National Consumer Disputes Redressal
Kusum Sharma And Ors. vs Batra Hospital & Medical Research ... on 30 August, 2000
ORDER Mr. B.K. Taimni

1. This is a complaint filed under Section 21 of the Consumer Protection Act claiming compensation of Rs. 45 lakhs attributing deficiency in service and medical negligence in the treatment of the deceased, late Shri R.K. Sharma, Sr. Operations Manager, India Oil Corporation (IOC), (Mrktg. Dvn.), New Delhi who is the husband of the first Complainant and father of other Complainants.

2. The facts of this case are that on 17.3.1990, the deceased Shri R.K. Sharma, with complaints of general oedema and hyper-tension, on reference from IOC, his employer's, came to Batra Hospital, Delhi for consultation whereupon Opposite Party No. 2, Dr. Mani examined him and diagonised it as 'Anarsarca' and advised admission. The deceased Shri Sharma got admitted on 18.3.1990 whereupon after a thorough examination and several tests, he was advised surgery for removal of 'left adrenal tumour' which was the cause of his aliments. On tests, the tumour was found to be malignant. The treatment for malignancy by way of administrating Mitotane could not be given as it is not known to have side effects. The surgery was carried out on 2.4.1990 by Opposite Party No. 3, Dr. Kapil Kumar. During the surgery, the body of the pancreas was damaged, which was treated and a drain was fixed to drain out the fluids. Since the flow of fluids did not stop thereby causing pain, inconvenience and anxiety to the deceased and the complainants, after another expert consultation with Dr. T.K. Bose, Opposite Party No. 4, a second surgery was carried out on 23.5.1990 in Batra Hospital by Dr. Bose assisted by Dr. Kapil Kumar. The surgery was successful. The deceased was fitted with two bags and drain the fluids and in due course, wounds were to heal inside and fluid to stop. The patient was discharged on 26.6.1990 carrying two bags in his body, with an advise to follow-up and change in dressing. The deceased next showed up in Batra Hospital only on 31.8.90 and that too to obtain a Medical Certificate from Opposite Party No. 2, Dr. Mani which was given. Next time the deceased cam to Batra Hospital was on 9.10.1990 after vomiting at home and when arrangements for bringing him by the Hospital's ambulance were made by Opposite Party No.2, Dr. Man, Shri Sharma died in the Hospital on 11.10.1990 on account of 'pyogenic meningitis'.

3. It will be relevant to mention few other dates. After discharge from the Batra Hospital on 23.6.1990, the deceased wrote a letter on 26.6.90 to his employer, IOC narrating the agony and pain he underwent at the hands of the Doctors in Batra Hospital. On the suggestion/request of Opposite Party No. 4, Dr. Bose, the deceased visited Modi Hospital on 10.7.90 where Dr. Bose, was a Consulting Surgeon, for change of dressing after seventeen days. Opposite Party Nos. 2, 3 & 4 visited the residence of the deceased on 14.7.90 found him in a bad condition and asked him to go to AIIMS where he was admitted on 22.7.90 and treatment was given for pancreatic fistula and chronic fistula and discharged on 26.7.90 with advise to follow-up in O.P.D. the patient again went to Mool Chand Hospital on 17.8.90 with pancreatic and fecal fistula which was dressed. The deceased discharged for Moll Chand Hospital on 31.8.90. The deceased went to Jodhpur on 29.9.90 and admitted in M.G. Hospital of Medical College where he was diagnosed with having:-

a) post-cooperative complications of Adrenoloctoy

b) Gluteal abscess.

4. The deceased was discharged on 3.10.90 with advise to get further treatment in AIIMS. When the patient went to AIIMS on 8.10.90, Dr. Kuchupillai wrote on a slip 'to be discussed in the Endo-Surgical Conference on 8.10.90'. The deceased vomited blood on the morning of 9.10.90 and died on 11.10.90 on account of 'pyogenic meningitis'.

5. In reply to the complaint, Opposite Party Nos. 1 to 4 filed Rejoinders and the Complainant filed reply to the Rejoinder. Affidavits by way of examination-in-chief were file by complainant No. 1 and one Dr. Doshora, on behalf of the Complainants as well as by Opposite Party Nos. 1 to 4. Affidavit was also filed by Dr. Nandi the then Head of Department of Gastro-Intestinal Surgery of AIIMS. An expert witness Dr. M.S. Shukla, Addl. Professor Oncology was examined at the request of Opposite Party Nos. 1 to 3. Arguments were heard form both the parties. They also made written submissions of their respective case and also filed several rulings of Hon'ble Supreme Court, House of Lords and Medical Texts, in support of their case. On the last date of arguments, learned Counsel for the Complainants was given one week's time to submit in writing any poin the wishes to make. No such written submissions have been given by him within the stipulated period.

6. The main thrust of the Complaints' hover around the following points:-

* Complainant was not informed in time of the damage caused toe the body of Pancreas and removal of spleen;

* The 'tumour' removed from the left adrenal of the deceased was not malignant;

* The 'anterior' approach adopted at the time of first surgery was not the right approach. Surgery should have been done adopting 'posterior' approach for removal of left adrenal tumour;

* At the time of second surgery by Dr. Bose advice/guidance as prescribed by D. nandi of AIIMS was not followed by Opposite Party No. 4 resulting in further complications to the body of the deceased;

* Gluteal abscess was for the first time detected at Jodhpur in September, 1990 which was the outcome of continued infection in the body of the deceased resulting from the negligence on the part of Opposite Party No. 3 while carrying out surgery on 2.4.90 in Batra Hospital.

7. According to the Complainant, it was the cumulative effect of series of acts of omission or commission that the patient never recovered after the first surgery carried out by Respondent No. 3 and which became the cause of death of Shri Sharma at a relatively young age leaving a widow and young children behind. Needless to say that all these points referred to above have been seriously contested by the Opposite Parties.

8. On the first issue according the complainants affidavit, immediately after the operation on 2.4.90, Opposite Party NO. 3 told them that the 'operation was successful, tumour was completely removed, it was one piece, well defined and no spreading was there'. After the surgery, blood was coming out

in a tube which was inserted on the left side of the abdomen. It was explained to them normal after surgery. This flow never stopped. After about 45 days of the operation i.e. on 17.5.90, the Doctors decided to carry out a special test (Endoscopic Retrograde Cliole and Pancreatography - E.R.C.P.) at Sir Ganga Ram Hospital. Only on specific enquiry by the deceased, Opposite Party Nos. 2 and 3 told him that pancreas was perfectly normal but during operation on 2.4.90, it was slightly damaged but repaired instantly, hence there was nothing to worry about. When the fact of damage to pancreas came to the notice of the deceased, he asked for the details which were not given. In the complaint, it was also mentioned that on 2.4.90 spleen of Shri Sharma was removed. At no time, the Complainants nor the deceased were ever informed about this. Opposite Party Nos. 1 to 3 in their Rejoinder have rebutted the above allegations. According to them at the time of surgery by Opposite Party No. 3 on 2.4.90, it became necessary t remove the spleen of Shri Sharma. Opposite Party No. 3 has also rebutted the allegation that neither the complainants nor deceased were told of the damage to pancreas. According to Opposite Party No. 3 the fact is cleary recorded in the operation notes and the Discharge Summary. During cross-examination, the complainant re-affirmed that it was only on 17.5.90 that she got a confirmation about the damage to pancreas. In his reply during the cross-examination by the Counsel for the Complainant, Opposite Party NO. 3 fails to give out the date on which operation notes were prepared and when a copy was made available to the Complainant/deceased indicating that the body of pancreas was damaged during the surgery. Opposite Party No. 3 relies on operation transcript and the discharge summary in his support of the fact that all information was shared with the complainant or the deceased. Opposite Party No. 3, in our view, has failed to establish as to when the operation transcript was made available. He has, at no time rebutted the complainant's observation that Opposite Party No. 3 told them more than the fact that operation was 'successful and tumour was completely removed.....'. He never mentioned a word about damage to pancreas or removal of spleen. Discharge Summary was given on 23.6.90 where as the surgery was carried out on 2.4.90. Opposite Party No. 3 has thus failed to meet the complainant's point on their not being informed about the damage to the body of pancreas or removal of spleen after the first surgery on 2.4.90.

9. Another issue raised by the Complainant is that the tumour taken out form the body was not malignant. They allege collusion between Batra Hospital and Sir Ganga Ram Hospital on this issue. According to them, Mool Chand Hospital did not return the finding of malignancy on the slides sent to them. Tata Memorial said that 'slides made by Novice - improper for evaluation - relevant details of size and weight not available'. The Opposite Party Nos. 1 to 3 strongly rebut this allegation. Evidence on record i.e. the Histology report, dated 2.4.90 clearly mentions adrenal cortex carcinoma i.e. the tumour was malignant. Report from Sir Ganga Ram Hospital dated 12.4.90 states clearly 'compatiable with carcinoma of the adrenal cortex'. Histology report from Moolchand Hospital dated 24.8.90 states 'there are stray foci of necrosis and stray mitosis'. Their opinion is that 'the tumour about this size and about 50 gms weight with above feature have a doubtful/uncertain malignant potential..... hence follow-up". In her cross-examination, the complainant confirms that the histology report form both Batra Hospital and Sir Ganga Ram Hospital stated the removed tumour to be malignant. In the affidavit and cross-examination, according to Opposite Party No. 3, his diagnosis was "the size of the tumour being more than 5 cm, the elements of malignancy of the tumour in a male more than 50 years old are high". There is no way that without biopsy i.e. taking a sample from the body of the patient, malignancy can be confirmed.In his cross-examination, witness

of the complainant and Dr. Dashora confirms as to this be the correct and right thing to do. There are clear findings of malignancy returned by two Hospitals, namely, Batra and Sir Ganga Ram Hospital. According to Opposite Party Nos. 1 to 3, the finding of Moolchand Hospital and finding of 'Mitosis' itself are indiculive of malignancy and this has not been rebutted by the Complainants. Since no report on finding was given by Tata Hospital, hence nothing can be inferred. Their wish that 'mass' should have been made available is understandable, but Batra Hospital states that they keep the 'mass' for one month, after which only slides are retained, which is also understandable. No Hospital can be expected to keep the 'mass' for an unlimited period unless asked specifically to do so which was not the position in the instant case. There are two clear findings, one based on the mass itself (Batra Hospital) and the other based on the slides by Sir Ganga Ram Hospital and Moolchand Hospital which support the fact of malignancy. It is not possible to draw any other inference based on the material on record. The very fact that the surgery was proposed to be done by a Surgical Oncologist to which the complainant and the deceased gave consent after due consultation in person with their family Doctor, Dr. Dashora is itself a proof that malignancy was a factor in the instant surgery.

10. Another point vehemently agitated and argued in extenso by both the parties is on the question of whether at the time of first surgery on 2.4.90 'posterior' approach should have been adopted as against the 'anterior' approach adopted by the operating surgeon, Opposite Party No. 3? According to the complainant there is unanimous medical opinion that operation of the left adrenal is done from the posterior side and not from the anterior side (by incision of stomach). This is on account of the fact that if incision is done from the anterior side, adrenals are placed below the spleen and therefore the spleen obstructs the approach to the adrenals. From the anterior side, spleen, then the adrenals and then pancreas are placed in that order informing thereby that there was no necessity for adopting the anterior approach. if 'posterior approach' had been adopted, then there would not have been any injury to the pancreas, no further complications, no sustained infections inside the body leading to his unfortunate death on account of pyogenic meningitis. In support of this argument, he produced large number of medical text material.

(i) "The advantages of the posterior approach are that it is anatomically the most direct route to the adrenal glands, it is relatively fast, it is extra-peritoneal, and no major muscles are transected, which minimizes incisional pain and encourages early postoperative ambulation. If indicated, both adrenal glands can be exposed simultaneously through bilateral posterior incisions.

The major disadvantages of the posterior approach is the relatively small operative field, which restricts visibility and exposure of the great vessels. Therefore, this approach should not be used to remove large adrenal lesions where wide exposure and early vascular control are necessary.This approach also is contraindicated in patients with a potentially malignant process, such as pheochromocytoma or adrenocortical carcinoma in whom exploratory laparotomy is required. Within these limitations, the primary indications for posterior adrenalectomy are patients with either bilateral hyperplasia from Cushing's disease or a small benign adenoma. The most common clinical diagnosis in the latter category is hyperaldosteronism, although small adenomata may also cause Cushing's syndrome". -- The Urologic Clinics of North America - Vol. 16/Number 3, August 1989.

(ii) "The goal of therapy is to eliminate cortisol hypersecretion. The treatment for patients with hypercortisolism resulting form a unilateral adrenal adenoma is total surgical excision of the involved gland to eliminate the source of the autonomous cortisol production. The prognosis is excellent. A successful operation is curative and no other therapy is necessary. The operation usually is accomplished using a posterior or laparoscopic approach for tumour that are <4 cm in diameter". -- Maingot's Abdominal Operation - Vol.-I -- X Edition.

(iii) "Removal of the left adrenal through the abdominal (anterior) approach is likely to be more difficult. Access to the gland is obtained either directly through he lesser peritoneal sac or by mobilizing the spleen, tail of the pancreas and splenic flexure of the colon toward the midline.

This approach is most useful in removal of the normal or hyperplastic gland, but is not suitable for removal of a neoplasm, for which better exposure is needed. In either case the tail of the pancreas, splenic vessels and the spleen must be handled carefully if injury is to be avoided ". -- Complications in Surgery And Their Management - By Curtis P. Artz -- II Edition.

(iv) "Removal of the left adrenal through the abdominal (anterior) approach is likely to be more difficult.

The splenic vessels are, of course, large, and if they are torn, profuse hemorrhage will result. Bleeding from this source can be controlled by digital pressure proximal to the bleeding point to allow repair in a dry field". -- Management of Surgical Complications - By Curtis P. Artz -- III Edition.

(v) "The posterior approach, so well presented in the illustrations, has the advantage that relatively little dissection is required to expose the adrenals, since they lie far posteriorly, adjacent to the aorta on the left and the vena cava and spinal column on the right. In this way, the thick panniculus of fat in the abdominal wall is avoided, and a relatively shallow posterior wound is substituted for a usually deep abdominal wound". Atlas of Technics in Surgery -- by John L. Madden -- Vol. 1 -- II Edition.

11. On the otherhand, Opposite Party No. 3 strongly rebutted this allegation on this account and stated in his affidavit that the anterior approach was preferred over the posterior approach as in the suspected case of cancer,, which was the case here - the former approach enables the surgeon to look at liver, the aortae area, the general spread and the opposites adrenal gland. Risk involved was explained to the patient and he agreed to the surgery after due consultation with the family Doctor.

12. The learned Counsel for the Opposite Party Nos. 1 to 3 also brought out medical texts in support of adopting 'anterior' approach in cases such as of the deceased.

(i) "The 'anterior' approach for adrenalectomy is mandatory whenever optimum exposure is required or when exploration of the entire abdomen is necessary. Therefore, this approach is used in patients with adrenal tumours >4 cm in diameter, or in patients with possibly malignant tumours of any size, such as pheochromocytoma or adrenocortical carcinoma.....

Resection of the left adrenal gland requires mobilisation of the spleen and left colon. The lateral peritoneal attachment of the left colon are freed, initially. Then the spleen is scooped out from the left upper quadrant medially and the avascular attachments between the spleen and diaphragm are divided. The spleen, stomach, pancreatic tail and left colon are retracted medially en bloc to the superior mesenteric vessels. The left adrenal gland is exposed splendidly in this manner". -- Peritoneum, Retroperitoneum and Mesentery -- Section IV.

(ii) "Adrenal operations. Surgery should be initial treatment for all patients with Cushing syndrome secondary to adrenal adenoma or carcinoma. Preoperative radiologic lateralisation of the tumour allow resection via a unilateral flank incision. Adrenalectomy is curative. Postoperative steriod replacement therapy is necessary until the suppressed gland recovers (3-6 months).

Adrenal carcinoma should be approached via a midline incision to allow radical resection, since surgery is only hope for cure". -- Principles of Surgery, 6 e Companion handbook -- Pg. 560.

(iii) "Adrenocortical malignancies are rate, often at advancedstage when first discovered, and should be approached using an anterior approach to allow adequate exposure of the tumor and surrounding soft tissue and organs". -- Technical Aspects of Adrenalectomy -- By Clive S. Grant and Jon A. Van Heerden -- Chapter Thirty Five.

11. The medical texts quoted above speak of the both the approaches for adrenaloctomy. Nowhere the complainant is able to support his contention that posterior approach was the only approach and Opposite Party No. 3 was negligent in adopting the anterior approach especially when the deceased after initial diagnosis was suspected with possibly having a malignant left adrenal tumor. The fact of malignancy and the Doctor's diagnosis was further buttressed by the Histology report obtained next day i.e. on 3.4.90.

12. During the arguments, it became clear that at best it was a matter of judgment and discretion for the surgeon to adopt. In this case, Opposite Party No. 3, Dr. Kapil Kumar used his judgment to adopt the 'anterior' approach to which the above quoted medical text lends support. Even if the decision of the Opposite Party No. 3, is held to be one balance, it tilts in favour of Opposite Party No. 3, with the oral evidence of Prof. M.K. Shukla, Additional Professor, AIIMS, when he unequivocally states in response to a specific question from Learned Counsel for the Complainant, that for malignant tumours, by and large, we prefer anterior approach. He reiterates in reply to another questions that if you are suffering of cancer, then it is anterior approach. he again says "..... If there is any doubt in our mind that this tumor can be malignant or the size is marginal or if we have got any suggestion that this could be malignant by any other investigation, in that situation, I will definetly use 'anterior' approach". Dr. Nandi, Professor and Head of Department of Gastro-Intestinal Surgery, AIIMS also supports 'anterior' approach and confirms and reconfirms adoption of 'anterior' approach in view of inherent advantages of the approach.

13. In our view, this settles the issue. Even if the medical material presented before us is taken to weigh, even then, in the light of material and evidence adduced, the Opposite Party No. 3 cannot be held guilty of any negligence for selecting the 'anterior' approach for left adrenal surgery in the case

of the deceased. It is admitted by both the parties and other witnesses, that risk is inherent in all surgeries. Thus, we do not find nay merit in this allegation of the Complaint.

14. According the Complainant, Opposite Party No. 4, Dr. Bose who performed the second surgery on 23.5.90 did not follow the advice of Dr. Nandi, Head of the Department of Gastro-Intestinal Surgery of AIIMS. The latter had suggested routing the flow of pancreatic fluid from the intestinal system. The large tubes ere to be inserted in the abscess of cavity and each made to emerge through left lower interior abdominal wall connected to the urobag. Dr. Nandi had also advised placing of feeding tube at designated place. This was not done. Subsequently, five attempts were made to place the tube which proved futile. Operation notes of Dr. T.K. Bose are silent about the damage caused to the fundus of the stomach of the deceased; which resulted in server hemateniesis and hypertension on 4.6.90 endangering the life of the patient.

15. Opposite Party No. 4, Dr. Bose in his Rejoinder and Affidavit rebuts this allegation. According to him, he himself is a surgeon of very high standing, experience and qualification. Opposite Party No. 4 in his Rejoinder states that there are three well known alternative methods of food supply of nutrition minimising and leakage of enzymes form the pancreas. Any of the alternative method could only be adopted only after opening the stomach and this is precisely what the Opposite Party No. 4 did i.e. cleared the are of abscess of all pus, dead and other infective tissues and inserted a second tube for drainage of fluid in the affected area and in pancreatic duct. Opposite Party NO. 4 also inserted a second tube connecting the exterior of the abdomen with the affected part of the pancreas and the abdomen for drainage and clearance in support of the first tube inserted for drainage. According to Opposite Party No. 4, this was the best which could be done keeping in view the status of inside of the stomach of deceased and this was done. The operation was successful. During the cross-examination, Dr. Nandi stated that after examination of the deceased on 20.5.90, he had suggested surgery to have the pancreatic abscess removed and secondly to have feeding jejunoctomy. He also stated that after examination of the deceased in OPD of AIIMS, he had given advice in writing to drain the abscess. Opposites Party No. 4 is quite categorical that the operating surgeon has the final word in the action to be taken after seeking the inside of a patient, as a result of which, he did whatever was deemed to be best for the patient. It is pertinent to note that Dr. Bose was not called for cross-examination as the Complainant, at the time of her cross-examination dropped the complaint of negligence against Opposite Party No. 4. Hence, this part of the Complainant cannot be held against the Opposite Parties.

16. Another point made by the complainant is that 'Gluteal abscess' which is attributed to 'pyogenic meningitis' resulting in the death of Shri Sharma was first observed in Medical College Hospital at Jodhpur, where the deceased had gone in connection with performing certain rights in connection with the death of his mother-in-law. the deceased was taken to Dr. Harban Singh, Head of Department of surgery in Medical College Hospital at Jodhpur on 30.9.90 on whose advice he was admitted in the attached Hospital. It is stated by the Complainants that the luteal abscess was drained (which had formed due to foecal discharge) by a simple incision. he was discharged from there on 3.10.90 with an advise to go to AIIMS, New Delhi and met Dr. Kuchupillai, the Endoconologist. Opposite Party No. 1 to 3 rebutted the claim of the complainant that gluteal abscess was ever drained even though is reiterated by the complainant and also in the cross-examination of

their witness, Dr. Dashora that Gluteal Abscess was incised. Neither Medical College Hospital, Jodhpur nor Dr. Harban Singh were made a party. The latter was not even examined. At a very late stage, Complainants filed certain document one of which was an 'Essentiality Certificate' issued by Dr. Harban Singh. There is not even a whisper of any incision or draining of gluteal abscess. No evidence or proof of any sort has been produced in support of the incision. the Essentiality Certificate makes it clear that no incision was made to drain out gluteal abscess.

17. The edifice of the whole case 'negligence' is based on the foundation of damage to pancreas caused at the time of first surgery on 2.4.90 carried out by Opposite Party No. 3. It is no one's case that surgery was without risk. All the evidence available, both based on the Medical Text Books or Expert Witnesses clearly spell out the approach to be adopted for surgery in such a case and it clearly is tilted in favour of anterior approach. It is also clear that in such cases, there is abundant risk of damage to pancreas. Dr. nandi in his cross-examination admits that he has carried out over 2000 operations of splenoetonomy and many times during the operation, the tail of the pancreas was cut. The Complainants has not even once cast aspersion on the follow-up action taken up by Opposite Party No. 3 to repair the damage which is as per Text Books and practice adopted in such cases and confirmed by Dr. Nandi during his cross-examination. It has also been stated by Dr. Nandi that he would wait for 3-4 months to do ERCP test which in the instant case was done within one-and-a-half month. The second surgery was done by Dr. T.K. Bose to celar the area of abscess of all pus, dead dn infected tissues and inserted a tube for drainage of the affected area. The operation was successful. The complainants dropped complaint against Opposite Party No. 4. Under these circumstances, when the earlier event was overtaken by a subsequent successful event, to continue to hold the perpetrator of first event guilty of negligence doe snot stand to any reason.

18. The conduct of the deceased after the discharge on 23.6.90 itself, on the contrary, could be said to be a case of 'negligence'. Affidavit of Opposite Party No. 4 throws light on the frustration on the part of the Doctors. When intra-venous feeding could not be kept on account of the deceased developing fever, the alternative was to feed him through naso-jejunal tube but the deceased refused leaving the deceased to be fed orally, thus thwarting the options for maintaining nutrition without stimulating pancreatic secretion. The Discharge Summary clearly advised 'Regular Medical Follow-up' but the deceased never showed up for such follow-up at Batra Hospital. On the contrary, it was Opposite Party No. 4 who called on the deceased and finally persuaded him to go for a change of dressing to Modi Hospital (Opposite Party No. 4 was a Consultant Surgeon there as well). The dressing was changed by Opposite Party No. 4 on 10.7.90 after 17 days after he found the drain site 'messy'. There was no follow-up by the deceased at all, at the place of work of Opposite Party Nos. 1 to 3. He shows up on 31.8.90 to get a Fitness Certificate which at the end, say 'he would need prolonged and regular follow-up'. In spite of this, there is no follow-up or visit to Opposite Party Nos. 1 to 3 for any follow-up consultation/check-up/advice. The next time, he gets in touch with Opposite Party No. 2 is on the morning of 9.10.90 wherein he is admitted to the Batra Hospital again having vomited blood earlier. According to Opposite Party No. 2, Shri Sharma had a fall and injured the peri-anal area. On 9.10.90 itself, he referred the case for a surgical reference regarding drainage of peri-anal abscess; but Shri Sharma died even before such treatment could be started. His cause of death is given as 'pyogenic meningitis'.

19. The Complainants has also not been able to establish by any evidence that gluteal abscess was drained in Jodhpur. Essentiality Certificate issued by Prof. Dr. Harban Singh, head of Surgery Department in Medical College Hospital, Jodhpur, who examined the patient and diagonised with gluteal abscess is singularly silent on any incision made to draw out the gluteal abscess. The deceased, at the time of discharge on 23.6.90, was fit to be discharged, though fitted with two tubes/bags and advised follow-up. No follow-up action is taken by the deceased with the Opposite Party No. 3. In her cross-examination, the Complainant says that they did come to Batra Hospital but no record is kept. She did not remember the dates. She does not even remember if she mentioned this in her affidavit. Opposite Party No. 2 denies any such visit made by the deceased except on 31.8.90 for obtaining fitness certificate to join duties.

20. To link in any manner, the unfortunate end to the first surgery is not substantiated especially when there has been a second surgery and there has been a gap of over three months after the discharge from the Opposite Party Nos. 1 to 3, and the death, not to say a gap of over six months between the first surgery to which the Complainant wish to attribute the negligence, and the unfortunate end. There has been a gap of over three months, in which the Opposite Party Nos. 1 to 3 are not in the picture and whereas the deceased visited several other Hospitals.

21. In support of their contentions, the learned Counsel for the Complainant brought to our notice several rulings of the Hon'ble Supreme Court and State Commissions. He relied upon 1998 Supreme Court Case 'Spring Meadows Hospital v. Harjot Ahuliwalia', AIR 1969 SC 123, Laxman v. Trumbak (1996) 2 SC Case 634, Achut Rao v. State of Maharashtra and host of orders of the State Commission of Maharashtra, Bihar, Gujarat. For purposes of facility, we reproduce the relevant extracts relied upon by the Learned Counsel for the Complainant, from the judgments of the Hon'ble Supreme Court only.

22. In the first referred to above, Hon'ble Supreme Court observed:

".....there was a clear dereliction of duty on the part of the nurse who was not even a qualified nurse and the hospital is negligent having employed such unqualified person as nurse and having entrusted a minor child to her care. The Commission also came to the conclusion that Dr. Dhananjay was negligent in the performance of his duties inasmuch as while Dr. Bhutani had advised that the injection should be given by the Doctor but he permitted the nurse to give the injection.

.....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..... an error of judgment would not tantamount to negligence.

23. Lord Fraser pointed out thus:

"The true position is that an error of judgment may or may not be negligent; it depends on the nature of the error. If it is one that would not have been made by a reasonably competent

professional man professing to have the standard and type of skill that the defendant held himself out as having, and acting with ordinary care, then it is negligence. If, on the other hand, it is an error that such a man, acting with ordinary care, might have made, then it is not negligence".

24. In the case of Laxman v. Trimbak Bapu godbole and Anr. -- AIR 1969 SC 128 -- (VOL. 56 C 27), the Hon'ble Supreme Court observed:

"The duties which a doctor owes to his patient are clear. A person who hold himself out ready to give medical advice and treatment impliedly undertakes that he is possessed of skill and knowledge for the purpose. Such a person when consulted by a patient owes him certain duties, viz., a duty of care in deciding whether to undertaken the case, a duty of care in deciding what treatment to give or a duty of care in the administration of that treatment. A breach of any of those duties gives a right of action for negligence to the patient. 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; (of Halsbury's Laws of England, 3rd Ed. Vol.26 p.17).

25. In the case of Achut Rao Haribhau Khodwa v. State of Maharashtra, Hon'ble Supreme court observed:

"A medical practitioner has various duties towards his patient and the must act with a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. This is the least which a patient expects from a doctor. The skill of medical practitioners differes 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 manner which is acceptable to the medical profession and the court finds that he has attended on the patient with due are, skill and diligence and if the patient still doe snot survive or suffers a permanent ailment, it would be difficult to hold the doctor to be guilty of negligence. But it cases where the doctors act carelessly and in a manner which is not expected of a medical practitioner, then in such a case an action in torts would be maintainable. (Paras 15 and 14).

26. On the otherhand, Learned Counsel for the Opposite Party Nos. 1 to 3 relied upon the Halsbury Laws of England Hon'ble Supreme Court's judgment in Laxman v. Trimbak, Achut Rao v. State of Maharashtra, Bolam v. Friern Hospital Management Committee as reported in All England Law Reports, Laws relating to medical practitioner, Roe v. Ministry of Health before the Courts of Appeal (Great Britain) (1954) Vol. II All. E>R. 131, White House v. Jordan and Anr. in the House of Lords, Malione v. Osborne before the King's Bench and Hon'ble Supreme Court's judgment in the State of Haryana v. Santra.

27. For purpose of facility, we rely upon and reproduce below:

Halsbury's Laws of England, Ed.3 -- Vol.26, P.17-18 "22. Negligence: duties owed to patient. A person who holds himself out as ready to give medical (a) advice or treatment impliedly undertakes that he is possessed of skill and knowledge for the purpose. Such a person, whether he is a registered medical practitioner or not, who is consulted by a patient, owes him certain duties, namely, a duty of care in deciding whether to undertake the case; a duty of care in deciding what treatment to give; and a duty of care in his administration of that treatment (b). A breach of any of these duties will support an action for negligence by the patient (c).

23. Degree of skill and care required. 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 (d); 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 (e); 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, although a body of adverse opinion also existed among medical men (f);

28. In Bolan v. Friern Hospital Management Committee (1975) I WLR 582. All ELR. (1957) 2 All ER (Queen's Bench Division - Lord Justice McNair.

"The jury were directed: (i) a doctor is not negligent, if he is acting in accordance with a practice accepted as proper by a reasonable body of medical men skilled in that particular are, merely because there is a body of such opinion that takes a contrary view.

The direction that, where there are two different schools of medial practice, both having recognition among practitioners, it is not negligence for a practitioner to follow one in preference t the other accords also with American law; see 70 Corpus Juris Secundum (1951) 952, 953, para.44. Moreover, it seems that by American law a failure to warn the patient of dangers of treatment is not, of itself, negligence libid. 971, para, 48m).

Lord Justice McNair said: Before I turn that, I must explain what in law we mean by "negligence". In the ordinary case which does not involve any special skill, negligence in law means this: Some failure to do some act which a reasonable man in the circumstances would do, or doing some act which a reasonable man in the circumstances would not do; and if that failure or doing of that act results in injury, then there is a cause of action. How do you test whether this act or failure is negligent? In an ordinary case, it is generally said, that you judge that by the action of the man in the street. He is the ordinary man. In one case it has been said that you judge it by the conduct of the man on the top of a Clapham omnibus. he is the ordinary man. But where you get a situation which involves the sue of some special skill or competence, then the test whether there has been negligence or not is not the test of the man on the top of a Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill 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".

29. I myself would prefer to put it in this way: A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a reasonable body of medical men skilled in that particular art.

30. Medical science has conferred great benefits on mankind, but these benefits are attended by considerable risks. Every surgical operation is attended by risks. Every surgical operation is attended by risks. We cannot take the benefits without taking risks. Every advance in technique is also attended by risks.

31. From Taylor's Principles and Practice of Medical Jurisprudence -- XIII Ed. - Laws relating to medical practice.

32. In Roe Woolley v. The Ministry of Health, Lord Justice Denning said: "it is so easy to be wise after the event and to condemn as negligence that which was only a misadventure.

We ought always to be on our guard against it, especially in cases against hospitals and doctors. Medical science has conferred great benefits on mankind but these benefits are attended by unaboidable risks. Every surgical operation is attended by risks. We cannot take the benefits without taking the risks. Every advance in technique is also attended by risks. Doctors, like the rest of us, have to learn by experience: and experience often teaches in a hard way".

33. It was also observed in the same case that "We must not look at the 1947 accident with 1954 spectacles:". "But we should be doing a disservice to the community at large if we were to impose liability on hospitals and doctors for everthing that happens to go wrong. Doctors would be led to think more of their own safety than of the good of their patients. Initiative would be stifled and confidence shaken. A proper sense of proportion requires us to have regard to the conditions in which hospitals and doctorsk have to work. We must insist on due care for the patient at every point, but we must not condemn as negligence that which is only a misadventure".

34. In white House v. Jordon & Anr. - House of Lords Per Lord Edmund-Davies, Lord Fraser and Lord Russell:

"The test whether a surgeon has been negligent is whether he has failed to measure up in any respect, whether in clinical judgment or otherwise, to the standard of the oridinary skilled surgeon exercising and professing to have the special skill of a surgeon (dictum of McNair Jo. in Bolam v. Friern Hospital Management Committee (1957) 2 All ER 118 at 121).

35. In Chin Keow v. Government of Malaysia (1967) 1 WLR 813: the Privy Council applied these words of McNair J in Bolam V. Friern Hospital Management Committee:

"..... where you get a situation which involves the use of some special skill or competence, then the test as to whether there has been negligence or nor is not the test of the man on the top of a Clapham omnibus because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill".

36. Hon'ble Supreme Court in the case of State of Haryana v. Santra in the matter of negligence relied upon the case of Bolan V Friern Hospital Management Committee and on White House V. Jordan & Anr. and on Halsbury's Laws of England and also on Poonam Verma V Ashwin Patel & Ors. (1996) 4 SCC 332 = AIR 1996 SC 2111, where the question of medical negligence was considered in the context of treatment of a patient, it was observed as under:

"40. Negligence has many manifestations - it may be active negligence, collateral negligence, comparative negligence, concurrent negligence, continued negligence, criminal negligence, gross negligence, hazardous negligence, active and passive negligence, wilful or reckless negligence or Negligence per se which is defined in Black's Law Dictionary as under:-

Negligence per se: Conduct, whether of action or omission, which may be declared and treated as negligence without any argument or proof as to the particular surrounding circumstances, either because it is in violation of a statute or valid municipal ordinance, or because it is so palpably opposed to the dictates of common prudence that it can be said without hesitation or doubt that no careful person would have been guilty of it. As a general rule, the violation of a public duty, enjoined by law for the protection of person or property, so constitutes".

37. It is not the case of the Complainant that Opposite Party No.3 was not qualified to conduct the surgery. Nowhere either in the complaint or in cross-examination of Opposite Party No.3, or at the time of arguments, his competence is challenged. On the contrary, he specialises in Surgical Oncology. Therefore, the judgment "Spring Meadows Hospital v. Harjot Ahluwalia" relied upon by the learned Counsel for the Complainant does not help him. There was no question of lack of qualification on the part of Opposite Party No. 3. He had the skill and knowledge of his specialised subject. His modus-operandi viz-a-viz, the approach adopted by him for the surgery carried out by him on 2.4.90 as well as the follow-up action taken up by him to repair the damage to the body of the pancreas, has been supported by the medical text and the expert witnesses. He cannot be held negligent on this count at all. An analysis of the spirit of other judgments also do not help the Complainant because there has been no error of judgment, dereliction of duty or non-application of reasonable degree of skill.

38. According to Halsbury's Laws of England, 'Negligence' could eminate from any of the following:-

- a duty of care in deciding whether to undertake the case;

- a duty of care in what treatment to give: and

- a duty of care in his administration of that treatment.

39. In the instant case, the investigative tests like CT Throax, Bone Scan and Skeletal Survey confirmed a secreting adrenal tumour suspected to be malignant, the family of the complainant was informed of the need for surgery. Since malignancy was suspected, hence the deceased was operated by Surgical Oncologist. Since Opposite Party Nos. 1 to 3 had the requisite in house facility, they took up the case. It is no one's case that there was anything wrong with that.

40. - While undertaking surgery, which approach should have been adopted would be the issue? According to the complainant, posterior approach should have been adopted. Whereas, in the judgment of the operating surgeion, anterior was the right approach and this is what he did. His approach has been fully backed by the Expert witnesses.

41. - No allegation has bene made by the complainant at all on the 'care' taken by the Opposite Party No.3, for repariring the damage to the body of the pancreas, or, in post-operative stage. Another expert by way of Opposite Party No.4 was associated as early as 28.4.90 and second surgery was carried out on 23.5.90 after and ERCP test on 17.5.90. Expert independent opinion is in 95% cases abscess dried up by itself and he would wait for three to four months before going for ERCP as it has its own dangers. In the instant case, it was done much earlier than that.

42. On all the three parameters, there appears to be no ground for holding Opposite Party Nos. 1 to 3 negligent. The 'key' is that the practitioner must bring to his task a reasonable degree of skill and knowledge. In the instant case, this has not been challenged. On the contrary, the main thrust of the complainant is that, had the 'posterior' approach been adopted, then there would have been no damage to the pancreas. This has neither been substantiated by text absolutely in their favour nor backed by the evidence of Expert Witnesses.

43. In Bolan v. Friern Hospital Mangement Committee, Lord McNair said "..... I myself would prefer to put it this way: A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men in that particular art". In the instant case, expert opinion is in favour of the procedure adopted by Opposite Party No. 3 at the time of Surgery on 2.4.90.

44. The test is the standard of the ordinary skilled man exercising and professing to have that special skill.

45. In Roe and Wooley v. The Ministry of Health, Lord Denning said:

"we should be doing a dis-service to the Community at large if we were to impose liability on Hospitals and Doctors for everything that happens to go wrong".

46. Other rulings and judgments also hold and support this view. It is on these judgments that the Supreme Court has relied to determine negligence or otherwise.

47. Judgment in the case of State of Haryana v. Santra JT 200 (5) SC-34 in the context of, 'Negligence per se', is not applicable in the instant case, as herein, there was no violation of public duty enjoined by law.....".

48. Medical Text produced and evidence adduced does not support the contention of the complainant that 'posterior' approach of the surgery was the only approach or that there is any relationship between the first surgery and gluteal abscess, and pyogenic meningitis which was the cause of the death. On the contrary, there are extenuating circumstances by way of evidence as well

as the fact the acts of omission or commission on the part of Opposite Party Nos. 1 to 3 get mitigated after the second surgery by Opposite Party No.4, against whom the complainat of negligence is dropped. After the discharge of the deceased to 10-20 m1/day, next time, he comes to the Hospital of Opposite Party Nos. 1 and 2, for treatment is only on 9.10.90 i.e. after a gap of over three months. Opposite Party No.3 goes out of the picture after 23.6.90. The deceased comes into contact with Opposite Party No.2 only on 9.10.90 at almost at terminal stage; this is not contested by the complainant. After relinquishing their claim against Opposite Party No.4, the complainants's case rested on establishing with proof, firstly, about negligence on the part of Opposite Party Nos. 1 to 3 at the time of first surgery on 2.4.90 and secondly, the connection/linkage between the first surgery and the cause of the death. In our view, the complainants have failed to prove or substantiate complaints Opposite Party Nos. 1 to 3 on either of these counts. As a result, the complaint against Opposite Party Nos. 1 to 3 of 'negligence' fails and the complainat is dismissed.

49. No order as to costs.