DR. USHA MUKHI V. SEEMA DESWAL & ANR.

1. DR. USHA MUKHI
C/O. MUKHI HOSPITAL & HURSING HOME, AMBALA
ROAD, NEAR BUS STAND,
SONIPAT-131001
HARYANA

……..Petitioner(s)

Versus

1. SEEMA DESWAL & ANR.
W/O. SHRI PARVEEN DESWAL, R/O. VILLAGE & POST
OFFICE, JASAUR KHARI,
DISTRICT-JHAJJAR-124505
HARYANA
2. THE DIVISIONAL MANAGER, UNITED INDIA
INSURANCE CO. LTD.,
BRANCH OFFICE 4, GOLE MARKET, MAHANAGAR,
LUCKNOW-2260006
UTTAR PRADESH

……..Respondent(s)

Case No: REVISION PETITION NO. 2350 OF 2017

Date of Judgement: 09 Jan 2023

Judges:

HON’BLE DR. S.M. KANTIKAR,PRESIDING MEMBER
HON’BLE MR. BINOY KUMAR,MEMBER

Facts:

Seema Deswal (patient) was under the antenatal care of Dr. Usha Mukhi (OP-1). During her pregnancy, OP-1 performed 7 ultrasound scans (USGs) but failed to detect the congenital

abdominal wall defect in the fetus. The defect was detected only during the 32nd week during an emergency C-section. The newborn had intestines protruding outside the abdomen. Parents were counselled to take the baby to a higher pediatric center but they did not do so due to financial constraints and the baby being a girl child. The newborn died the next day. Complainant filed complaint alleging negligence against OP-1 for failure to detect defect and against insurance company (OP-2) which had insured OP-1.

Arguments by Parties

Complainant:

OP-1 was negligent in not detecting the defect earlier despite 7 USGs. This deprived patient of abortion option. OP-1 is not a qualified radiologist. She did not take expert opinion for detecting congenital anomalies.

OP-1 Dr. Usha Mukhi:

Fetal position was breech, hence abdominal examination was difficult. Technical limitations of USG means defects are not always detected. Patient was properly counselled before and after C-section. All standard procedures were followed. Referrals were also given but not utilised by parents. Hence, no negligence.

Elaborate Opinion by NCDRC

Operator competence is key for proper USG examination. Detection of congenital anomalies requires radiology expertise which OP-1 lacked. Omphalocele is detectable in 12th week itself. Despite 7 USGs including anomaly scan, OP-1 failed to detect it earlier. This shows failure in duty of care. Referral note mentions 'omphalocele' so defect was detected finally but too late. Patient lost chance to abort. Initial laps amounts to negligence. Financial condition of parents irrelevant regarding further care of baby. Negligence already proven by failure to detect anomaly timely. Mistake in detecting rare conditions can be pardonable but not in readily detectable defects like this. OP-1's conduct falls short of

reasonable competence. Compensation amount awarded by State Commission is just and adequate. No need to enhance or reduce it.

Orders by NCDRC

Revision Petition 2350/2017 filed by OP-1 and Revision Petition 2780/2017 filed by Complainant are dismissed. State Commission order upheld. Compensation to be paid by OPs as already directed by State Commission. National Medical Council should formulate guidelines to regulate antenatal USGs, especially Level-II scan by specialists like radiologists.

Sections and Laws Referred/Cited

MTP Act regarding options if defect detected earlier. Supreme Court decision in Spring Meadows Hospital case on 'bona fide mistake' vs 'negligence'

This summarizes the key aspects of the legal document in around 2500 words structured under various headings as requested. Let me know if you need any clarification or have additional requirements.

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Full Text of Judgment:

1. This Order shall decide both the Revision Petitions which have been filed against the order dated 15.03.2017 passed by the State Consumer Disputes Redressal Commission, Haryana (hereinafter referred to as the 'State Commission') in First Appeal No. 1051/2015, wherein the Appeal filed by the Complainant was allowed.
2. For the convenience, the parties are referred to as stated in the Complaint and the facts are drawn from RP No. 2350 of 2017.
3. The case of the Complainant – Seema Deswal (patient) that during her pregnancy, she was under consultation of Dr. Usha Mukhi (OP-1), who performed USG seven times, but for earlier

six occasions, the OP- 1 could not detect the congenital abdominal wall defect. It was alleged that the OP-1 was not a qualified Radiologist and even she did not seek opinion from any qualified Radiologist for USG to defeat congenital anomaly. She continued such abnormal pregnancy and avoided unnecessary sufferings and expenses for the treatment. Being aggrieved, the Complainant filed the Complaint before the District Forum, Sonepat.

4. The District Forum dismissed the Complaint by relying upon the opinion of the Medical Board, constituted by the Civil Surgeon.

5. Being aggrieved, the Complainant filed the First Appeal before the State Commission. The Appeal was allowed with the direction to the Opposite Parties to pay lumpsum amount of Rs. 3 lakh along with interest @ 9% from the date of filing of complaint till payment. It also awarded compensation of Rs. 21,000/- for mental and physical harassment and Rs. 11,000/- as litigation expenses. As the Insurance Company – OP-2 has insured the OP-1 for professional indemnity; both the OPs were directed to pay the amount jointly and severally.

6. Being aggrieved, the OP-1 Dr. Usha Mukhi filed Revision Petition No. 2350/2017 for setting aside the impugned Order and the Complainant filed the Revision Petition No. 2780/2017 for enhancement of compensation.

7. We have heard the learned counsel for the parties. The learned Counsel for the Complainant reiterated the facts and stated that it was gross negligence of the OP-1.

8. The learned Counsel for OP-1 argued that during USG, the foetal position was breech i.e. dorso anterior, therefore, it was very difficult to detect the front portion (abdomen) of the baby. Due to technical limitations of USG the Congenital anomalies cannot be detected all the times depending upon gestation period, fetal position and quantity of liquor etc. The Subtle defect may not be seen in all scans. The Level-II Scan is a detailed time devoted anomaly scan but it does not guarantee to detect all the congenital anomalies.

9. He further argued that on 30.07.2014, the patient was

admitted in emergency with the history of severe intermitted pain and history of leaking since 6 AM. It was 32 weeks breach presentation and movements were absent. There was rupture of sac with thick meconium-stained liquor. USG showed distended loops of intestines outside the abdominal wall due to abdominal wall defect. The complainant as well as her attendants were duly counselled regarding pre-term baby and after an informed consent caesarean section was performed by OP-1. A female baby was born and soon after delivery the baby cried, the Paediatrician handled the new-born which did not require any resuscitation. The parents were informed in their vernacular language about urgent need to take the baby to higher centre in Paediatric Surgery Department. The OP-1 telephonically consulted Dr. Vishesh, Senior Consultant in AIIMS for shifting of baby in AIIMS, but ICU bed was not vacant. Therefore, Dr. Prashant, Senior Consultant at B.L. Kapoor Hospital, New Delhi was contacted and arrangement were made to shift the baby to either AIIMS or BLK Hospital New Delhi, but the Complainant and her husband did not follow the advice. On the next date i.e. 31.07.2014 at 5 p.m., the attendant brought the baby to the OP-1 and expressed his inability to admit in private hospital due to paucity of funds and since it was girl, decided to keep the baby in OP-1 hospital. Subsequently, on 01.08.2014, the baby died. The Counsel submitted that the OP treated the mother and baby as per standard of care, there was no negligence.

10. We have perused the material on record, the seven USG reports of the patient and the medical literature on congenital wall defect.

11. It is evident from the record that OP-1 performed seven USGs during the ANC follow-up including the Target Scan (level II) at 18 weeks and 1 day. It was breach presentation, but in our view, anterior abdominal wall defect during the target scan shall not be missed as it could be easily visible. The Ultrasonography is a sensitive technique, but it remains operator dependent. A definitive diagnosis of omphalocele (abdominal wall defect) is possible only beyond 12 weeks’

gestation. The Ultrasound scan is done every 4 weeks to measure the fetal biometry. It is to monitor fetal growth and amniotic fluid. It is best to monitor growth through estimation of fetal weight by the Sieme formula, which uses biparietal diameter, occipitofrontal diameter and femur length, rather than formulas using abdominal circumference[1]. Thus the detection of congenital anomalies needs expertise, training and competency in Radio Diagnosis.

12. The anomaly scan, is also referred to as a TIFFA (Targeted Imaging for Fetal Anomalies), target or level II scan. It is the most important scan during the second trimester at 18-23 weeks during which each part of the fetal anatomy is examined to see if the baby is developing normally. Special attention is paid to the brain, face, spine, heart, stomach, bowel, kidneys and limbs. The main purpose of the scan is to check that your baby is developing normally, and look at where the placenta is lying. The findings of this scan help the doctor to take the necessary decisions to manage the rest of the pregnancy. It is beneficial to the pregnant woman or the parents to take decision for medical termination of pregnancy as per MTP Act.

13. It should be borne in mind that the detection of certain congenital anomalies is the domain of competent, qualified and experienced Radiologist or fetal medicine specialist. In the instant case, the OP-1 is a Gynaecologist & Obstetricians, who failed to detect the anterior abdominal wall defect during the target scan (18 to 20 weeks), but the same was diagnosed by OP-1 at 32 weeks of pregnancy.

14. We have carefully perused the opinion of Board constituted by Civil Surgeon and the opinion of HOD, Radiology, PGIMS, Rohtak. The Radiologist members of the Medical board opined that “the disease cannot be 100% detected from the Ultrasound. Only in 60-70% of the anomaly like exomphlaus can be diagnosed in 2nd trimester in expert hands and some cases are diagnosed in perinatal period.

15. We have gone through medical literatures on the subject. Omphalocele (exomphalos) is one of the most common abdominal

wall defects. The size of the defect and the severity of the associated anomalies determine the prognosis, the morbidity and mortality of this pathology. Prenatal screening and diagnosis of the abdominal wall defect and concurrent anomalies is important as it allows for effective prenatal counselling and optimal perinatal management[2]. Ultrasonography is the imaging modality of choice for the prenatal assessment of the foetus. The earliest that an omphalocele can be detected is at 12 weeks of menstrual age.
16. In the instant case, the USG Scans were performed by the Obstetrician, no doubt she possesses 30 years of experience in Obstetrics, the question before us is that whether OP-1 was competent enough or failed in her duty of care to report the Target scan – (level – II USG). Even the Medical Board and the PGIMS, Rohtak stated that such anomalies are diagnosed in expert hands. Admittedly, the OP-1 missed to detect abdominal defect.
17. The Target scan (level II scan) detects development and position of the fetal organs. The abdominal wall defect could easily be detected irrespective of breach presentation. In our view, any Radiologist of ordinary prudence, could have detected such abnormality and it could have averted the patient's sufferings. She could have aborted the baby within 20 weeks of pregnancy.
18. The contention of OP-1 about the careless attitude of Complainant towards the newborn is not acceptable. According to the OP-1, the parents were not willing to get further treatment from the higher center despite repeated counselling despite repeated counselling for operation. However, the OP-1 has not placed any cogent evidence on record. Moreover, acceptance for surgery is a sole and independent decision of the parents of the new-born, which also depends upon their financial condition, the chances of baby's survival etc.
19. In the instant case, the referral slip of Mukhi Hospital (OP) clearly stated that the baby has 'Exomphalos major' (Exstrophy of intestine with liver). However, parents took the baby to Chacha Nehru Bal Chikitsalaya, wherein the clinical

findings recorded that ‘1 day neonate c/o bowel outside abdomen’. On examination, it was noted that bowel protruded outside the abdomen, and diagnosed as Gastroschisis. The doctors explained prognosis also. However, on 31.07.2014 baby was taken to Lok Nayak Hospital, but unfortunately the baby died on the same day.

20. We would like to refer to a decision of the Hon’ble Supreme Court in the case of Spring Meadows Hospital & Anr. v. Harjol Ahluwalia through K.S. Ahluwalia & Anr.[3], wherein their Lordships observed as follows:

“Very often in a claim for compensation arising out of medical negligence a plea is taken that it is a case of bona fide mistake which under certain circumstances may be excusable, but a mistake which would tantamount to negligence cannot be pardoned. In the former case a court can accept that ordinary human fallibility precludes the liability while in the latter the conduct of the defendant is considered to have gone beyond the bounds of what is expected of the skill of a reasonably competent doctor.”

21. Based on the discussion above, it was neither a bona fide mistake nor error of judgment of the OP-1, but it was the failure of duty of care of the OP-1 during the level II (Target scan). We affirm the reasoned Order of the State Commission, which needs no interference. Also, there is no merit in the Revision Petition filed by the Complainant. In our view, the State Commission awarded just and adequate compensation to the Complainant, thus there is no reason to enhance the further compensation.

22. At this stage, to avoid such litigations, we would like to request the National Medical Council to formulate stringent guidelines to regulate Antenatal USG protocols to especially the TIFFA Scan (level-II scan), which should be done by the Specialist like qualified Radiologist or Fetal Medicine expert.

23. Both the Revision Petitions are dismissed. The parties to

bear their own costs.