Bombay Hospital And Medical Research ... vs Asha Jaiswal . on 30 November, 2021

Author: Hemant Gupta

Bench: V. Ramasubramanian, Hemant Gupta

REPORTABL

IN THE SUPREME COURT OF INDIA

CIVIL APPELLATE JURISDICTION

CIVIL APPEAL NO. 1658 OF 2010

BOMBAY HOSPITAL & MEDICAL RESEARCH CENTRE .....APPELLA

VERSUS

ASHA JAISWAL & ORS. .....RESPONDENT

WITH

CIVIL APPEAL NO. 2322 OF 2010

JUDGMENT

HEMANT GUPTA, J.

1. The present appeals are directed against an order passed by the National Consumer Disputes Redressal Commission 1 on 06.01.2010 against the appellants i.e., Bombay Hospital & Medical Research Centre2 and Dr. C. Anand Somaya3, directing to pay a sum of Rs. 14,18,491/- along with interest @ 9% p.a. from the date of filing of the complaint till the date of payment.

1 For short, the 'Commission' 2 For short, the 'Hospital' 3 For short, the 'Doctor'

2. The complaint was filed before the Commission by the legal heirs 4 of the deceased - patient Dinesh Jaiswal5, alleging medical negligence on the part of the Hospital and the Doctor in treating the patient. The patient was admitted to the Hospital on 22.04.1998 and breathed his last on 12.06.1998. The Hospital charged a sum of Rs. 4,08,800/- for the treatment of the patient during

the period of his admission in the Hospital. The said amount is included in and is part of the amount of compensation awarded against the appellants herein.

3. The patient was taking treatment since 1990 for having difficulties in walking due to the pain and discomfort in legs. For his complaint of inability to walk, a Colour Doppler Test was conducted on 13.04.1998 at Khemuka X-Ray & Ultrasound Clinic, Nagpur which detected the following:

> "Aneurismal dilatation of the lower abdominal aorta just above bifurcation is seen. The aneurism measures 5.4 x 2.6 in its maximum dimensions.
>
> Irregular thrombus is seen within the aneurism on colour flow studies.
>
> Prostate is normal in echo – pattern and measures 4 x 3 x 3cms. Prostatic capsule is intact. Urinary bladder is normal in capacity and contour. Post void residual urine is not significant.
>
> Impression: Mild hepatomegaly with aneurism of lower abdominal aorta just above the bifurcation."
>
> 4. Dr. K.G. Deshpande Memorial Center, Nagpur was consulted by the 4 For short, the 'Complainant' 5 For short, the 'patient' patient on 15.04.1998 and Dr. Deshpande diagnosed the following:
>
> "A case of Abd Aortic Aneurysum Involvement on left side with Left PVB (Embolism) H/O Trauma 1983, Pain Left LL 1990 S/O Embolism Vascular Duplex Seen S/O Large Abd. A. Aneurysum 6*3*5.1cm Adv- Urgent Surgical repair of the aneurysum"
>
> 5. After diagnosis, Dr. Deshpande referred the patient to the appellant-

Doctor who is a Vascular Surgeon. The patient consulted the appellant-Doctor on 21.4.1998. The Doctor ordered the admission of the patient as an urgent case of aorta aneurysum. On 22.4.1998, the Doctor advised urgent DSA/CAT Scan [Digital Sub-Traction Angiography and Computerized Axial Tomography] and surgery after noticing the following physical conditions:

> "A 42 years old male with aorta pain left lower limb and right leg below knee. Gradual Claudication BP – 100/80 Ischaemic changes both lower limbs. Seen with impending Gangrene Both legs left muscles are tested.
>
> ....."
>
> 6. The Doctor after examining the patient recorded that there were ischemic changes in both lower limbs and also noted an impending gangrene. Subsequent to the pre-operative preparations, surgery was conducted on 23.04.1998 by a team of surgeons including Dr. Partha and Dr. Bindra, led by the appellant-Doctor. The

operation notes read as thus:

"On inspection there was a huge aneurysum on the latral aspect on left side arising infra renal.

It was densely adherent to the surrounding structure. The aneurysum was directed out. The tape was passed around the left Renal artery/vein for retraction. A tape was passed around the aorta just below the renal artery and above the aneurysum. Both the common iliac arteries were exposed. Tapes were passed around both the iliac arteries.

After achieving proper exposure/slinging around all the vessels. The aorta was iron clamped just infra-renally. The aneurysum opened out. The aorta transected and both illiacs transected. (A PTFE 'Y' Limb Graft) was sutured in place. The short main limb to the aorta using continuous prolure and both the limbs of the graft were sutured to the common iliacs end to end anastomosis on right side. After checking the flow in the graft after suture the upper end the lower anastomosis were done.

On the left side, the side of the graft was sutured the end of the common iliac. The limb of the graft further brought down through a tunnel to the femoral artery and the end of the graft sutured to the side of the femoral artery.

After achieving proper haemostasis and checking the pulsation.

Intra-operatively, the abdomen closed using drainage tubes.

The patient was later shifted to recovery room on ventilator with stable vital signs."

7. It is the case of the complainant that on 24.4.1998 at about 4 am, that is the night after surgery, the nurse who was attending the patient observed that the pulsation of the patient had become feeble and body temperature was low and the lower limbs had gone cold. The relatives were informed at about 7 a.m. that the patient was unconscious, legs were cold with no pulsation. The complainant further alleged that the nurse had informed the Doctor at 4 am but he came only at 9.30 a.m. The patient upon assessment by the Doctor was directed to get second DSA test but DSA machine was out of order. Hence, the Doctor advised angiography but the patient was made to wait for both DSA test as well as for angiography. One Dr. B.K. Goyal examined the patient and reported that the patient had probably developed block of abdominal aorta.

8. The angiography conducted at 12.30 pm on 24.4.1998 showed a block (clot) at the graft due to which the blood supply to the lower limbs had totally stopped. The complainant contended that the earlier surgery was not performed correctly and there was negligence in conducting the same. A decision was taken to re-

explore the earlier surgery done at about 3:30 pm but since all the four operation theatres were occupied, he could only be taken to the operation theatre for re-grafting at 5.30 p.m. As there was no pulsation in the graft and there was clot in the graft extending into both limbs of the graft, a fresh graft was sutured and the patient was shifted to recovery room and put on ventilator.

9. It was contended by the Hospital that the patient was in the care of qualified doctors such as Dr. Nemish Shah, Dr. J. A. Pachore, Dr. A.L. Kripalani, Dr. Partha, Dr. H.S. Bindra and many others throughout his course of admission and no stone was left unturned to ascertain the complications and treat the same. Various specialist doctors were treating the patient and medicines/treatment was timely regulated and changed as and when required on a daily basis. Regular daily dialysis, dressing of wounds etc. were also done. However, unfortunately, despite the best efforts of the qualified doctors, the patient did not respond to the treatment and passed away on 12.06.1998.

10. The complainant in the complaint enumerated the facts suggesting negligence and deficiency of service on the part of the appellants. The averments made by the complainant and the corresponding reply by the Doctor is extracted hereinunder:

> "34. In all cases of grafting "16. Without prejudice to the above the patient is kept under close and with reference to para 34 of the observation to find out whether complaint under reply, I deny the blood is flowing normally. In case allegations made therein are false. there is stoppage or lack of flow With further reference to the said immediate action is taken to para it is substantially correct to control the situation because lack state that in all cases of grafting of blood is certain to rupture and patient is kept under closer deaden the muscles. The tissues observations to find out whether cannot survive without blood flow. blood is flowing normally. In case But in this case after the patient there is stoppage or lack of flow was taken to recovery room he was immediate action is taken to control not examined by any doctor. The the situation because lack of blood attending nurse observed at 4.30 is certain to rupture and deaden the a.m. on 24.4.98 that lower limbs muscles. I say and submit that even had become cold and did inform while treating the said deceased, the doctors. The doctors were utmost care was taken by the opp. called in writing at 8 a.m. but Dr. party in post operative period. In Somaya came at 9.30 a.m. This this connection I say and submit time gap was enough to rupture that patient was kept in Cardio the muscles. The process is Vascular Incentive Care Unit CVICU irreversible. It cannot be corrected. which is considered to be finest in Timely medical care could have India. The patient was continuously saved the life of the complainant. monitored by efficient and trained nursing staff and was also monitored for 24 hours by resident doctor. With further reference to the said para I deny that at about 4.30 a.m. on 24-4-1998 the attending nurse observed that lower limbs had become cold as alleged or at all. I deny that, doctors were summoned and that I came to the said unit, only at 9.30 a.m. as alleged or at all.
>
> I deny that, because of the so called delay on my part further complications took place in the case of the said deceased as alleged or at all. I say and submit that

immediately after I received message from the resident doctor attached to the opp. party no.1 attended the said patient at about 9.00 a.m. and not at 9.30 a.m. as sought to be suggested by the complainant.

35. That in spite of the critical 17. With reference to paras 35 and condition of the complainant on 36 of the complaint under reply, I 24.4.98, he was made to stand in deny that in spite of critical queue for DSA test for more than 3 condition of the complainant on hours. This delay further worsened 24.4.1998 he was deliberately made the condition of the complaint it to stand in queue for DSA test for appears that Bombay Hospital had more than 3 hours. I deny that the no medical ethics. said delay was deliberate and due to the said delay the condition of

36. The situation turned darker the said patient, further worsened because after waiting for 3 hours as alleged or at all. I say and submit the complainant was informed that that to the best to my knowledge the machine was dis-functional. immediately I suggested DSA test on 24.4.1998, the staff of the opp.

party no.1 took the said deceased for DSA test but unfortunately during the relevant time the equipment was not functioning properly and as soon as the defects were located the said test was conducted to enable the opp parties to give further treatment to the said deceased. I say and submit that on perusal of the case papers on record, it is crystal clear that the best possible treatment and due care was given to the said deceased under circumstances. I say and submit that during the relevant time the condition of the said deceased was critical and therefore it was not possible to shift the said patient to any other hospital in nearby vicinity for any test including DSA. It is also significant, to note here that during the relevant time DSA test machinery was available only in Jaslok Hospital, Hinduja Hospital and Breach Candy Hospital. However, it was not possible to shift the said patient for the said test considering the patient condition. In any event I dispute the allegations made by the complainant as the complainant's failed to substantiate the said allegations by producing any independent material on that behalf.

Besides this the said allegations are not based or supported on the basis of the independent expert's opinion.

37. That on the same day at 12.30 18. With reference to para 37 of the p.m. (8 hours after it was discovered complaint under reply, it is that blood supply has stopped) substantially correct to state that on angiography was performed. But the same day at about 12.30 p.m. again the report was given at 3.30 angiography was performed. p.m. a further delay of 3 hours which However, I deny that report was were crucial to the life of the made available only at 3.30 p.m. as complainant. alleged or at all. I deny that further delay of 3 hours which were crucial to the life of the deceased, contributed towards further complications as alleged or at all.

38. That on receipt of the report 19. With reference to paras 38 and the surgeon decided to reopen the 39 of the complaint under reply, it is abdomen to make correctness. substantially correct to state that Again the operation could not be the surgeon decided to reopen done immediately because the abdomen to make correctness after hospital did not have a vacant perusing the angiography report.

operation theatre. The hospital did However, I deny that operation was not have emergency operation postponed or delayed as theatre theatre. The hospital did not even was not available. I say and submit try to operate the patient in an that the said delay was not at all outside operation theatre. This deliberate. During the relevant time, caused another delay of 3 hours. the operation theatres of opp. party no.1 were occupied as other

39. The sequence of event shows patients were under treatment. that for various causes wholly 20. With further reference to the attributable to the Bombay Hospital said para the allegations made that treatment was delayed by 12 therein are not only baseless but hours while the muscles cannot the same are made with ulterior survive lack of blood supply for more motive and malafide intention. I say than two hours. and submit that to my personal knowledge and the opp. party no.1 is one of the most well equipped hospital in Asia. I say and submit that there are 4 operation theatres available for CU surgery only which is a rear phenomenon in city of Mumbai and therefore the allegations made by the complainants that the hospital did not have emergency operation is totally baseless.

40. There was a finding of 21. With reference to paras 40 and impending gangrene in the DSA 41 of the complaint under reply, I report dated 22.4.98 by Dr. Somaya deny the allegation made therein as himself but no heed was paid to it. false. I say and submit that on perusal of the case papers

41. That Dr. Somaya being the maintained by the opp. party no.1 it Senior most surgeon of the team is abundantly clear that I was was duty bound to keep the patient constantly monitoring the said in constant observation, but after deceased therefore allegations that the patient was shifted to recovery I examined the said patient nearly room, he came to examine the after 16 hours from the surgery is patient after nearly 16 hours. Had he totally false, frivolous and vexatious seen the patient one or two hours and the said allegations appears to after he was shifted, he could have have been made with ulterior observed that no blood was flowing motive and malafide intention to through the graft. The surgeons some how make out case of medical negligence caused the patient his negligence against me with an life. intention to knock out hand sum ransom from me and opp. party no.1. I say and submit that I treated the said patient with best of my ability and with due and diligent care and therefore, I am pained to hear such allegations from the family members of the deceased, that too, after 18 months from the said treatment. It is significant to note here that if the complainants were really convinced about the so called negligence on the part of the opp. parties, surely the complainants or other relatives of the said deceased would have lodged complaint with local police station or insisted for post-mortem of the said deceased and/or would have approached the Court against the hospital as well as against me.

The very fact that present complaint has been filed on 10.7.1999 without sending any proper notice thereby railing upon the opp. parties to explain the so called negligence also supports my case that present complaint is filed with ulterior motive with an intention to knock out hand sum ransom from the opp.

parties.

42. That leaving the patient 22. With reference to para 42 of the fighting for his life in the care of complaint under reply, I deny that inexperienced junior doctors viz. Dr. during the relevant time I went Partha and Bindra, Dr. Somaya went abroad for vacation thereby leaving abroad for vacationing. He was not the patient fighting for his life in the available even for advice for more care of inexperienced junior doctors than 30 days. viz. Dr. Partha and Dr. Bindra as alleged or at all. I say and submit that aforementioned allegations are not only false but the said allegations are made with an intention to cause prejudice in the mind of the Hon'ble Members of National Commission. In this connection, I say and submit that during the relevant time i.e. between 9th May 1998 to 7.6.1998, I had to China, England and USA to attend medical conferences and both the said conferences were fixed well in advance. Similarly the allegations of the complainants that Dr. Partha and Dr. Bindra are inexperienced junior doctors is also baseless for the simple reasons that both the aforementioned doctors are postgraduate and experienced in their respective field and both are having adequate experience in the aforementioned field. Besides this the said deceased was being treated by senior specialist at the opp. party no.1 hospital and in case of any emergency opp. party no.1 could have arranged senior experts and therefore merely because I was away from India that too in connection with my professional activities, the complainants should not be permitted to make capital out of it.

43. That Dr. Kripalani a neurologist 23. With reference to para 43 of the when called to examine the patient complaint under reply, I say and remarked that "both the legs are submit that Dr. Kripalani is a gone and it is a gone case. Your Nephrologists. I deny that Dr. doctor should tell each and Kripalani remarked that both the everything". But Dr. Somaya legs are gone and it is a gone case. I continued to conceal the health deny that Dr. Kripalani further prognosis from the complainant and observed that doctors deliberately his relatives and continued to delay suppressed the said fact from you in taking vital decisions. Had he as alleged or at all. I say and submit taken a decision to amputate the that though the said allegations are legs at the right time he could have made by the complainant in the saved the life of the complainant. name of Dr. Kripalani, the complainants have miserably failed to substantiate the said allegation by filing affidavit of Dr. Kripalani. I say and submit that after perusing the aforementioned allegations I have consulted Dr. Kripalani and Dr. Kripalani has confirmed that he had no such occasion to make any such observations to the relatives of the said complainant. I am filing the affidavit of Dr. Kripalani to substantiate my contention.

44. It is clear to even a novice 24. With reference to paras 44 and medical student that dead muscles 45 of the complaint under reply, I invite septicemia and gangrene. So deny the allegations made therein what was required was a timely as false save and except the factual action to prevent further damage. position that the said deceased died But Dr. Somaya refrained from on 12.6.1998 at 9.30 p.m. I say and adopting the requisite procedure. submit that though it is unfortunate The patient's

legs were amputated that the said deceased died only when all the consultants opined prematurely at the age of 43, even that it was the only procedure for then the complainants have no right saving life. Yet his negligence in of whatsoever nature to make taking timely action killed the only allegations against the opp. parties.

chance which the patient had.	I say and submit that my sympathies are with the
45. That it is apparent from the series of events that there has been lack of diligence and an established case of negligence on the part of	complainant and other family members and relatives of the said deceased. I say and submit that the said deceased died due to medical,

opposite party in providing services mishap and not due to any to the complainants as a result of negligence either on my part or on which the complainant died on the part of the staff of the opp. 12.6.1998 at 9.30 p.m." party no.1."

11. The affidavit of the complainant is on the same lines as the averments made in the complaint before the Commission.

12. The grievance of the complainant against the appellants can be summarized under the following heads:

(a) The Doctor had not examined the patient after surgery;

(b) The patient was made to stand in queue for DSA test despite his critical condition whereafter the machine was found to be dysfunctional;

(c) Angiography was performed after 8 hours of discovering that blood supply has stopped;

(d) The Hospital delayed treatment by 12 hours as no operation theatre was available;

(e) The Doctor did not attend the patient and left him in the care of inexperienced doctors;

(f) Doctor failed to amputate legs on time on account of gangrene and did not try to treat the gangrene; and

(g) The reliance on the principle of res ipsa loquitor to support the finding that it is a case of medical negligence.

13. Learned Commission while analyzing the evidence observed that the complainant had filed evidence affidavits but the Hospital and the Doctor, though have filed their written versions, but have not filed evidence by way of affidavits except an affidavit of Dr. Kripalani. We however find at

the outset that such primary observation is itself erroneous. The Hospital and the Doctor had filed their written version by way of affidavit dated 7.1.2000 i.e., the same date on which Dr. Kripalani had filed an affidavit. The Commission has overlooked the fact that written version is by way of an affidavit. Later, the Hospital had also filed evidence affidavit on 13.07.2009 whereas the Doctor had filed a short affidavit on 30.8.2009 reiterating and confirming the statements, averments and the contentions raised in the written version filed on 7.1.2000. Thus, there is factual error in the order of the Commission.

14. The Commission had commented adversely against the Doctor that he had not seen or attended the patient for several days before his departure for his tour to U.S.A and U.K for about a month and had not even indicated the name of any super specialist in his field who should look after the patient in his absence. The Commission mentioned that the Doctor observed at the first instance within a couple of days of admission at the Hospital that there was impending gangrene and that Dr. Partha and Dr. Bindra did not take timely decision for amputation of legs and by the time Dr. Pachore was consulted, it was too late. Moreover, it was also noted that Dr. Pachore had scolded Dr. Partha for the delay in consulting him as even if the amputation was done at such belated occasion, nothing could be said about the survival of the patient.

15. The Commission opined that considering the conditions in India, it is very difficult to secure the presence of an expert doctor to file an affidavit against another expert doctor and thus it would be a case of res ipsa loquitor. It was mentioned that though the Doctor was present at Mumbai from 29.4.1998 to 9.5.1998, he did not give advice for amputation of the legs and thereafter from 9.5.1998 to 7.6.1998, he went to U.S.A and U.K to attend medical conferences. He had visited the patient only on 8.6.1998 after several days of amputation. The Commission relied upon judgment in Whitehouse v. Jordan and Anr.6 to apply the principle of res ipsa loquitor. A reference was also made to an article “Repair of Infraneral Abdominal Aortic Aneurysms (AAAs): Introduction” to say that the mortality associated with repair of AAAs has been greatly reduced by improvements in preoperative evaluation and perioperative care. Another text book by Robert B. Rutherford was referred to note that paraplegia was a rare complication in the case of Aneurysms whereas in the present matter, paraplegia occurred instantaneously.

16. Learned counsel for the appellants herein argued that the Hospital is a renowned hospital having four operation theatres and advance machines including DSA. Three other hospitals in Mumbai such as Jaslok Hospital, Hinduja Hospital and Breach Candy Hospital alone 6 [1981] 1 Weekly Law Reports 246 had DSA machines at the relevant time. The Hospital in its affidavit had inter alia mentioned that the DSA test is not a bed side test. The patient has to be carefully shifted to the cardiac cauterization department where the DSA machine was installed. The patient hence had to be stabilized before he was shifted to DSA department. Since the patient was put on ventilator and on several support medications, it was not possible to immediately undergo the DSA test. But when the patient was taken for DSA test, the machine developed certain technical problem. Since the DSA machine was not working, angiography was thought to be the best possible test and was thus conducted. The Hospital had specialized staff in all branches of medicine and the medical assistance as was required from time to time including nephrology, orthopedics etc. was provided to the patient. It was argued that the professional competence of Doctor has not been doubted even by the

Commission but two factors have been taken against the Doctor for holding him negligent; first, that he did not visit the patient soon after the surgery till 9/9.30 a.m. on the next day to verify the blood flow after the surgery, and second, he did not visit the patient from 29.4.1998 to 9.5.1998 when he was in Mumbai and from 9.5.1998 to 7.6.1998 when he went abroad for attending medical conferences.

17. We do not find that the basis of finding the Doctor negligent in providing medical care is sustainable as there are both legal and factual errors in the findings recorded by the Commission.

18. Dr. K.G. Deshpande had referred the patient to the Doctor on 15.4.1998 with advice of urgent surgical repair of Aneurysum. The patient had taken another six days to consult Doctor at Mumbai and it was only on 21.4.1998 that the patient was examined by the Doctor and was advised immediate Aneurysmectomy in view of the impending gangrene. Therefore, gangrene was not found to be impending after few days of admission to the Hospital but even before the patient was admitted. The patient was in critical condition when the Doctor was consulted on 21.4.1998 and surgery was thereafter performed within two days.

19. Further, the non-working of the DSA machine and consequent delay in performing the test cannot be said to be negligence on the part of the Doctor or the Hospital. The DSA machine is a large, expensive and complicated machine which unfortunately developed certain technical problem at the time when patient had to be tested. Any machine can become non-functional because of innumerable factors beyond the human control as the machines involve various mechanical, electrical and electronic components. The DSA test was conducted in the Hospital on 22.4.1998 and hence DSA machine cannot be said to be dysfunctional for a long time. The alternative process to determine the blood flow was carried out by angiography and the decision for re-exploration was taken at 12.30 p.m. No fault can be attached to the Hospital if the operation theatres were occupied when the patient was taken for surgery. Operation theatres cannot be presumed to be available at all times. Therefore, non-availability of an emergency operation theatre during the period when surgeries were being performed on other patients is not a valid ground to hold the Hospital negligent in any manner.

20. The re-exploration of operative notes dated 24.4.1998 shows that a fresh graft was sutured in place after establishing the flow. The patient was then put on ventilator and shifted to recovery room. On 25.4.1998, a note by Dr. Bindra indicated that the patient was seen by Dr. Shruti. It was noted that there was no movement in both the legs but had pin prick sensation and below mid-thigh, sensation was present on the lower limbs. Further, legs were warm till the ankles and the feet were cold. On 27.4.1998, Dr. H.S. Bindra had sought consultation from Dr. Khadilkar giving case history that limbs were warm and that the patient had pain in the lumber region and was also feeling tightness in both the lower limbs. Dr. Khadilkar noted his impressions that it was very likely lower spinal cord/conus syndrome and thereafter advised MRI of the lower cervical spine and till then to continue with the medicine pentosiflin and lomodex and for muscle ischemia – high CK and Myoglobulin. Dr. Khadilkar suggested the same treatment to continue on 28.4.98. On 29.4.1998, Dr. Khadilkar had reported the sensory level dropped to upper 1/3rd of the thigh and that there was no power in limbs. No changes were however seen in the MRI report. It was also reported that probably

myonecrosis was playing more significant role in the weakness. The patient was put on dialysis thereafter.

21. The patient was examined by Dr. Kripalani or his unit from 1.5.1998 and thereafter for many days till 23.5.1998. The dialysis was being conducted in the meantime as well. The patient was being monitored by Dr. Bindra throughout. Subsequently, the patient was referred to Dr. Amarapurkar on 12.5.1998 when it was noted that Ischemic Injury to liver needed no treatment on 13.5.1998. The patient was then referred to Dr. Amin for enternal nuirisim on 16.5.1998.

22. It was further noted on 18.05.1998 from Colour Flow Imaging of limb arteries that both common femoral, superficial femoral and popliteal arteries were patent. The flow in both posterior tibial arteries was of low velocity and of venous type, suggesting refilled flow. Dr. Pachore also examined the patient on 27.5.1998 and observed that the patient had wet gangrene below knee and was thus advised amputation. On 29.5.1998, the patient was operated for amputation below the knee at the level of tibial tuberosity for treatment of wet gangrene and the Bilateral Guillatine Amputation was carried out.

On 30.05.1998, it was noted that the acute renal failure was improving. Further septicemia was diagnosed on 30.05.1998. Later, on 12.06.1998, the patient was put on ventilator and he subsequently passed away at 9.30 pm due to septicemic shock.

23. It is to be noted that it is not the case of the complainant that Doctor was not possessed of requisite skill in carrying out the operation. In fact, the patient was referred to him by Dr. Deshpande keeping in view the expertise of the Doctor in vascular surgery. There is no proof that there was any negligence in performing the surgery on 23.4.1998 or in the process of re-exploration on 24.4.1998. The allegation is of failure of the Doctor to take the follow-up action after surgery on 23.4.1998, a delayed decision to amputate the leg subsequent to re-exploration on 24.4.1998, and the alleged undue foreign visit of the Doctor.

24. In respect to such contention of the Doctor being on a foreign visit, it is well known a medical professional has to upgrade himself with the latest development in his field which may require him to attend conferences held both in and outside the country. Mere fact that the Doctor had gone abroad cannot lead to an inference of medical negligence as the patient was admitted in a hospital having specialists in multi-faculties. Two doctors from the unit of the Doctor namely Dr. Bindra and Dr. Partha, both post graduates, were present to attend to the patient. Moreover, as per the stand of the Hospital and the Doctor, the patient was kept in Cardio Vascular Intensive Care Unit after the surgery and was continuously being monitored by qualified post-graduate doctors including Dr. Nemish Shah, Head of Cardio Vascular Surgery. The patient was even attended by other specialist doctors as well which is evident from the brief summary of treatment given to the patient. The experts in the other fields have been consulted from time to time and the treatment was modulated accordingly. In spite of the treatment, if the patient had not survived, the doctors cannot be blamed as even the doctors with the best of their abilities cannot prevent the inevitable.

25. The blood was flowing properly soon after the surgery but later the formation of clot was confirmed after the angiography test was conducted at 12.30 p.m. An immediate decision was taken for re- exploration at 3.30 p.m. The allegation of delay in treatment after the surgery seems to be baseless as the patient was being administered antibiotics like Metrogyl 400 and Piperacillin Injection which are used for treatment in gangrene. Dr. Kripalani in his affidavit denied the allegation leveled by the complainant. Dr. Kripalani had treated patient continuously including carrying out the dialysis. In respect of the allegation that doctors failed to amputate legs on time, efforts were being made to save the limbs as amputation is considered as the last resort. The amputation was done as per the advice of Dr. Pachore. In the present era of super- specialization, one doctor is not a solution for all problems of a patient. Each problem is dealt with by an expert in the concerned field and that is what is apparent from the medical record. The stand of the complainant is that since surgery was performed by a doctor, he alone would be responsible for different aspects of the treatment required and given to the patient. However, it is an incorrect assumption to be made.

26. It is a case where the patient was in serious condition impending gangrene even before admission to the Hospital but even after surgery and re-exploration, if the patient does not survive, the fault cannot be fastened on the doctors as a case of medical negligence. It is too much to expect from a doctor to remain on the bed side of the patient throughout his stay in the hospital which was being expected by the complainant here. A doctor is expected to provide reasonable care which is not proved to be lacking in any manner in the present case.

27. The sole basis of finding of negligence against the Hospital is of res ipsa loquitor. It is to be noted that res ipsa loquitor is a rule of evidence. This Court in a judgment reported as Syad Akbar v. State of Karnataka7 explained the principle in a criminal trial as under:

> “19. As a rule, mere proof that an event has happened or an accident has occurred, the cause of which is unknown, is not evidence of negligence. But the peculiar circumstances con- stituting the event or accident, in a particular case, may themselves proclaim in concordant, clear and unambiguous voices the negligence of somebody as the cause of the event or accident. It is to such cases that the maxim res ipsa lo- quitur may apply, if the cause of the accident is unknown and no reasonable explanation as to the cause is coming forth from the defendant. To emphasise the point, it may be reiter- ated that in such cases, the event or accident must be of a kind which does not happen in the ordinary course of things if those who have the management and control use due care. But, according to some decisions, satisfaction of this condi- tion alone is not sufficient for res ipsa to come into play and it has to be further satisfied that the event which caused the accident was within the defendant's control. The reason for this second requirement is that where the defendant has con- trol of the thing which caused the injury, he is in a better po- sition than the plaintiff to explain how the accident occurred. Instances of such special kind of accidents which “tell their own story” of being offsprings of negligence, are furnished by cases, such as where a motor vehicle mounts or projects over a pavement and hurts somebody there or travelling in the ve- hicle; one car ramming another from behind,

or even a head- on collision on the wrong side of the road. (See per Lord Nor- mand in Barkway v. South Wales Transport Co. [(1950) 1 All ER 392, 399] ; Cream v. Smith [(1961) 8 AER 349] ;Rich- ley v. Faull [(1965) 1 WLR 1454 : (1965) 3 All ER 109])

20. Thus, for the application of the maxim res ipsa loquitur "no less important a requirement is that the res must not only bespeak negligence, but pin it on the defendant".

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26. From the above conspectus, two lines of approach in re-

gard to the application and effect of the maxim res ipsa lo- quitur are discernible. According to the first, where the maxim applies, it operates as an exception to the general 7 (1980) 1 SCC 30 rule that the burden of proof of the alleged negligence is, in the first instance, on the plaintiff. In this view, if the nature of an accident is such that the mere happening of it is evidence of negligence, such as, where a motor vehicle without appar- ent cause leaves the highway, or overturns or in fair visibility runs into an obstacle; or brushes the branches of an over- hanging tree, resulting in injury, or where there is a duty on the defendant to exercise care, and the circumstances in which the injury complained of happened are such that with the exercise of the requisite care no risk would in the ordinary course ensue, the burden shifts or is in the first instance on the defendant to disprove his liability. Such shifting or casting of the burden on the defendant is on account of a presump- tion of law and fact arising against the defendant from the constituent circumstances of the accident itself, which be- speak negligence of the defendant. This is the view taken in several decisions of English courts. [For instance, see Burke v. Manchester, Sheffield & Lincolnshire Rail Co. [(1870) 22 LJ 442] ; Moore v.R. Fox & Sons [(1956) 1 QB 596 : (1956) 1 All ER 182] . Also see paras 70, 79 and 80 of Halsbury's Laws of England, Third Edn., Vol. 28, and the rulings mentioned in the footnotes thereunder.]

27. According to the other line of approach, res ipsa loquitur is not a special rule of substantive law; that functionally, it is only an aid in the evaluation of evidence, "an application of the general method of inferring one or more facts in issue from circumstances proved in evidence". In this view, the maxim res ipsa loquitur does not require the raising of any presumption of law which must shift the onus on the defen- dant. It only, when applied appropriately, allows the drawing of a permissive inference of fact, as distinguished from a mandatory presumption properly so-called, having regard to the totality of the circumstances and probabilities of the case. Res ipsa is only a means of estimating logical probabil- ity from the circumstances of the accident. Looked at from this angle, the phrase (as Lord Justice Kennedy put it [Rus- sel v. London & South Western Railway Co, (1908) 24 TLR 548]) only means, "that there is, in the circumstances of the particular case, some evidence which, viewed not as a matter of conjecture, but of reasonable argument, makes it more probable that there was some negligence, upon the facts as shown and undisputed, than that the occurrence took place without negligence .... It means that the circumstances are, so to speak, eloquent of the negligence of somebody who brought about the state of things which is complained of."

28. Recently, a three Judge Bench in a judgment reported as Iffco Tokio General Insurance Company Limited v. Pearl Beverages Lim- ited8 approved the aforesaid judgment in a case of medical negli- gence being examined by the consumer fora. It was held as under:

> "86. Thus, it is used in cases of tort and where the facts with- out anything more clearly and unerringly point to negligence. The principle of res ipsa loquitur, as such, appears to be inap- posite, when, what is in question, is whether driver was under
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> the influence of alcohol. It may be another matter that though the principle as such is inapplicable, the manner in which the accident occurred may along with other circum- stances point to the driver being under the influence of alco- hol."

29. In Martin F. D'Souza v. Mohd. Ishfaq9, this court observed that the doctor cannot be held liable for medical negligence by applying the doctrine of res ipsa loquitur for the reason that a patient has not favourably responded to a treatment given by a doctor or a surgery has failed. There is a tendency to blame the doctor when a patient dies or suffers some mishap. This is an intolerant conduct of the family members to not accept the death in such cases. The in- creased cases of manhandling of medical professionals who worked day and night without their comfort has been very well seen in this pandemic. This Court held as under:-

> 8 (2021) 7 SCC 704 9(2009) 3 SCC 1 "40. Simply because a patient has not favourably responded to a treatment given by a doctor or a surgery has failed, the doctor cannot be held straightaway liable for medical negligence by applying the doctrine of res ipsa loquitur. No sensible professional would intentionally commit an act or omission which would result in harm or injury to the patient since the professional reputation of the professional would be at stake. A single failure may cost him dear in his lapse.
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> 42. When a patient dies or suffers some mishap, there is a tendency to blame the doctor for this. Things have gone wrong and, therefore, somebody must be punished for it.

However, it is well known that even the best professionals, what to say of the average professional, sometimes have failures. A lawyer cannot win every case in his professional career but surely he cannot be penalised for losing a case provided he appeared in it and made his submissions."

30. In case of medical negligence, this Court in a celebrated judgment reported as Jacob Mathew v. State of Punjab and Anr.10 held that simple lack of care, an error of judgment or an accident, is not a proof of negligence on the part of a medical professional. The Court held as under:

> "48. We sum up our conclusions as under:

> (1) Negligence is the breach of a duty caused by omission to do something which a reasonable man guided by those considerations which ordinarily regulate the conduct of hu-

man affairs would do, or doing something which a prudent and reasonable man would not do. The definition of negli- gence as given in Law of Torts, Ratanlal & Dhirajlal (edited by Justice G.P. Singh), referred to hereinabove, holds good. Negligence becomes actionable on account of injury result- 10 (2005) 6 SCC 1 ing from the act or omission amounting to negligence at- tributable to the person sued. The essential components of negligence are three: "duty", "breach" and "resulting damage".

(2) Negligence in the context of the medical profession nec- essarily calls for a treatment with a difference. To infer rash- ness or negligence on the part of a professional, in particu- lar a doctor, additional considerations apply. A case of occu- pational negligence is different from one of professional negligence. A simple lack of care, an error of judgment or an accident, is not proof of negligence on the part of a med- ical professional. So long as a doctor follows a practice ac- ceptable to the medical profession of that day, he cannot be held liable for negligence merely because a better alter- native course or method of treatment was also available or simply because a more skilled doctor would not have cho- sen to follow or resort to that practice or procedure which the accused followed. When it comes to the failure of taking precautions, what has to be seen is whether those precau- tions were taken which the ordinary experience of men has found to be sufficient; a failure to use special or extraordi- nary precautions which might have prevented the particular happening cannot be the standard for judging the alleged negligence. So also, the standard of care, while assessing the practice as adopted, is judged in the light of knowledge available at the time of the incident, and not at the date of trial. Similarly, when the charge of negligence arises out of failure to use some particular equipment, the charge would fail if the equipment was not generally available at that par- ticular time (that is, the time of the incident) at which it is suggested it should have been used.

xxx xxx xxx (4) The test for determining medical negligence as laid down in Bolam case [(1957) 1 WLR 582 : (1957) 2 All ER 118 (QBD)] , WLR at p. 586 [[Ed.: Also at All ER p. 121 D-F and set out in para 19, p. 19 herein.]] holds good in its ap- plicability in India.

xxx xxx xxx (8) Res ipsa loquitur is only a rule of evidence and operates in the domain of civil law, specially in cases of torts and helps in determining the onus of proof in actions relating to negligence. It cannot be pressed in service for determin- ing per se the liability for negligence within the domain of criminal law. Res ipsa loquitur has, if at all, a limited applica- tion in trial on a charge of criminal negligence."

31. In another judgment reported as Arun Kumar Manglik v. Chirayu Health and Medicare Private Limited and Anr.11, this Court held that the standard of care as enunciated in Bolam case must evolve in consonance with its subsequent interpretation by English and Indian Courts. The threshold to prove unreasonableness is set with due regard to the risks associated with medical treatment and the conditions under which medical professionals' function. The Court held as under:

> "45. In the practice of medicine, there could be varying approaches to treatment. There can be a genuine difference of opinion. However, while adopting a course of treatment, the medical professional must ensure that it is not unreasonable. The threshold to prove unreasonableness is set with due regard to the risks associated with medical treatment and the conditions under which medical professionals function. This is to avoid a situation where doctors resort to "defensive medicine" to avoid claims of negligence, often to the detriment of the patient. Hence, in a specific case where unreasonableness in professional conduct has been proven with regard to the circumstances of that case, a professional cannot escape liability for medical evidence merely by relying on a body of professional opinion." 11 (2019) 7 SCC 401

32. In C.P. Sreekumar (Dr.), MS (Ortho) v. S. Ramanujam12, this Court held that the Commission ought not to presume that the alle- gations in the complaint are inviolable truth even though they remained unsupported by any evidence. This Court held as under:

> "37. We find from a reading of the order of the Commission that it proceeded on the basis that whatever had been al- leged in the complaint by the respondent was in fact the in- violable truth even though it remained unsupported by any evidence. As already observed in Jacob Mathew case [(2005) 6 SCC 1 : 2005 SCC (Cri) 1369] the onus to prove medical negligence lies largely on the claimant and that this onus can be discharged by leading cogent evidence. A mere aver-

ment in a complaint which is denied by the other side can, by no stretch of imagination, be said to be evidence by which the case of the complainant can be said to be proved. It is the obligation of the complainant to provide the facta probanda as well as the facta probantia."

33. In another judgment reported as Kusum Sharma and Others v.

Batra Hospital and Medical Research Centre and Others13, a complaint was filed attributing medical negligence to a doctor who performed the surgery but while performing surgery, the tumour was found to be malignant. The patient died later on after prolonged treatment in different hospitals. This Court held as under:

> "47. Medical science has conferred great benefits on mankind, but these benefits are attended by considerable risks. Every surgical operation is attended by risks. We cannot take the benefits without taking risks. Every advancement in technique is also attended by risks.
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12 (2009) 7 SCC 130
13 (2010) 3 SCC 480

> 72. The ratio of Bolam case [(1957) 1 WLR 582 : (1957) 2 All ER 118] is that it is enough for the defendant to show that the standard of care and the skill attained was that of the ordinary competent medical practitioner exercising an ordinary degree of professional skill. The fact that the respondent charged with negligence acted in accordance with the general and approved practice is enough to clear him of the charge. Two things are pertinent to be noted. Firstly, the standard of care, when assessing the practice as adopted, is judged in the light of knowledge available at the time (of the incident), and not at the date of trial. Secondly, when the charge of negligence arises out of failure to use some particular equipment, the charge would fail if the equipment was not generally available at that point of time on which it is suggested as should have been used.
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> 78. It is a matter of common knowledge that after happening of some unfortunate event, there is a marked tendency to look for a human factor to blame for an untoward event, a tendency which is closely linked with the desire to punish.

Things have gone wrong and, therefore, somebody must be found to answer for it. A professional deserves total protec- tion. The Penal Code, 1860 has taken care to ensure that people who act in good faith should not be punished. Sec- tions 88, 92 and 370 of the Penal Code give adequate protec- tion to the professionals and particularly medical profession- als."

34. Recently, this Court in a judgment reported as Dr. Harish Kumar Khurana v. Joginder Singh & Others14 held that hospital and the doctors are required to exercise sufficient care in treating the pa- tient in all circumstances. However, in an unfortunate case, death may occur. It is necessary that sufficient material or medical evi- dence should be available before the adjudicating authority to arrive 14 (2021) SCC Online SC 673 at the conclusion that death is due to medical negligence. Every death of a patient cannot on the face of it be considered to be medi- cal negligence. The Court held as under:

> "11. ..... Ordinarily an accident means an unintended and unforeseen injurious occurrence, something that does not occur in the usual course of events or that could not be rea- sonably anticipated. The learned counsel has also referred to the decision in Martin F.D'Souza v. Mohd. Ishfaq, (2009) 3 SCC 1 wherein it is stated that simply because the patient has not favourably responded to a treatment given by doc- tor or a surgery has failed, the doctor cannot be held straight away liable for medical negligence by applying the doctrine of Res Ipsa Loquitor. It is further observed therein that sometimes despite best efforts the treatment of a doc- tor fails and the same does not mean that the doctor or the surgeon must be held guilty of medical negligence unless there is some strong evidence to suggest that the doctor is negligent.
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> 14. Having noted the decisions relied upon by the learned counsel for the parties, it is clear that in every case where the treatment is not successful or the patient dies during surgery, it cannot be automatically assumed that the medi-

cal professional was negligent. To indicate negligence there should be material available on record or else appropriate medical evidence should be tendered. The negligence al- leged should be so glaring, in which event the principle of res ipsa loquitur could be made applicable and not based on perception. In the instant case, apart from the allegations made by the claimants before the NCDRC both in the com- plaint and in the affidavit filed in the proceedings, there is no other medical evidence tendered by the complainant to indicate negligence on the part of the doctors who, on their own behalf had explained their position relating to the medi- cal process in their affidavit to explain there was no negli- gence. ....."

35. It may be mentioned here that the complainant had led no evidence of experts to prove the alleged medical negligence except their own affidavits. The experts could have proved if any of the doctors in the Hospital providing treatment to the patient were deficient or negligent in service. A perusal of the medical record produced does not show any omission in the manner of treatment. The experts of different specialities and super-specialities of medicine were available to treat and guide the course of treatment of the patient. The doctors are expected to take reasonable care but none of the professionals can assure that the patient would overcome the surgical procedures. Dr. Kripalani has been attributed to have informed the complainant that the patient's legs were not working but Dr. Kripalani denied all the averments by filing of an affidavit.

36. As discussed above, the sole basis of finding the appellants negligent was res ipsa loquitor which would not be applicable herein keeping in view the treatment record produced by the Hospital and/or the Doctor. There was never a stage when the patient was left unattended. The patient was in a critical condition and if he could not survive even after surgery, the blame cannot be passed on to the Hospital and the Doctor who provided all possible treatment within their means and capacity. The DSA test was conducted by the Hospital itself on 22.4.1998. However, since it became dysfunctional on 24.4.1998 and considering the critical condition of the patient, an alternative angiography test was advised and conducted and the re-exploration was thus planned. It is only a matter of chance that all the four operation theatres of the Hospital were occupied when the patient was to undergo surgery. We do not find that the expectation of the patient to have an emergency operation theatre is reasonable as the hospital can provide only as many operation theatres as the patient load warrants. If the operation theatres were occupied at the time when the operation of the patient was contemplated, it cannot be said that there is a negligence on the part of the Hospital. A team of specialist doctors was available and also have attended to the patient but unfortunately nature had the last word and the patient breathed his last. The family may not have coped with the loss of their loved one, but the Hospital and the Doctor cannot be blamed as they provided the requisite care at all given times. No doctor can assure life to his patient but can only attempt to treat his patient to the best of his ability which was being done in the present case as well.

37. Therefore, we find that the findings recorded by the Commission holding the Hospital and the Doctor guilty of medical negligence are not sustainable in law. Consequently, the present appeals are

allowed. The order passed by the Commission is set aside and the complaint is dismissed.

38. By virtue of an interim order passed by this Court on 8.3.2010, a sum of Rs. 5 lakhs was disbursed to the complainant. The said amount is ordered to be treated as ex gratia payment to the complainant and not to be recovered back by either the Hospital or the Doctor.

.....J. (HEMANT GUPTA) .....J. (V. RAMASUBRAMANIAN) NEW DELHI;

NOVEMBER 30, 2021.