.

On 16.5.1998, I.V. Fluids were prescribed by Dr. Prasad (OP-5).

15. Thereafter on 17.5.1998, the complainant removed Mrs. Anuradha from AMRI Hospital and shifted her to the Breach Candy Hospital at Mumbai. On her admission to the Breach Candy Hospital, it was recorded as under :

Mrs. Anuradha Saha has been admitted to Breach Candy Hospital on 17.5.98 at night - 9.30 PM. Her condition on admission is serious. She has been accompanied by her husband Dr. Saha, who has given the history of antibiotic injections for respiratory treatment injection - Rovamycin, Roithromycin, Ampicillin, Ampiclox and Nemuslide followed by development of Toxic Epidermal Necrolysis. She has received Prednisolone 120 mg/day for 7 days and also Inj.Depomedral IM x 3 days. She has been haemodynamically stable till now. She is able to swallow liquids which has been her only nourishment over the past few days. She has been shifted by flight from Calcutta. She was examined on admission.

16. On 18.5.1998, Dr. Farokh E. Udwadia at the Breach Candy Hospital examined Mrs. Anuradha and recorded as under:

Patient has come with a diagnosis Toxic Epidermal Necrolysis (TEN). She has had a number of drugs at Calcutta from antibiotics to non-steroid and inflammatory agents. Is there any way of distinguishing this from a Stevens & Johnson Syndrome? There is no skin left. The mucus of the mouth, genitals and area is also severely affected. And have not seen the evolution of the skin lesions to the point where there is now no skin left. So far there is no organ evolvement in particular. No pulmonary lesion nor any urinary lesion (organs commonly involved as in a Steven Johnson Syndrome). In any case the basic management is the same. I do feel that the dose of steroids used in Calcutta is either excessive - 120 mg. daily for a number of days, preceded by 80 mg. injections. I would not give more than 40 mg./day - 1 mg./kg. Body weight.

17. The patient is actually ill (TEN). I foresee the following problems :

1. Hypotension ;

2. Almost certainly she is already infected: (a) because of skin being totally denuded ; (b) because of high dose of steroids she has received in Calcutta ; (c) because of transfer from Calcutta in this situation. I feel she should never have been transferred because the risk of infection in this state is well nigh 100%.

18. In the Breach Candy Hospital Mrs. Anuradha died on 28.5.1998.

19. On 30.9.1998, the complainant issued notices to 26 persons which included doctors, hospital management at Calcutta and Breach Candy Hospital at Mumbai.

20. Thereafter, he filed a Criminal Complaint on 19.11.1998 against Dr. Sukumar Mukherjee, Dr. Baidyanath Halder and Dr. Abani Roy Chowdhury (OPs 1,2 & 3) for offence under Section 304-A of the Indian Penal Code. On 9.3.1999, the present complaint was filed against 19 Opp.parties.

21. On 17.7.1999, the complaint was lodged against Dr. Sukumar Mukherjee, Dr. Baidyanath Halder and Dr. Abani Roy Chowdhury before the West Bengal Medical Council (hereinafter referred to as the WBMC). Further, on 29.5.2000, OP No. 179 of 2000 was filed by Dr. Kunal Saha against the doctors and the Breach Candy Hospital.

22. In the present case, the complainant has claimed a large amount of compensation of Rs. 77,76,73,500/- with interest for the deficiency in the service rendered by the doctors (OPs No. 1, 2, 3, 5, 6 and AMRI hospital (OP No. 4).

23. Despite voluminous record produced, the entire matter revolves around and requires decision on the following few facts -

Dr. Sukumar Mukherjee (OP-1) examined the deceased, Mrs. Anuradha Saha, on 7.5.1998. After examining her, his diagnosis was that she was suffering from 'Allergic Vasculitis'. He prescribed steroid 'Depomedrol' 80 mg. twice daily for a period of 3 days.

Mrs. Anuradha was admitted in the AMRI Hospital on 11.5.1998. Again Dr. Mukherjee was requested to visit and prescribe the treatment. Dr. Mukherjee came and visited the patient despite the fact that he was required to leave India on the same night. He again prescribed 'Depomedrol' 80 mg. twice daily for 2 days followed by 40 mg. twice daily for two more days. Admittedly, on 11.5.1998, Dr. Mukherjee left India.

On the next day, i.e., on 12.5.1998, Dr. Baidyanath Halder, Sr.Dermatologist and Dr. Abani Roy Chowdhury, Sr.Physician (OPs 2 & 3) examined Mrs. Anuradha and stopped "Depomedrol' and put her on a quick-acting steroid 'Prednisolone' 40 mg. thrice daily.

OP-4 is the AMRI Hospital where the patient was admitted. Allegations against the Hospital are:

(a) it was not having Burns ward;

(b) vital parameters were not examined/noted by doctors during her treatment from 11th May to 16th May;;

(c) IV fluid was not administered in the Hospital despite it is considered to be a supportive treatment for TENs.

OP-5, Dr. Balram Prasad was the Jr. Consultant Physician attached to the AMRI Hospital.

OP-6, Dr. Kaushik Nandy was the Plastic Surgeon who was called for giving bandage to the deceased.

Contentions of the Complainant:

24. The contentions raised by the complainant are -

Dr. Mukherjee (OP1) gave overdose of "Depomedrol' 80 mg. twice a day for 3 days. He further directed on 11.5.1998 to continue the same medicine for 2 days followed by 40 mg. of the same medicine twice daily for 2 more days. This being an overdose of the steroid, it has affected the immunity of the deceased as steroid is not the treatment for TEN. Therefore, Dr. Mukherjee is liable for deficiency in service.

25. Dr. Baidyanath Halder (OP2) continued the steroid despite the deceased being diagnosed as TEN which adversely affected her immunity.

26. Secondly, Dr. Halder (OP2) and Dr. Abani Roy Chowdhury (OP3) failed to direct simultaneous giving of I.V. Fluids as a supportive therapy when steroids were administered to the deceased. It is, therefore, contended that Opposite Parties 2 & 3 are responsible for the said deficiency.

27. For AMRI Hospital (OP 4) it is contended that the hospital failed to monitor the vitals of the deceased during the treatment; failed to administer I.V. Fluids; that the hospital was not having any burn center and that Mrs. Anuradha was not shifted to ICU during the treatment.

28. Against OP5, Dr. Balram Prasad, allegation for deficiency is made on the ground that he was in-charge of the patient and he ought to have suggested that steroid cannot be administered to such patients and in any case, he ought to have taken care that I.V. Fluids are given to the deceased as a supportive therapy.

29. Against OP-6, Dr. Kaushik Nandy, it is contended that the bandage which was applied by him was not proper. He ought not to have used the cotton as the skin of the deceased at the relevant time had peeled off. It is stated that Dr. Kaushik Nandy suggested giving of I.V. Fluids to the deceased on 16.5.1998. However, there is nothing on record to show that I.V. Fluids were given to the deceased on 16.5.1998. Admittedly, she was shifted to Breach Candy Hospital, Bombay, on 17.5.1998.

30. As against this, learned counsel appearing on behalf of the Opposite Parties relied much on the statements made in the complaint and the notices issued by the complainant against the opposite parties as well as all the doctors who had treated Mrs. Anuradha at Breach Candy Hospital, Bombay.

Submissions of the Opposite Parties:

31. In short, the submissions of the learned counsel for the OPs are-

It was difficult for Dr. Mukherjee to diagnose whether the deceased was suffering from TEN;

It is also contended that by no standard it can be said that the dose of 'Depomedrol' 80 mg. twice daily for 3 days is in any way excessive;

32. With regard to administration of I.V. Fluids, it is pointed out that intake of the patient was more than sufficient and, therefore, there was no necessity of giving I.V. Fluids;

33. It is pointed out that the complainant has wrongly and mischievously joined Dr. Prasad and Dr. Kaushik Nandy (OPs 5 & 6) and has intentionally omitted to join Dr. Ghoshal, who was the first person to diagnose that the deceased was suffering from TEN. It is also contended that Dr. Ghoshal has prescribed the same dose of medicine as prescribed by Dr. Mukherjee.

Questions for determination:

34. For the time-being, without referring to the above, we would decide:

1. Whether the prescription of 'Depomedrol' 80 mg. twice a day for 3 days by Dr. Mukherjee was overdose and, thereafter, further prescription of the same treatment for 2 more days was justified

2. Whether OPs 2 and 3 (Dr. Baidyanath Halder & Dr. A.R.Chowdhury) committed apparent deficiency in service by continuing steroid, namely, 'Prednisolone' 40 mg. thrice a day without administering I.V. Fluids?

3. In any case, whether Opposite Parties 5 & 6 (Dr. Balram Prasad and Dr. Kaushik Nandy) can be held liable for any alleged lapse on their part?

.4. Whether AMRI Hospital failed to give proper treatment by not monitoring the vital parameters of the deceased?

35. At this stage, we have to state that Dr. Ghoshal was the first Doctor who diagnosed the disease suffered by Mrs. Anuradha as TEN on 11.5.1998, has not been made a party in this case for the reasons best known to the complainant.

Submissions of the Complainant with regard to administration of Depomedrol:

36. Learned Senior Counsel, Mr. Krishnamani, submits that everything in this matter would turn out by deciding whether Inj. Depomedrol 80 mg. twice a day can be administered to a patient or not. According to him administration of injection Depomedrol per se is deficiency in service by the doctors as per the medical literature. [overdose of Depomedrol].

37. For this, he refers to the prescription given by Dr. Mukherjee on 7.5.98 wherein it is stated that Inj. Depomedrol 80 mg. is to be taken twice a day for 3 days. On 11.5.98 also, he has continued the same treatment by specifically mentioning that further tests as stated in the medical sheet are to be carried out. Thereafter, he left India. According to the learned Senior Counsel Mr. Krishnamani, this amounts to overdose of Depomedrol.

38. He further submits that in this case what the doctors ought to have done, has not been done by them, i.e. (i) the moment TEN is diagnosed, immediately I.V. fluids ought to have been started; this was not done; (ii) Supportive therapy should have been given which consists of proteins, and, electrolyte balance was not maintained by regular blood examination. (iii) other vital signs were not monitored by the doctors or the staff of the hospital. (iv) Patient ought to have been kept in the burn center or in the ICU.

39. He has also submitted that TEN was diagnosed by Dr. Ghoshal on 11.5.98 itself in the evening after Dr. Mukherjee had left. However, appropriate treatment for TEN was not given by the doctors who had examined the deceased on 11.5.98 and thereafter.

Submissions of Opposite Parties 1 and 2:

40. As against this, learned counsel Mr. Vasdev for Opposite Parties No. 1 & 2 submitted that:

(i). all the necessary medical care was taken by Dr. Mukherjee and Dr. Halder when consulted. There is no negligence on their part. Further, the case against them is cooked up and they are unnecessarily dragged to various litigations for no fault of them;

(ii). The drugs prescribed by them are drugs of choice in such cases. The dose which was given by them is as per the medical literature;

(iii). Thirdly, the complainant has filed complaint before the West Bengal Medical Council and the W.B.Medical Council has specifically arrived at the conclusion that there is no deficiency or negligence on the part of the doctors. Against the decision of the Medical Council, the complainant has approached the High Court by filing a Writ Petition. The said Writ Petition was dismissed by the High Court. However, against that order, the Complainant has preferred an Appeal;

(iv). In the Criminal Complaint which was filed against them, they are all acquitted by the High Court and against that the complainant has filed an SLP where leave has been granted;

(v). He further submitted that on 17th May 1998 the deceased was removed to the Breach Candy Hospital in Mumbai, where Dr. F.E.Udwadia, who is a known consultant physician, has specifically mentioned in the record that the complainant was unnecessarily intervening in the administration of the drug. It is also mentioned in the history sheet that the treatment which was given at AMRI hospital in Calcutta was also proper;

(vi). In the Breach Candy hospital, different steroids were continued. No postmortem was carried out after the death of Mrs. Anuradha so as to find out the exact cause of the death;

(vii). In the Legal Notice which was issued by the complainant, allegations were made against 26 persons without any basis. This reveals the conduct of the complainant in involving a number of persons;

(viii). Before this Commission also, two separate complaints were filed. One against the Breach Candy Hospital, Mumbai and the doctors, and the other, against the presents Opposite Parties. For reasons best known to the complainant, the complaint filed against the Breach Candy hospital and its Doctors was withdrawn. The learned counsel for the respondent alleged that Dr. Udwadia was examined by the complainant as a witness in a criminal case and as he has supported the complainant, the complaint against him before this Commission was withdrawn.

(ix). He further pointed out by relying on the order dated 27.8.2003, wherein this Commission has observed : "We find that host of opp.parties have been added against whom no negligence has been alleged in the complaint" and submitted that on the basis of the said order, the names of those Opposite Parties were deleted from the complaint without any amendment to the complaint.

(x). Further, against the advice of the doctors, the deceased was removed to Mumbai at Breach Candy hospital. This is also recorded in the history sheet of the Breach Candy hospital. It is mentioned that the patient ought not to have been removed from Calcutta.

Deficiency in service:

Real test for determining deficiency in service

41. Well laid down tests for determining deficiency in service are - whether there is failure to act in accordance with standard of a reasonable competent medical practitioner?

(i). Whether there was exercise of reasonable degree of care?(ii). The degree of standard or reasonable care varies in each case depending upon expertise of medical man and the circumstances of each case. On this aspect, it would be worthwhile to refer to the enunciation from Halsbury's Laws of England.

With regard to degree of skill and care required by the doctors, it has been stated as under in (pr.36, p.36, Vol.30, Halsbury's Laws of England, 4th Edn.)

The practitioner must bring to his task a reasonable degree of skill and knowledge, and must exercise a reasonable degree of care. Failure to use due skill in diagnosis with the result that wrong treatment is given is negligence. Neither the very highest nor a very low degree of care and competence, judged in the light of the particular circumstances of each case, is what the law requires, and a person is not liable in negligence because someone else of greater skill and knowledge would have prescribed different treatment or operated in a different way; nor is he 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, even though a body of adverse opinion also exists among medical men; nor is a practitioner necessarily negligent if he has acted in accordance with one responsible body of medical opinion in preference to another in relation to the diagnosis and treatment of a certain condition, provided that the practice of that body of medical opinion is reasonable.

42. The Apex Court aptly stated the said principles further in Dr. Laxman Balakrishna Joshi v. Dr. Trimbak Bapu Godbole , which reads as under:

The practitioner must bring to his task a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. Neither the very highest nor a very low degree of care and competence judged in the light of the particular circumstances of each case is what the law requires: (cf. Halsbury's Laws of England, 3rd ed. Vol. 26 p.17). The doctor no doubt has discretion in choosing treatment which he proposes to give to the patient and such discretion is relatively ampler in cases of emergency.

43. Similarly in Poonam Verma v. Ashwin Patel , dealing with medical negligence, the Court observed that:

14. Negligence as a tort is the breach of a duty caused by omission to do something which a reasonable man would do, or doing something which a prudent and reasonable man would not do.

15. The definition involves the following constituents:

(1) a legal duty to exercise due care;

(2) breach of the duty; and

(3) consequential damages.

16. The breach of duty may be occasioned either by not doing something which a reasonable man, under a given set of circumstances would do, or, by doing some act which a reasonable prudent man would not do.

17. So far as persons engaged in the medical profession are concerned, it may be stated that every person who enters into the profession, undertakes to bring to the exercise of it, a reasonable degree of care and skill. It is true that a doctor or a surgeon does not undertake that he will positively cure a patient nor does he undertake to use the highest possible degree of skill, as there may be persons more learned and skilled than himself, but he definitely undertakes to use a fair, reasonable and competent degree of skill. This implied undertaking constitutes the real test, which will also be clear from a study and analysis of the judgment in Bolam v. Friern Hospital Management Committee5 in which, McNair, J., while addressing the jury summed up the law as under:

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 at the risk of being found negligent. It is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art. I do not think that I quarrel much with any of the submissions in law which have been put before you by counsel. Counsel for the plaintiff put it in this way, that in the case of a medical man, negligence means failure to act in accordance with the standards of reasonably competent medical men at the time. That is a perfectly accurate statement, as long as it is remembered that there may be one or more perfectly proper standards; and if a medical man conforms with one of those proper standards then he is not negligent.

18. This decision has since been approved by the House of Lords in Whitehouse v. Jordan; Maynard v. West Midlands Regional Health Authority; Sidaway v. Bethlem Royal Hospital; Chin Keow v. Govt. of Malaysia.

19. The test pointed out by McNair, J. covers the liability of a doctor in respect of his diagnosis, his liability to warn the patients of the risk inherent in the treatment and his liability in respect of the treatment.

44. If there there are alternative procedures of treatment and if a Doctor adopts one of them and conducts the same with due care and caution then no negligence can be attributed towards him.

45. In substance, for establishing negligence or deficiency in service there must be sufficient evidence that a Doctor or a hospital has not taken reasonable care while treating the patient. Reasonable care in discharge of duties by the hospital and Doctors varies from case to case and expertise expected on the subject which a Doctor of a hospital has undertaken. Courts would be slow in attributing negligence on the part of the Doctor if he has performed his duties to the best of his ability with due care and caution.

46. It has been held in Dr. Anita Prashar v. Preeti Kochar and Anr. III (2005) CPJ 638, and also in Hon'ble Supreme Court casein the case of Achutrao that there are various mode and course of treatment and if a Doctor adopts one of them with due care and caution the Court could indeed be slow in attributing negligence on the part of a Doctor if he has performed his duties to the best of his ability and with due care and caution.

47. Same view is expressed in Achutrao Haribhau Khodwa and Ors. v. State of Maharashtra and Ors. , wherein the Court observed:

14. The skill of medical practitioners differs from doctor to doctor. The very nature of the profession is such that there may be more than one course of treatment which may be advisable for treating a patient. Courts would indeed be slow in attributing negligence on the part of a doctor if he has performed his duties to the best of his ability and with due care and caution. Medical opinion may differ with regard to the course of action to be taken by a doctor treating a patient, but as long as a doctor acts in a manner which is acceptable to the medical profession and the court finds that he has attended on the patient with due care, skill and diligence and if the patient still does not survive or suffers a permanent ailment, it would be difficult to hold the doctor to be guilty of negligence.

Medical literature on TEN:

48. At this stage, we would refer to the literature produced by the Complainant with regard to Toxic Epidermal Necrolysis : A review and Report of the Successful Use of Biobrane for Early Wound Coverage, wherein it stated that:

Toxic epidermal necrolysis (TEN) is an extoliative dermatological disorder of unknown cause. A patient with TEN loses epidermis in sheet-like fashion leaving extensive areas or denuded dermis that must be treated like a larze, superficial, partial-thickness burn wound.

Over the last decade, the treatment of TEN has stressed early transfer to a burn unit, maintenance of fluid and electrolyte balance, avoidance of corticosteroids, aggressive septic surveillance and early wound debridement and coverage. Adequate enteral nutritional support and ophthalmological care are equally important to maximize favourable outcome.

49. "Discussion: These three cases serve to highlight a number of the clinical and management problems encountered with TEN and to demonstrate the efficacy of Biobrane for early wound coverage.

50. TEN, also known as Lyell's syndrome, was first described by Lyell in 1956 (6). He described a dermatological condition that resulted in slough of the epidermis, resembling a scald. The incidence of TEN has been reported at 1 to 1.3 per million per year (7). The female-male ratio is 3:2(2). TEN accounts for nearly 1% of drug reactions that require hospitalisation (8). Mortality rates of 25 to 70% have been reported (9-14).

51. Almost all drug types have been implicated in the development of this disorder, but the most frequently cited are sulfonamides, nonsteroidal anti-inflammatory drugs, and anticonvulsants (6-8, 15-17). Unfortunately, there is no reliable test to implicate a specific drug definitely (18). Immunizations (19), Epstein-Barr virus (3), influenza (10), graft-versus host disease (20,21), as well as multiple systemic diseases such as leukemia (11), ulcerative colitis and Crohn's disease (15) and systemic lupus erythematosus (16) have all been implicated in the development of TEN.

52. The pathophysiology of TEN is unknown. Although it has generally been thought of as a "hypersensitivity" reaction to drugs (8), it has also been described as being an immune reaction in which the drug metabolites act as haptens, combining with carrier proteins to evoke an immune response (22). Specific antibodies have not been found in TEN, in contrast to Stevens-Johnson Syndrome (SJS) or erythema multiforme (EM) (23). Cellular cytotoxic mechanisms have been postulated (24, 25), and genetic susceptibility involving a human leukocyte antigen histocompatibility complex has been mentioned (26). The therapy of an exaggerated immune response and circulating toxin-immune complexes are the rationale for the use of hyperbaric oxygen (27) and plasmapheresis (28) in the treatment of TEN by some clinicians.

History and Treatment Chart at Breach Candy Hospital:

53 Now, we would refer to the statements of Dr. Farokh E.Udwadia who had treated Mrs. Anuradha at Breach Candy Hospital.

54. As per the history record, recorded by the Bombay Hospital, the Complainant informed the Breach Candy Hospital that:

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

55. She has been shifted by flight from Calcutta. She was examined on admission- hemodynamically stable, conscious, HR - 120 per min., good volume. Attempt at uncovering the patient for examination was unwelcome. T-99 degrees F - B.P. could not be recorded. Lungs - clear. Dr. Saha was informed that she needed to be hydrated well and that such patients are usually grossly hypovolemic. A functional angiocath was secured in Rt. Hand.

56. Complete bio- chemistry, Blood counts & Blood C/S sent. XRC was ordered (refused by Dr. Saha). It was planned to give 4 pints (DNS, alternating with Normal saline) till 8 AM coming morning which were not transfused at the collective request of the patient and her husband. Dr. Saha agreed to continue i.v. cifran as the antibiotic.

57. On 18th she was examined by Dr. Farokh E. Udwadia, who had recorded as under:

Patient has come with a diagnosis Toxic Epidermal Necrolysis (TEN). She has had a number of drugs at Calcutta form antibiotics to non-steroid and inflammatory agents. Is there any way of distinguishing this from a Stevens & Johnson Syndrome? There is no skin left. The mucus of the mouth, genitals and area is also severely affected. And have not seen the evolution of the skin lesions to the point where there is now no skin left. So far there is no organ evolvement in particular. No pulmonary lesions nor any urinary lesions (organs commonly involved as in a Steven Johnson Syndrome). In any case the basic management is the same. I do feel that the dose of steroids used in Calcutta is either excessive - 120 mg. Daily for a number of days, preceded by 80 mg Depomedral Injections. I would not give more than 40 mg /day Kg. body weight.

58. The patient is actually ill (TEN). I foresee the following problems:

1. Hypotension.

59. Almost certainly she is already infected : (a) because of skin being totally denuded; (b) because of high dose of steroids she has received in Calcutta; and, (c) because of transfer from Calcutta in this situation. I feel

she should never have been transferred because the risk of infection in this state is well nigh 100%.

60. 9 PM: The brother -in -law has brought a new 'Quinalone' antibiotic from the USA as highly recommended for infections. I have never used the drug, am totally unfamiliar with it, and feel that we should use drugs we are familiar with.

61. On 20th Dr. Farokh E.Udwadia further recorded as under:

Have had great problems with the husband and brother-in-law. It is with great difficulty that I have controlled myself. When presented with his arrogance and condescends - merely and solely for the patient's sake. To keep the peace, I have compromised on the following:

(a) To allow he use of Erythropoeitin. I reasoned that though it cannot do much good, it does not do harm.

(b) To allow the use of a Zinc preparation - totally unnecessary but not likely to lead to Zinc poisoning.

(c) I would not allow parenteral alimentation through the same central line as fluids and electrolytes as I feel gut if viable used at IV alimentation at this point of time may add to her hazards.

62. The resident and nursing staff are to keep peace for obvious reasons. I have asked them to keep up and look at the patient's interest and to keep focused solely on patient care.

3AM : Patient breathless. Patient's own relations told " no need to inform any hospital doctors".

63. The hospital records show that the steroids in blood were in normal ranges and the skin was healing. The general condition of the patient was better.

However, on request of Dr. Saha the injection (I.V. Vancomycin) was postponed".

It is further recorded on the same date:

Rt. Femoral cannulation attempted by Dr. Saha - unsuccessful

Deposition of Dr. Udwadia (before the Criminal Court):

64. Dr. Farokh E.Udwadia was examined as a witness in criminal case filed by the Complainant before the Chief Judicial Magistrate, Alipore. In his deposition, he has stated as under:

Q. Would you agree that overuse or misuse of steroid can cause infection in TEN?

A. As I mentioned earlier the danger of corticosteroid used in any condition is the possibility of immuno-suppression and infection.

Q. Would you agree that inadequate fluid replacement can lead to the fatality in TEN or any acutely ill patient? (objected to).

A. Yes.

Q. Could anything be done other than what was already done by the Breach Candy Hospital to save the life of Mrs. Anuradha at that satage?

A. No. In fact, the treatment of TEN is solely supportive. There is no proven specific treatment. This goes for corticosteroids as well and in the year 1998 this goes for all other modalities, example "plasmaphorisis, use of immunoglobuline, use of thalidomide. It is a rare disease (TEN) one in a million and at least till 1998 there was no controlled, randomized series that could prove whether any specific treatment was clearly effective.

Q. Is aggressive "supportive therapy" an absolute requirement for treatment of TEN patient?

A. Yes.

Q. Was the patient already infected in Calcutta? (objected to).

A. I cannot answer that. But in Bombay the wounds were infected.

Q. Can a long -acting corticosteroid like Depomedrol be used for the treatment of TEN?

A. I have never ever used that drug. So, I have no first -hand experience.

Q. Do you know the use of Depomedrol at 80mg twice daily doses by any Doctor?

A. I cannot recall the doses used by any Doctor. My personal experience is zero.

Q. Please look at the reports of Dr. A.K. Ghoshal and Dr. Sukumar Mukherjee (Exhibt.3). In the prescription of Dr. Mukherjee do you find any diagnosis or any specific disease?

A. No.

Q. Does prescription justify the use of injection Depomedrol at the incomprehensible dose of 80mg., twice daily?

A. I have never used that drug. The person who used it is the best person to answer.

Q. What is the most serious and immediate complication if excessive corticosteroids are used in TEN patients?

A. G.I. bleeds. Infection and delay in re-epithelialization of skin.

Q. Can overuse or excessive use in a TEN of corticosteroid cause immuno- suppression?

A. Yes, in any serious ill patient or any patient, an excessive dose tends to cause immuno-suppression.

Q. Was any post-mortem done at Breach Candy hospital after Mrs. Anuradha's death?

A. No.

Q. Should post-mortem have been performed at Breach Candy hospital after Mrs. Anuradha's death?

A. If the cause of death is natural cause or the cause is quite obvious, it is not incumbent to do so unless their relatives ask for that. I was not there at the time of death. But I gathered that the relatives were keen to get the body as quickly as possible.

Q. Is the treatment at Breach Candy hospital in any way responsible for the death of Mrs. Anuradha Saha?

A. No, As I have already mentioned we slaved to save her life. I had a senior Registrar in constant attendance. I had a house Physician entirely devoted to her. We had made her room as a mini intensive care unit as far as possible. We only shifted her to regular ICU when she needed ventilatory support. I used to see her at least three times a day, was in constant communication with the house-staff looking after and as is my custom for treating Doctors or their wives or their children or their parents from the very start of my professional career, I did not levy any single palse as my professional fee. It was, however, heart-rendering to see young lady die.

Cross-examination of Dr. Udwadia by Dr. Sukumar Mukherjee, Opposite Party No. 1

.Q. I refer here certain factors for sepsis such as therapeutic intervention, hospital micro-environment, transportation of a patient from Calcutta to Bombay, and unhygienic handling of patient in transport or in transit. What is your opinion?

A. Any medical invasive intervention carries a small risk of infection besides others. It has to be done meticulously and in the operation theatre by skilled individuals. Nosocomial infections are the risks in any and every hospital though the infection rate by a specific infection control committed supervising the hospital infections at Breach Candy Hospital is around 2% which is as low as one can get in any other hospital. Transportation from Calcutta to Bombay could cause grave hazards unless it was done in appropriate manner. Unhygienic handing is covered by the last answer.

Q. From the papers what you have seen in the Court i.e. the hospital records of Breach Candy original as well as Xerox are brought by you today itself?

A. Yes.

Q. I put it to you that the corticosteroid can be used in allergic condition as well as in inflammatory condition. What do you think?

A. Yes.

O. I put it to you that steroids is also used to control the effects of infection. What do you say?

A. Yes, provided the root cause of infection is also attacked by specific therapy against the infection and that too in certain selected examples.

O. I put it to you that to combat the infection steroid can be used along with antibiotic. What do you say?

A. In my opinion, only in certain selected instances, but not as a general principle.

O. I put it to you that the Clinician is the best man to choose his drug. What is your opinion?

A. Yes.

Opinion of Dr. Peter Fritsch:

65. Complainant has produced on record the opinion given by Dr. Peter Fritsch, Chairman, Department Dermatology, University of Innsbruck, Austria, the relevant portion thereof is as under:

More importantly, no account is given on the basic clinical parameters except scant measurements of blood pressure and pulse (May 11, May 12). Although specifically asked for by the dermatologist (note of May 11- "maintain fluid/electrolyte balance"), no hematocrit, blood gas analysis or electrolyte values are recorded in the files. Fluid input/output measurements are only recorded for May 12 and 13. Temperature was recorded

only on May 12 and 13. Although the last reading (May 12, 10p.m., was 100.8F, there was no further monitoring of body temperature (or no recording)

In view of the fact that the most common complication of toxic epidermal necrolysis is bacterial superinfection, it must be noted that no attempts were obviously undertaken to identify a possible infectious origin of the fever which was present from May 12 onwards.

No mention is made of a more vigorous antibiotic treatment, even not on May 15 when Dr. Prasad states: prognosis poor. This judgement does not seem to have prompted the attending physicians to a more active stance. In contrary, the number of notes contained in the records appears to be ever decreasing the sicker the patient became. It is even not clear if a venous life was installed to fluid and electrolyte imbalances and to administer i.v. antibiotics.

Judging from the note of the plastic surgeon of May 13 "occlusive.. dressings to back, rest left exposed", one may assume that this was not the case. Patients with toxic epidermal necrolysis must be admitted to a critical care unit or, in Europe, to a Dermatology hospital experienced in the care of this devastating disorder. From the documents given to me it is likely that both was not the case.

Conclusions: Form the documents in my possession it is quite clear that diagnostic endeavours and therapeutic measures in this case were inadequate. Treatment consisted more or less only of very high doses of systemic corticosteroids, but no proper flanking measures were taken (antibiotic treatment, correction of fluid and electrolyte imbalances, adequate topical treatment). As is well known, the scientific community is divided over the issue if corticosteroids should be used for the treatment of toxic epidermal necrolysis or not. Still, even the advocates leave no doubt that corticosteroids should not be taken longer than the first period of the disease and then quickly tapered; furthermore, everybody agrees that corticosteroids pose an extra risk of secondary infection which has to be properly faced. In the case of Mrs. SAHA, the corticosteroid doses were excessively high (in view of her slim body weight; also, it is unclear why show release corticosteroids were used). Finally, the hospital records are more than deficient by any standard.

Opinion of Dr. J.S.Pasricha:

66. The Complainant has also produced on record answers given by Dr. J.S.Pasricha of Skin Diseases Centre wherein Question nos. 1 to 23 are as under:

Qn. No. 1: Is the diagnosis made by Dr. Sukumar Mukherjee correct?

Ans: The diagnosis made on 7.5.1998 is angioneurotic oedema with allergic vasculitis. Subsequently, on 11.5.1998 the diagnosis written is macullo-papular-bullous lesions (which is only a description of the lesion but no diagnosis). The diagnosis made by Dr. B.N.Halder on 12.5.1998 is toxic epidermal necrolysis. It, therefore, seems that Dr. Mukherjee missed the correct diagnosis. It may be noted that I have not seen the patient myself and presume that Dr. Halder who is a dermatologist is likely to make a correct diagnosis of the dermatological disease. TEN is very serious disease and is potentially fatal if not controlled adequately and quickly.

Qn. No. 2 Is the treatment given by Dr. Mukherjee correct?

Ans. There is worldwide controversy whether corticosteroids should be used for TEN or not. In my opinion corticosteroids used appropriately are the best way of saving the patient. The chief parameters of my approach include : (1) controlling the reaction within 24 hours by using a large dose of corticosteroids. Use of Depo-preparations at this stage will be incorrect. In fact Depo-preparations are used for chronic diseases and not for acute disease like TEN. Secondly, Depo preparations are not to be used twice a day. (2) The second important component of my approach consists of withdrawing the corticosteroids quickly (within 7-10 days)

after the reaction has been controlled. In my opinion the causes of death due to TEN are : (i) not controlling the reaction quickly, and (ii) not withdrawing the corticosteroids quickly. Continuing corticosteroids for a long period, can lead to secondary infections which contribute to the fatalities in this disease.

Qn. No. 3: Did Dr. B.N.Halder provide adequate supportive treatment to the patient?

Ans. The additional treatment for this disease depend upon the state of the patient on a day to day basis. Since I have not seen the patient it is difficult for me to comment on this aspect.

Findings of West Bengal Medical Council:

67. The proceedings and the findings recorded by the West Bengal Medical Council, after going through the papers and evidences produced, are as under:

The proceedings and the conclusions of the Penal and Ethical Cases Committee are as under:

The P.E. Committee examined the three Doctors as well as Dr. Kunal Saha the Complainant and also the following witnesses -

1. Dr. Balaram Prasad [

2. Dr. N. Iqbal [All attached to AMRI, Hospital

3. Dr. Koushik Nandy [

4. Dr. Purnima Chatterjee [

5. Vice - President of AMRI Hospital [

68. The P.E.Committee also obtained opinions from experts in Medicines, Dermatology and Pharmacology during their course of investigation.

69. Thereafter, on completion of the process of investigation, the P.E. Committee placed its Reports to the Council with following comments:

(i) The allegations against Dr. Abani Roy Choudhuri and Dr. Baidyanath Halder could not be substantiated, they may be exonerated.

(ii) Dr. Sukumar Mukherjee was exonerated of the charge of use of FCCP fraudulently.

(iii) That charges of negligence of treatment against all the three Doctors i.e. Dr. Sukumar Mukherjee, Dr. Abani Roy Choudhuri and Dr. Baidyanath Halder were not established.

(a) Dr. Sukumar Mukherjee (Dr. Mukherjee) first examined the patient on April 24, 1998, [though there was no mention in complaint of Dr. Kunal Saha (Dr. Saha)]. However, Dr. Saha admitted this in his deposition before P.E.Committee. Many Doctors examined Mrs. Anuradha Saha between April 24, 1998 and May 07,1998. There is no evidence that these were communicated to Dr. Mukherjee. After thirteen days, Dr. Saha took his wife to Dr. Mukherjee.

(b) On May 07,1998,Dr. Mukherjee diagnosed this as Allergic Vasculitis on clinical grounds. One injection of 80 mg Depomendrol was given by Dr. Mukherjee himself while prescribing injection Depomedrol 80 mg (IM) BD for three days. Dr. Saha could not produce any evidence that 5 other injections were administered at

all or not, nor could he "remember"who gave these injections (Deposition before P.E. Committee).

(c) Evidence shows that many Doctors examined Mrs. Anuradha Saha between 7th and 11th May, 1998, including Dermatologists Dr. A.K.Ghoshal and Dr. Sanjay Ghosh. There is no evidence that these were communicated to Dr. Mukherjee. There was no evidence that these consultations were taken after obtaining approval and / or consent (except in case of Dr. Ghoshal who was requested to examine Mrs. Anuradha Saha by Dr. Mukherjee himself on May 07,1998) from Dr. Mukherjee or the same were at all communicated to Dr. Mukherjee.

(d) Initially on 24.4.1998, Dr. Mukherjee noted that Mrs. Anuradha Saha was allergic to Chinese food. Dr. Saha confessed that Mrs. Anuradha Saha used to take Chinese food. In her deposition before P.E. Committee, Dr. Purnima Chatterjee, Gynaecologist, while examining Mrs. Anuradha Saha at AMRI stated that Dr. Saha informed her that Mrs. Anuradha Saha's symptoms flared up after taking Chinese food on May 10,1998.

(e) Evidence shows that patient was admitted in AMRI under Dr. Balaram Prasad. Dr. Prasad stated in his deposition before P.E. Committee - I that he received Pager Message on May 11, 1998, requesting him to see Mrs. Anuradha Saha, who was admitted under Dr. Prasad. Dr. Prasad stated that this was choice of Dr. Kunal Saha, Dr. Kunal Saha himself stated that admission was under Dr. Prasad as Dr. Mukherjee was scheduled to leave for abroad. Dr. Prasad himself on his own advised two injections i.e. Injection Depomderol.

Dr. Mukherjee produced an authenticated copy of his application dated April 22, 1998, addressed to AMRI authorities intimating his absence with effect from May 12, 1998. He also informed Dr. Saha on April 24, 1998, and also subsequently about his pre-planned visit to U.S.A from May 12, 1998. Dr. Mukherjee requested Dr. Balaram Prasad to consult Dr. Abani Roy Choudhuri and Dr. B.N. Halder regarding Mrs. Anuradha Saha at AMRI as Dr. Mukherjee was leaving for U.S.A.

(f) Evidence shows that Dr. Mukherjee left for U.S.A. on May 12, 1998, and hence there was no scope for him to participate in the management of the patient at AMRI.

(g) Dr. Kunal Saha repeatedly interfered and sometimes modified the line of management as were advised by the doctors. As per deposition of the Vice President of AMRI before the P.E. - I . Committee, Dr. Saha even did not allow nurses and doctors to examine Mrs. Anuradha Saha at AMRI Dr. Kunal Saha also interfered with treatment at Breach Candy Hospital (as per Breach Candy Hospital records).

Dr. Kunal Saha also did not follow the advice of Dr. Sanjay Ghosh dated May 06,1998, for skin biopsy of his wife.

70. However, the dosage of Depomedrol as has been advised in this case by Dr. Sukumar Mukherjee appeared to be very high.

71. The Council, however, referred back the case to the concerned P.E. Committee for elaborating its recommendation for exonerating the Doctors. This was complied with.

72. Thereafter, the Council, after consideration of the Report along with evidences and other documents of the P.E. Committee exonerated Dr. Abani Roy Choudhury and Dr. Baidyanath Halder of the charges levelled against them.

73. However, it appeared that the dosage of Depomedrol, advised by Dr. Sukumar Mukherjee, was high and, hence, the Council issued charge sheet to Dr. Sukumar Mukherjee dated 8.11.2001, as follows:

That you have used Injection Depomedrol 80 mg BD on Mrs. Anuradha Saha, wife of Dr. Kunal Saha of U.S.A who was under your treatment on and from April 24, 1998, to May 11, 1998, which is much above the

recommended dose of the drug and, hence, you are required to justify use of the said drug at such a high dose.

74. On receipt of the reply of Dr. Sukumar Mukherjee dated 29.11.2001 received by the West Bengal Medical Council on 7.12.2001, in respect of the Charge Sheet issued to him, the Council started its enquiry as per Rule 15 of the Bengal Medical Act 1914. During the hearing both Dr. Kunal Saha and Dr. Sukumar Mukherjee were accompanied by their lawyers all throughout. Adequate opportunities were given to the complainant as well as the practitioner Dr. Sukumar Mukherjee. Both Dr. Kunal Saha and Dr. Sukumar Mukherjee placed their submissions but did not produce any witness. Dr. Kunal Saha and Dr. Sukumar Mukherjee wanted to be assisted by their lawyers, not to be represented by them.

75. Dr. Kunal Saha in his submission dealt mainly with methodology of clinical trials of Drugs, stressing upon the over dosage of Depomedrol from the opinion of Skin and other Specialists from India and abroad with quotations from Foreign and Indian Literature. A submission was also made by the Learned Counsel of Dr. Saha on legal aspects which was allowed by the Council.

In reply Dr. Sukumar Mukherjee submitted before the Council that he treated the patient as Allergic Vasculitis and not TEN [Toxic Epidermal Necrolysis] and Dr. Mukherjee in support of his contention in justifying use of Injection Depomedrol in his final address to the Council he stated:

(I) His diagnosis was Allergic Vasculitis;

(ii) He examined patient on April 24, 1998 and on May 07, 1998. He was also consulted on May 11, 1998, at AMRI by Dr. B.Prasad;

(iii) He never diagnosed the patient as TEN and never used Depomedrol on Mrs. Anuradha Saha as a patient of TEN;

(iv) Very brief period of Depomedrol use (3 to 4 days) in a relatively high dosage to mitigate gradually evolving immuno-inflammation was explained. The dosage regimen was supported form the global literatures, which were submitted before the Council by Dr. Mukherjee.

(v) Of the six injections prescribed by Dr. Sukumar Mukherjee, one was injected by Dr. Mukherjee himself. Regarding the remaining 5 Injections Dr. Kunal Saha could not produce any evidence that they were actually administered.

(vi) The presence of Sepsis had not been consistently established beyond doubt at AMRI upto May 18,1998.

(vii) The use of Depomedrol is not proved to be a direct or proximate cause of her death. No Autopsy was done, nor diagnosis of TEN was confirmed by biopsy.

(viii) The administration of Depomedrol in the form of a single injection (other five such injections were not conclusively proved to be administered to the patient due to lack of authentic records) was not related to be the sole cause of her death - either directly or indirectly specially when death occurred after a lapse of about 3 weeks after single dose of proved administration by Dr. Mukherjee. Furthermore, proper investigation viz skin biopsy etc was not done (though advised) to arrive at the diagnosis of TEN nor any post mortem examination was ever advised by the concerned Doctor of Breach Candy Hospital or Dr. Kunal Saha himself had not insisted on such autopsy to know the actual cause of death.

At the conclusion of submission, the case was closed and the Members of the Council deliberated upon the whole matter.

76. After going through the papers and evidences produced the Council came to the following conclusions:

(a) Re: Dr. Abani Roy Choudhuri - There was no evidence that Dr. Abani Roy Choudhuri either examined Mrs. Anuradha Saha, or a advised any medicine and participated in her treatment at AMRI Hospital;

(b) Re: Dr. Baidyanath Halder - Dr. Halder was consulted only once on 12.5.98 and there is no evidence that he participated in treatment of Mrs. Anuradha Saha;

(c) The Council could not come to the conclusion whether five injections of Depomdrol, prescribed by Dr. Mukherjee were actually administered to Mrs. Anuradha Saha or by whom during 7th to 10th May, 1998;

(d) As Dr. Sukumar Mukherjee was not present in India after May 11, 1998, he cannot be held responsible for any lapse or mis-management of the case in the treatment of Mrs. Anuradha Saha;

(e) The Council was of the view that there was extreme lack of coordination in managing Mrs. Anuradha Saha's illness at AMRI as many Doctors were consulted and there was lack of interaction among themselves;

(f) "Dr. Kunal Saha interefered with treatment of Mrs. Anuradha Saha and even did not allow Doctors and Nurses to examine Mrs. Anuradha Saha at AMRI (as per Deposition of Vice-President, AMRI at P.E. Committee). He also interfered with treatment of Mrs. Anuradha Saha at Breach Candy Hospital (Breach Candy Hospital Record);

(g) Dr. Kunal Saha did not follow advice regarding skin biopsy on May 06, 1998 and on May 12, 1998 which would have helped coming to early diagnosis;

(h) Mrs. Anuradha Saha was allergic to Chinese food. "Mrs. Anuradha Saha was fond of Chinese food which she took at times". (Deposition of Dr. Kunal Saha before P.E.Committee). Dr. Kunal Saha informed Dr. Purnima Chatterjee, Gynaecologist who examined Mrs. Anuradha Saha at AMRI that her flare up followed intake of Chinese food on May 10, 1998.

(i) Opinion of experts expressed in global literatures regarding use and dosage of Depomedrol as USPDI Vol.I 1994, page 966, Harrison's Principles of Internal Medicine CD-ROM 1998, Principles of Pharmacology by Paul Munsen, Dermatology of Fitzxpatrick, Drug Therapy by Collin Dollery and other authoritative Books, were cited by Dr. Sukumar Mukherjee. He also provided Xerox copies of relevant reference after reading them all from original texts. These were gone through by the Members of the Council and overwhelming majority of the Members were of the opinion that the dose of Depomedrol advised by Dr. Sukumar Mukherjee was not unjustified.

77. In the concluding meeting dated May 20, 2002 all members present expressed their views. The President of the Council presided over the said meeting but did not take part in the deliberation or ever expressed his views. The explanation offered by Dr. Mukherjee was accepted by the majority of the members present in the meeting and considering such acceptance, the Council exonerated Dr. Sukumar Mukherjee of the charges framed against him (as required under Section 25(a)(ii) of the West Bengal Medical Act, 1941).

Taking opinion of the majority of the members, the Council exonerated Dr. Sukumar Mukherjee of the charges levelled against him. It was also decided to intimate the complainant, Dr. Kunal Saha that the allegations against Dr. Abani Roy Chowdhury and Dr. Baidyanath Halder could not be substantiated as was evident from their deposition and records and was exonerated by the Council but the decision of the Council was withheld for completion of the total case."

Facts emerging from the record:

78. The facts which can be culled out from the record are:

Dr. Kunal Saha himself is a Doctor (M.D., Ph.D.) Assistant Professor, Department of Paediatrics and Medical Microbiology, (Research Department) in State University of Ohio in the U.S.A. Undisputedly:

(i) On 1.4.1998, after arriving at Calcutta Mrs. Anuradha developed a sore throat with some palpable neck glands.

(iii) On 3.4.1998, she developed low-grade fever.

(ii) On 17.4.1998, she developed high-grade fever with upper respiratory tract infection.

(iii) On 25.4.1998 her fever increased with a skin rash and enlarged neck glands (lymph nodes).

(iv) On 26.4.1998 Complainant contacted Dr. Sukumar Mukherjee (OP-1). He examined Mrs. Anuradha at the residence of the complainant and diagnosed as post viral (measles like skin rash). Skin rash subsided by 3 May, 1998 but reappered the next day. Dr. Mukherjee has not given any treatment but prescribed a number of tests.

(v) There is nothing on record to indicate as to what type of disease Mrs. Anuradha was suffering from 3rd April, 1998 and what treatment was given by the Complainant, who himself is an M.D., Ph.D.

(vi) Only on 7th May, 1998 when the condition of Mrs. Anuradha deteriorated, the Complainant contacted Dr. Mukherjee. She was examined by Dr. Mukherjee in his chamber. At that time Mrs. Anuradha walked into the clinic. At that stage, Dr. Mukherjee prescribd steroid namely 'Depomedrol' injection 80 mg. twice a day for a period of three days. This was based on blood reports revealed eosinephilia and mild leucocycosis. On the basis of aforesaid blood and clinical examination by the Dr. Mukherjee, steroid was prescribed for controlling infection.

It cannot be said that his judgment or treatment was on the face of it unreasonable or was not as per the standard prescribed for a competent medical man.

(vii) From 7th May to 11th May, 1998, it is pointed out that the Complainant contacted two dermatologists, namely, Dr. A.K. Ghoshal and Dr. S.Ghosh. The Complainant has not produced on record what treatment was given by these two Dermatologists.

(viii) Thereafter, she was admitted to AMRI Hospital. Dr. Mukherjee examined her at 2.30 PM and prescribed the treatment. Thereafter, he left for USA at night.

(ix) On the same day, Dr. A.K.Ghoshal examined Mrs. Anuradha and diagnosed that the disease, from which she was suffering, was 'TEN' and maintained the same medicines as prescribed by Dr. Mukherjee.

It is admitted that Dr. Ghoshal has not been joined as a party respondent to this complaint.

79. As per the settled law discussed above, deficiency in medical negligence is to be judged on the following principles:

(i). It is to be remembered that a Doctor or a Surgeon does not undertake that he will positively cure a patient nor does he undertake to use the highest possible degree of skill, as there may be persons more learned and skilled than himself, but he definitely undertakes to use a fair, reasonable and competent degree of skill.

(ii). It is to be stated that if there are several modes of treatment and if a Doctor adopts one of them and conducts the same with due care and caution then no negligence can be attributed towards him;

(iii). Secondly, in the case of medical man, negligence means, failure to act in accordance with the standards of reasonably competent medical men at the time.

(iv). A medical practitioner is expected to exercise a reasonable degree of care and exercise skill and knowledge which he possess;

(v). No doubt, failure to use due skill in diagnosis with the result that wrong treatment is given is negligence;

(vi). Medical opinion may differ with regard to diagnosis or treatment, but in a complicated case if they occur and Court will be slow in attributing negligence on the part of the Doctor if he has performed his duties to the best of his ability and with due care and caution.

Findings:

Findings qua Opposite Party No. 1:

(a). From the aforesaid treatment chart quoted above it would be difficult to arrive at the conclusion that there was negligence or deficiency in service on the part of Dr. Mukherjee, Opposite Party No. 1, because, even Dr. A.K.Ghoshal, Dermatologist, who had examined Mrs. Anuradah on 11th May diagnosed the disease as TEN and prescribed the same treatment;

(b). It appears that much of the difficulty has arisen because Dr. Kunal Saha, being a qualified medical practitioner, may be a researcher as contended by him, has not produced on record what type of treatment was given by him to Mrs. Anuradha from 1st April, 1998 to 7th May, 1998 despite her condition was deteriorating day by day and that she was suffering from fever, high fever with skin rash and enlarged neck glands.

(c). It appears that the complaint is directed against the opposite parties solely on disagreement in the pattern of treatment rendered by Dr. Mukherjee and others after the death of Mrs. Anuradha.

(d). From the medical literature for the treatment of TEN, as quoted above, there is no specific treatment for TEN, only supportive treatment is provided. Further, from the opinion of Prof. Dr. Peter Fritsch, Chairman, Department Dermatology, University of Innsbruck, Austria, which the Complainant has produced, it is clear that with regard to use of steroid in treating TEN there is a division of opinion with the medical practitioners. He has specifically stated that: "As is well known, the scientific community is divided over the issue if corticosteroids should be used for the treatment of toxic epidermal necrolysis or not.

(e). Error of Judgment in the process of diagnosis does not amount deficiency in service, as the disease, TEN is a rare one occurring 1 to 1.3 per million per year and that the most common complication of TEN is bacterial superinfection. As stated by Dr. Peter no attempts were obviously undertaken to identify the possible infectious origin of the fever which was present from May, 12 onwards.

(f). From the record it is apparent that the patient was never in absolute care of Dr. Mukherjee (O.P. No. 1) or Dr. Baidyanath Halder (O.P. No. 2) and Dr. Abani Roy Chowdhury (O.P. No. 3), because from time to time she was treated by a whole host of Doctors as suggested by the Complainant including the Complainant. It is pointed out that Dr. Baidyanath Halder (O.P. No. 2) had examined the patient only on 12.5.1998 yet he has been made opposite party unnecessarily. Even before Dr. Baidyanath Halder examined the deceased Dr. Ghoshal diagnosed the disease as TEN.

80. It is also contended that Dr. Abani Roy Chowdhury, (O.P. No. 3) never examined the patient , but from the records it appears that his name is mentioned in certain prescription. Therefore, he is added as party Respondent.

(e) From the history of case, as stated above, i.e. from 1st April, 1998 Dr. Kunal Saha (Complainant) himself was treating his wife, administering a variety of drugs which were not prescribed by the opposite parties or other doctors. This is further corroborated by the medical record of the Bombay Hospital produced by the Complainant, wherein Dr. Udwadia, who was incharge, has specifically stated that he had great problems with the husband and brother-in-law (brother of the deceased's) and that it was with great difficulty that he could control himself. When presented with his arrogance, he compromised merely and solely for the patient's sake. He also instructed the resident and nursing staff to keep peace for obvious reasons for the patient's sake. This leaves no doubt that the Complainant who himself is a Doctor has created all problems in giving treatment to the deceased. He called a number of doctors to examine the deceased and created problem in her treatment.

(f). Further, presuming what the Complainant says is correct, but in this Case, Mrs. Anuradha developed a low grade fever on 1.4.98. On 17.4.1998 she developed high fever followed by skin rash on 25.4.1998. It was also admitted that there was worsening of the skin rash after a meal at Chinese Restaurant and for this Complainant had not disclosed what treatment was given to Mrs. Anuradha prior to 7th May. If drug reaction is the cause of TEN, then it is quite possible that the treatment which was given by the complainant from 1st April, onwards and also a Chinese meal, might be the cause of TEN.

(g). Finally, even the mortality rate as stated in the Review and Report of the Successful Use of Biobrane for Early Wound Coverage, was between 25 to 70% and there was no reliable test to implicate a specific drug which causes TEN. With regard to the law as discussed above, a Doctor does not undertake that he will positively cure a patient, nor does he undertake to use the highest possible degree of skill as there may be persons more learned and skilled than himself. In the present case, Dr. Kukherjee is M.D. and not Dermatologist. His diagnosis may be erroneous that the deceased was suffering from Allergic Vasculitis but that would not mean, he has not acted with reasonable degree of skill.

.(h). Further, the expert-body of Doctors, i.e. the West Bengal Medical Council, has also arrived at the conclusion that there was no negligence/deficiency in service on the part of the Doctors or the hospital. The findings of the West Bengal Medical Council are quoted above. In the first instance, they have exonerated Dr. Baidyanath Halder and Dr. Abani Roychoudhury. Thereafter, with regard to Dr. Mukherjee, the P.E. Committee examined the case as to whether the dose of Depomedrol was excessive and finally arrived at the conclusion that it was because of circumstances and based on clinical examination of the patient.

81. The Medical Council could also not come to the conclusion as to whether the 5 injections of Depomedrol prescribe by Dr. Mukherjee were actually administered to Mrs. Anuradah, or if administered, by whom during 7th to 10th May.

82. His treatment was not for TEN, but for Allergic Vasculitis and it cannot be said that use of Depomedrol for treatment of such disease was in any unjustified.

83. No doubt, the Council was of the view that there was extreme lack of coordination in managing Mrs. Anuradha Saha's illness at AMRI as many Doctors were consulted and there was lack of interaction among themselves.

84. The aforesaid findings, recorded by the West Bengal Medical Council, were challenged by the Complainant in a Writ Petition before the High Court of Calcutta. That petition was dismissed. Against that order, he had preferred appeal before the Division Bench of the High Court.

85. On this aspect we make it clear that we have relied upon the said findings as a piece of evidence and not as a conclusive proof.

86. It is also found from the literature filed by Opposite Party No. 6 that some consider TEN to be an extreme form of erythema multiforme major (Stevens-Johnson Syndrome (SJS)], but others contend that TEN is an

entirely separate disease with some similarities to SJS. There is a lot of difference of opinion among the Doctors worldwide. Hence, a Doctor cannot be held guilty for wrong diagnosis.

87. Finally, it can be held that undisputedly administration of overdose of steroids is not the cause of TEN. The only contention is that the overdose of steroids has affected the immunity of the deceased and that has resulted in the death of the patient. It is also contended that supportive I.V. Fluids were not administered and that has further reduced immunity. It is to be stated that, on occasions, such high dose of steroids is administered for saving the life. It is also to be stated that for the cause of death post-mortem report is not produced on record, as the same was not carried out at the behest of the Complainant.

88. The Bombay Hospital record on 28th May, 1998 reveals that the steroids in blood were in normal ranges and the skin was healing. Dr. Udwadia has admitted that the treatment of TEN is solely supportive. There is no proven specific treatment and at least 1998 there was no controlled, randomized series that could prove whether any specific treatment was clearly effective. Dr. Udwadia has admitted in his cross-examination that the corticosteroid can be used in allergic condition as well as in inflammatory condition, and is used to control the effects of infection.

89. Further, as per the facts stated above, Mrs. Anuradha was suffering from fever from 1st April onwards. She developed low grade fever on 3rd Ap[ril, high grade fever on 17th April, and on 25th April her fever increased with skin rash and enlarged neck glands. No treatment required is produced.

90. In such a case, with regard to diagnosis of disease, it varies from Doctor to Doctor and for want of exact diagnosis, the doctors cannot be held liable.

91. In this view of the matter, it would be difficult to arrive at a conclusion that there was apparent deficiency in discharge of duty on the part of Dr. Mukherjee (O.P. No. 1).

Qua Dr. Kaushik Nandy, Opposite Party No. 6:

92. At this stage we would refer to exhaustive relevant written submissions given by Dr. Nandi, Opposite Party No. 6, as under:

93. It is pointed out that O.P. No. 6, namely, Dr. Kaushik Nandy was contacted on 13.5.1998 to conduct dressing, as per the medical norms, because of the skin rasher, major portion of the of the skin of the deceased had peeled off. He said that dressing could not be done on 14th and 15th May, 1998 as consent of the same was not given by the complainant.

94. Allegation against the O.P. No. 6 was that he had not given tropical and biological dressing. He gave local skin care by occlusive dressing on the line of burn patient and within the guideline set forth by senior Dermatologist Dr. Halder (O.P. No. 2). He had carried out dressing only on 13th and 17th May.

95. Dr. Nandi has also produced on record the medical literature : "Fitzpatrick's Dermatology in General Medicine, 5th Edn., Vol.-I, 1999, New York", with regard to TEN. For the treatment of TEN it has been mentioned as under:

Treatment:

Obviously, identification of the provocative agent must be attempted. Suspected drugs must be withdrawn, and infections appropriately treated if treatment is available. Care of patients with SJS - TEN is difficult and complex and requires considerable experience and flexibility to adjust for individual problems. Controlled prospective treatment studies are absent, as are generally accepted guidelines.

Whereas very mild cases of SJS-TEN may be treated as an out-patient basis, admission to dermatology units in hospitals is mandatory for the majority of cases, if available (which is the case in most European countries); intensive care in burn units, as recommended particularly by plastic surgeons, may be advisable in special situations but not generally so. Although it has often been claimed, it cannot be concluded from the literature that mortality rates are higher in dermatologic wards than in intensive care units.

The rationale for treating patients with TEN in burn units would be to apply the therapeutic principles of burn injuries - i.e., rigorous adjustment of fluid, protein, and electrolyte balance; fending off infection; and early surgical debridement of skin lesions. This rational is at best questionable, however, because second degree burns and TEN are pathophysiologically different despite their clinical similarity; in burns, prominent vascular damage is responsible for drastic fluid electrolyte, and protein imbalances; in TEN, however, vascular damage is much milder, resulting in our experience and that of others, in much less edema and less drastic laboratory anomalies than burns of equal extent. Moreover, necrolysis does not extent to the dermis; as a rule, spontaneous reepithelialization is rapid and surgical intervention is thus not necessary to expedite healing. Finally, burns result from a single thermal trauma, whereas TEN represents an immunologic attack that may progress for more than a week (not just 3 to 4 days, as often claimed), depending on detoxification and excretion of the offending agent. It should be the treatment strategy in this early phase to halt disease progression and thus limit the extent of skin and mucosal necrolysis and reduce the severity of sequelae. It is clinical experience of numerous authors including one of us (P.O.F.) that glucocorticoids may in fact curb disease progression albeit often only in relatively high dose (e.g., 100 mg of methylprednisolone per day). Obviously, glucocorticoids, may promote the risk of infection (pneumonia, septicemia); they should thus be tapered immediately, after disease progression is halted and prophylactic antibiotics should be given.

96. With regard to dressing it has been mentioned as under:

Topical treatment may be carried out with hydrocolloid or, more conservatively, with gauze dressing. Obviously, sulfonamide containing topical agents should be avoided. Patients should be placed on aluminium sheets. Cadaver allograft skin and porcine allografts have been advocated, but their use is of questionable benefit. Alternative systemic treatment methods for the acute phase of SJS-TEN are skill experimental and include hemodialysis, plasmapheresis, cyclophosphamide, and cyclosporine.

97. He has pointed out that the dressing conducted by him was by providing local skin care by occlusive dressing on the line of burn patient and within the guidelines set forth by senior Dermatologist, Dr. B.N.Halder and the same was in accordance with the medical standards.

98. He has also produced on record the Clinical Review on Toxic Epidermal Necrolysis: A Review BY Robert Avakin, Franklin P. Flowers, Oscar E. Araujo and Francisco A. Ramos Caro, wherein it has been stated:

Toxic epidermal necrolysis (TEN) is a severe, id..ncratic, excoliative disease of skin and mucous membranes. It is primarily manifested by a dramatic sloughing of the epidermis that can affect 20% to 100% of the total body surface area (TBSA). Although Ruskin described this condition in 1948, it was Lyeb in 1956 who reported four cases and proposed the name "toxic epidermal necrolysis". Subsequently, TEN has also been referred to as ... syndrome. Some consider TEN to be an extreme form of erythema multiforme major (Stevens-Johnson syndrome [SJS]), but others contend that TEN is an entirely separate disease with some similarities to SJS.

TEN is often fatal. In a few small series mortality free outcomes have been reported. In larger series, however, mortality ranged from 25% to 70%. Of 19 TEN patients treated in a burn center, two died.

99. In that Article, under the Heading "Miscellaneous complications", it has been further stated:

TEN patients have lower fluid and metabolic requirements than burn patients. If appropriate measures are not initiated, however, significant fluid and electrolyte losses may ensue. On the other hand, pulmonary edema may result from overaggressive fluid replacement

100. In view of the above literature/discussion, there is nothing against Dr. Kaushik Nandy, O.P. No. 6, for the so-called negligence of deficiency in rendering service. Hence, complaint against him is baseless.

101. For appreciating further, it would be worthwhile to quote the questions posed by the Complainant and its reply as stated in the written submissions of Dr. Balram Prosad, Opposite Party No. 5, which demolishes the contentions raised by the Complainant:

With regard to High Dosage of Steroid:

a) It is the case of Dr. Kunal Saha that Prednisolone prescribed for the patient on 12.5.98 having knowledge of the fact that the patient had already received enormous amount of Depomedrol, a long acting steroid was excessive.

b) It is also his case that daily use of 120 mg. of Prednisolone as prescribed by Dr. Halder was excessive and wrong.

c) The argument proceeds on a wrong premise that 120 mg of Prednisolone cannot be prescribed to a human being and is lethal dose. According to Godman and Gilman upto 120 mg of Prednisolone can be given as a life saving dose in Pemphigns Vulgaris (skin disease). According to wysolone product literature for Multiple Sclerosis (neurological disorder) upto 20 mg per day Wysolone can be prescribed. These examples will show that in a given case and situation, a Doctor can prescribe even upto 200 mg per day Wysolone/ Prednisolone. Therefore, prescription of 120 mg Prednisolone cannot be stated to be lethal.

(d) Dr. Prosads' prescription was 40 mg of Wysolone (steroid) per day. This was increased to 50 mg per day by Dr. Mukherjee on 11.5.1998 and then to 120 mg. per day by Dr. Halder on 12.05.1998.

(e) (f) ...

(g) On the treatment of TEN, the opinion of Dr. J.S.Pasricha on which reliance has been placed by the complainant (Pg.709 of the Evidence Complainant, Vol.II, may be relied upon). He opines as follows:-

There is Worldwide controversy whether Cortico steroids should be used for TEN or not. In my opinion, Cortico steroids used appropriately are the best way of saving patient. The chief parameter of my approach include:

1) Controlling the reaction within 24 hours by using a large dose of Cortico steroids.

2) The second important component of my approach consists of withdrawing of Cortico Steroids quickly (within 7-10 days) after the reaction has been controlled

h) It is submitted that Godman and Gilman in its 1996 Edition at page 1480 deals with Skin disease as follows:-

Glucocorticoids are administered systemically for severe episodes of acute dermatological disorders and for exacerbations of chronic disorders. The dose in these settings is usually 40 mg/day of prednisolone. Systemic steroid administration can be life saving in pemphigus, which may require daily doses upto 120 mg of prednisolone

102. Thereafter, Opposite Party No. 5 has appropriately replied to the contentions with regard to excess dose of steroids, etc., raised by the Complainant, which is as under:

a) That on 11.5.98 considering the fact that the patient was on Depomedrol and steroid (Wysolone) for the past four days, Dr. Prosad had reduced the dosage of steroid to 40 mg. per day and Depo-Medrol for one day.

b) This dose prescribed by Dr. Prosad was amended or modified by Dr. Sukumar Mukherjee and continued by Dr. A.K. Ghosal at 50 mg per day. Thereafter, Dr. Halder, who is also a very senior and experienced Doctor changed the medication and maintained 120 mg of steroids (Prednisolone) daily.

c) Dr. Prosad however reviewed the patient on 15.5.98 when he felt that Prognosis was poor and accordingly he wrote the same in the Treatment Sheet and he further advised that the treatment should continue as advised by Dr. S.K.Mukherjee and Dr. Roy Chowdhury, suggesting thereby reduction in dosage of steroid from 120 mg. to 50 mg. at least.

d) This judgment of Dr. Prosad has been commended by Prof. Dr. Fritisch on whose opinion the complainant has relied on and which has been disclosed with his evidence (pg.655 at 656 of Evidence of Dr. Kunal Saha,Vol II). In his advice Dr. Fritsch mentions as follows:-

No mention is made of a more vigorous anti biotic treatment, even not on May 15 when Dr. Prosad states - Prognosis poor. This judgment does not seem to have prompted the attending physicians to a more active stance.

e) This opinion takes into consideration the participation by Dr. Prosad as a junior consulting physician.

f) The contention of the complainant as stated in his additional written argument (at pg.5) in this respect is as follows:

(5) Both OP No. 2 and 3 came next date (12.5.98) and took over the change of Anu's treatment. The Opposite Party No. 2 corroborated TEN diagnosis made by Dr. Ghosal. Although O.P. No. 2 in consultation with O.P. No. 3 stopped the lethal therapy with "Depomedrol" that Anu was receiving, they put her on a quick acting steroid "Prednisolone" at an excessive dose (40 mg thrice daily) without any instruction for "Tapering" which is a must for the controversial steroid therapy in TEN patients. It is thus the Complainant's own case that Depomedrol was stopped on 12.5.98 after Dr. Halder and Dr. Abani Roy Chowdhury had seen the patient and they put her on a quick acting steroids at an excessive dose, which submission is not correct on the face of it.

g) In this context it is pertinent to mention that even in Breach Candy Hospital high dosage of steroid was continued after 17.5.1998 as would appear from the notice sent by the Counsel for Dr. Kunal Saha and dated 3rd September, 1998 where against the Doctors of Breach Candy Hospital (Pg. 722 at pg.729 of the evidence of Dr. Kunal Saha, Vol.II at para 16). It was inter alia mentioned as follows:-

That further you negligently failed to provide nutritional supplements and further you never recommended the use of drugs like, Erythropeition and G.S.F. which is necessary to stipulate the blood cells. That further you negligently and wilfully gave high dosage of steroid knowing fully well that it would be harmful to the said patient.

(h) It is submitted that administration of dosage of steroid @ 120 mg per day being an accepted method of treatment, was even continued at the Breach Candy Hospital in Mumbai; between the period 17th May, 1998 and 28th May, 1998 (i.e. 11 days), after the said patient was released from AMRI on 17.5.98 in the morning. Therefore no negligence or rashness can be attributed for prescribing the said medicine.

(i) Dr. Kunal Saha in his cross examination (answer to Q.327) by the counsel of O.P. No. 1 has not disputed the fact that the patient did receive high dose of steroids in the Breach Candy Hospital, dosage thereof was higher than what she received in Calcutta. Therefore the dosage of steroid at 120 mg per day by Dr. Halder is not and cannot be termed as a lethal dosage of steroid. It is a dosage which is medically acceptable and that is why the so-called Medical Expert Dr. Pasricha has opined in favour of high dosage of steroids. His opinion is being relied upon by the complainant.

From the aforesaid response given by the Opposite Party No. 5 and the Review and Report of the Successful Use of Biobrane for Early Wound Coverage it can be stated that: (i) TEN an extoilative dermatoligical disorder of unknown disease; (ii) the incidence of TEN has been reported at 1 to 1:3 per million per year, the female ratio is 3:2; TEN accounts for nearly 1% of drug reaction and that require hospitalisation; almost all the types of drugs have been implicated in the development of this disorder; unfortunately, there is no reliable test to implicate a specific drug definitely; specific anti-bodies have not been found in TEN, in contrast to Stevens-Johnson Syndrome (SJS) or erythema multiforme (EM); therapy of an exaggerated immune response and circulating toxin-immune complexes are the rationale for the use of hyperbaric oxygen; mortality rates of 25 to 70% have been reported. Further, Dr. Udwadia has specifically found that Mrs. Anu Radha when examined by him was already infected. If infection was there, then it cannot be said that use of steroids were unjustified.

103. Hence, in our view, for the foregoing discussion, there is no deficiency on the part of Opposite Party Doctors, 1, 2, 3, 5 and 6 in rendering service.

104. In addition, we would deal with the complaint against Dr. Balaram Prosad (O.P. No. 5). His contentions are that: (i) he did not take part in the treatment; (ii) never said that AMRI was not an ideal place for treatment of patient suffering from TEN and (iii) that he was in full praise of AMRI. (These allegations are made in pragraph 44 of the complainant). In our view, these contentions on the face of them are without any substance. Because, Dr. Balram Prosad, (O.P. No. 5) had to treat the patient as per the advice of the consulting Doctors. Further, it cannot be said that as he was having some praise for AMRI hospital, there is any deficiency in service by him. In any case, when Mrs. Anuradha was admitted, nobody had diagnosed that she was suffering from TEN. Diagnosis of TEN came only at about 4.30 PM on 11.5.1998 when Dr. Ghoshal, Dermatologist, diagnosed her disease as TEN.

Dr. Abani Roy Chowdhury, Opposite Party No. 3:

105. Dr. Abani Roy Chowdhury's defence is that he never participated in the treatment of Mrs. Anuradha at AMRI. He has relied upon the order of acquittal passed by High Court of Calcutta and submitted that both the High Court as well as the Magistrate have not found him guilty in any manner as it was found that he never took part in the treatment of Mrs. Anuradha. However, learned Counsel for the Complainant relied upon the endorsement in the bed history sheet wherein Dr. Mukherjee has suggested consulting of Dr. Baidyanath Halder and Dr. Abani Roy Chowdhury. The main allegation against them is that they have neglected to provide supportive therapy and that they have not taken wound care. He has pointed out that the entire allegation rests on joint diagnosis, joint treatment, joint mismanagement to be deduced from the prescription of Dr. B.N.Halder dated 12th May, 1998 and that has eminently been disproved. That being so, there is no foundation for making any allegation whatsoever against Dr. Roy Choudhury. In our view, there is no definite evidence on record that Dr. Roy Choudhury took part in treatment of Mrs. Anuradha

106. Therefore, it can be said that the allegations of deficiency in service against Opposite Parties Nos. 1, 2, 3, 5 and 6 are without any substance.

Non-Administration of I/v fluids:

107. For non-administration of i/v fluids it has been constantly pointed out that the intake of the patient was sufficient.

108. Dr. Mukherjee has stated in his prescription : Daily fluid intake : 2 litres a day". Because, at that time, the deceased was in a position to take fluids as well as meals.

109. Similarly, Dr. A.K.Ghoshal has also stated that : Maintain fluid and electrolyte balance.

110. It has been pointed out that the patient was eating normally and was not dehydrated. No Doctor visiting on the patient between 11th and 15th May suggested for administration of IV fluids. IV fluid is administrated in a patient whose intake of water and food is affected. It is also pointed out that i/v cannulation increases the risk of infection, therefore, unless i/v fluid is necessary for the body, it is not given.

111. In his deposition Dr. Balram Prasad, OP No. 5, stated that on examination of the patient he found her vital organs like brain, heart, lungs, abdomen were functioning normally including kidney; haemodynamically she was stable, fully concscious and was able to communicate freely; she could also take her food and liquids by mouth; her tongue was moist and there was no feature of dehydration. Opposite Party No. 5, Dr. Balaram Prasad had requested the ICCU R.M.O. of AMRI to start intravenous fluid on 16th May. Thereafter, his prescription is as under:

16/5 - May I request ICCU R.M.O. for I.V.Cannulation if required. I/V fluid: 5% Dextrose charged C.M.V.I. (Multi Vitamin Injection).

6hrly

Isolyte M "(Intravenous fluid with essential electrolytes)

(i) In the cross examination of O.P. No. 5 by the counsel for the complainant no questions were asked about I.V. fluid and even no suggestion was given that O.P. No. 5 was negligent in not prescribing I.V. fluid until 16.05.1998.

(ii) In fact the O.P. No. 5 is the only Doctor who prescribed I.V. fluid as soon as he felt that it was necessary.

(iii) In this respect it is pertinent to mention that the stand of the Hospital taken in the Written submission is as follows:-

The complainant being a qualified medical practitioner himself, further sought to interfere with the treatment regimen of the deceased patient. It was at the insistence of the complainant that the deceased patient could not be put on I.V. fluid, as the complainant feared that it would lead to infection.

Even in Breach Candy Hospital it is not stated that the deceased was de-hydrated when she was brought in the hospital.

112. It is to be stated that on 12th May, Opposite Party No. 2, had advised intake of egg-white, high calorie biscuits, proteinix/complan as Mrs. Anuradha was able to take food orally. It is therefore, pointed out that the contention of the Complainant that as i/v fluids were not given, she suffered, is baseless. In any case, it is pointed out that the Complainant did not allow the hospital staff in giving i/v fluids due to unsubstantiated fear of infection. Even at the admission stage at Breach Candy Hospital Mrs. Anuradha was able to swallow liquids.

113. In this set of circumstances, if intake of fluids and meals were sufficient, it cannot be held that the Doctors committed gross error or negligence in not giving i/v fluids between 11th to 15th May.

114. Even Dr. Udwadia has stated that the basic management was the same for treating Mrs. Anuradha was the same.

115. In Clinical Review on TEN: A Review by Robert Avakin, Franklin P. Flowers, Oscar E. Araujo and Francisco A. Ramos Caro, it is stated that "TEN patients have lower fluid and metabolic requirements than burn patients".

116. It is to be stated that even at the Breach Candy Hospital the Complainant has not permitted giving of 4 Pints (DNS, alternating with Normal saline) till 8 AM. In the bed-sheet it is stated that the same was not not transfused at the collective request of the patient and her husband. Dr. Saha agreed to continue i.v. Cifran as the antibiotic."

117. In this view of the matter, the submission of not giving of the i/v fluids has affected Mrs. Anuradha is without any substance.

Monitoring of vital organs:

118. It is to be stated that Mrs. Anuradha was examined by a number of Doctors on each day from 11th to 16th, May. It would be difficult to believe that they would not monitor the vitals. On the contrary, Opposite Party No. 5, Dr. Balaram Prasad stated that the vital organs like brain, heart, lungs, abdomen were functioning normally including kidney; haemodynamically she was stable, fully conscious and was able to communicate freely; she could also take her food and liquids by mouth; her tongue was moist and there was no feature of dehydration.

119. No doubt, Respondent No. 4 failed to produce all these reports on the ground that there was no such prayer in the complaint. But, in our view, that is no ground for not assisting the Court by producing the relevant medical record.

120. However, non-production of this record would not establish that there was deficiency in service by the Doctors in treating Mrs. Anuradha. Their prescriptions establish that everyday Doctors were taking care of her and monitoring her vitals.

Skin Biopsy:

121. The Complainant has also not allowed the skin biopsy of the deceased for the reasons best known to him. If biopsy was carried out, as suggested by Dr. Balaram Prosad exact cause of disease might have been diagnosed earlier.

Dr. Mukherjee on 11th May, 1998 after examining Mrs. Anuradha had advised various tests: "Repeat: HC, TC/DC ESR CRP SGPT, Urea Creatinine, Total Protein, Uric Acid Platelets, ANA factor, DS-DNA, Complement". He has also advised to puncture blister and sent fluid to School of Tropical Medicine, Virology Department. Complainant has not produced all these reports. Dr. Balaram Prosad had directed for skin biopsy for histopathology by Dr. N.Iqbal. On 13th Dr. Poornima Chatterjee directed : "Once vaginal swab taken from vagina just above introitus sent for bacteria smear and culture". This also reveals Doctors were all throughout directing for carrying out various tests and the results of those tests are not produced on record. It is also pointed out by the Opposite Parties that the Complainant was all throughout interfering in the treatment and he had not permitted skin biopsy as suggested by Dr. Balaram Prosad.

ICU/Burn Unit:

122. Complainant is a Doctor. Knowing fully well that there is no burn ward in the AMRI he got Mrs. Anuradha amitted in that hospital. There is no burn ward even in the Breach Candy Hospital. Therefore, his

say that there was negligence on the part of the Hospital or its doctors in admitting Mrs. Anuradha in the AMRI Hospital, and, therefore, her treatment was affected is totally baseless. The Complainant chose the Hospital for treating his wife. Since the case was diagnosed as TEN for ensuring better Aseptic care, the patient was shifted on 11.5.1998 to Cabin No. 430, the VIP Cabin in a corner of AMRI. This room no. 430 was kept fully isolated, temperature was controlled, access to this room was restricted, and sterilisation in several form were maintained. Even the consultant/medical staff or the nursing staff who were attending the patient were required to put on protective clothings (sterilised gloves, aprons etc.). No other patient was kept in the same room to prevent all chances of cross-infection.

123. The nursing staff was also directed to take extra precaution, which they did to prevent any further outside infection to maintain the aseptic condition. Entry of outsider was also restricted.

124. Further, there is a specific direction by the Nursing Superintendent on 11.5.1998 for maintaining sterile isolated room. The directions are as under:

1. Restrict the nursing staff entering the room to the minimum;

2. Permit no visitors without authorization;

3. Provide adequate sterile cap, musk gown, jacouret, linen and slipper for change before entering the room;

4. Maintain all types of hygienic and sterile procedures as advised by attending physicians. Even in cross-examination the Complainant has admitted that there was environmental temperature control available in the exclusive and isolated and special room which was designated for his wife and full nursing care was also available as was directed by the physicians and the Doctors attending on her.

125. Finally, we would say that the Complainant has first issued notice against 27 persons including the Doctors who had treated at Bombay Hospital. Thereafter, we do not know for what reasons he has withdrawn the complaint against the Doctors who had treated at the Breach Candy Hospital. In criminal cases also, at present, they are acquitted.

126. In the result, we reiterate that Doctors or Surgeons do not undertake that they will positively cure a patient. There may be occasions beyond the control of the medical practitioner to cure the patients. From the record, it would be difficult to arrive at the conclusion that the injection Depo-Medrol prescribed by Dr. Mukherjee was of such excessive dose that it would amount to deficiency in service by him which was his clinical assessment. Thereafter, with regard to the alleged deficiency in the treatment given to Mrs. Anuradha by Opposite Party Doctors 2, 3, 5 and 6, there is no substance. The contention against the hospital that it was not having Burns-Ward, and, therefore, the deceased suffered is also without substance. Hence, this complaint is dismissed. There shall be no order as to costs.