

**IN THE NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION  
NEW DELHI**

**FIRST APPEAL NO 772 of 2017**

**(against the order dated 27.01.2017 passed in CC No. 74/2014 by the  
State Consumer Dispute Redressal Commission, Haryana)**

**Dr. Madhu Gupta (dead) now represented through Legal Representatives  
(Original appellant expired on 21.12.2017 and Legal Representatives were  
impleaded as present appellants vide order dated 27.09.2018)**

**1. Umesh Gupta**

**H/o Dr. Madhu Gupta**

**2.Sajal Gupta**

**S/o Dr. Madhu Gupta**

**3. Garima Gupta**

**D/o Dr. Madhu gupta**

**All residents of Getwell Hospital**

**Opposite Power House**

**Mahendergarh, Narnaul**

**Haryana**

**...Present Appellants**

**V**

**1. Medanta, The Medicity Global Health Private Limited  
Through Dr. Naresh Trehan Chairman and Managing Director  
Sector-38, Gurgaon**

**2. Medanta, Mediclinic**

**Registered Office at 18, Defence colony**

**New Delhi -24**

**Through its Authorized Officer/ Managing Director**

**3. Dr. Ashok Rajgopal**

**Chairman, Knee Unit, Medanta Bone & Joint Institute**

**Medanta, The Medicity**

**Global Health Private Limited,**

**Sector-38, Gurgoan**

**At present-Chairman, Knee & Hip/Sport Injuries**

**Fortis Escorts Heart Institute & Research Centre**

**Okhla Road, New Delhi-110025**

- 4. Dr. Vivek Dahiya, Associate Consultant**  
**Bone & Joint Institute**  
**Medanta, The Medicity**  
**Global Health Private Limited,**  
**Sector-38, Gurgaon**  
**At present-Fortis Escorts Heart Institute & Research Centre**  
**Okhla Road, New Delhi-110025**
- 5. Dr. Saleem Ahmed, Senior Resident**  
**Radiology Medanta, The Medicity**  
**Global Health Private Limited**  
**Sector-38, Gurgaon**  
**At present- City Diagnostics**  
**40/74, Hospital Road, Parade**  
**Kanpur Uttar Pradesh**
- 6. Inderprasath Apollo Hospital**  
**Sarita Vihar, Delhi-Mathura Road**  
**New Delhi**  
**Through Its Director/Authorized Office/Chairman**
- 7. All India Institute of Medical Sciences**  
**Ansari Nagar**  
**New Delhi-110029**  
**Through its director**

**...Respondents**

**HON'BLE DR. INDER JIT SINGH, PRESIDING MEMBER**  
**HON'BLE JUSTICE DR. SUDHIR KUMAR JAIN, MEMBER**

**For present Appellants : Mr. Siddharth Mittal, Advocate**  
**Mr. Sumit Kumar Sharma, Advocate**

**For the Respondents no 1 to 5: Madhukar Pandey, Advocate &**  
**Mr. Umesh Kumar Singh, Advocate**

**For the Respondent no 6: Ms. Rasya Rawal, Advocate (VC)**

**For the Respondent no 7: Mr. Anuj Jain, Advocate (VC)**

**Dated: 25<sup>th</sup> March, 2026**

## ORDER

**DR. SUDHIR KUMAR JAIN, J**

1. Dr. Madhu Gupta/the complainant/the original appellant, now represented through Legal Representatives (hereinafter referred to as **“the appellant”**) was suffering from arthritis since long and in the year 2010 developed problems in knees. The appellant consulted Medanta, The Medicity, Global Health Private Limited/the opposite party no 1/the respondent no.1 (hereinafter referred to as **“the respondent no 1”**) and advised by Dr. Ashok Rajgopal/the opposite party 3/the respondent no. 3(hereinafter referred to as **‘the respondent no 3’**) for knees replacement. The appellant was accordingly admitted in the respondent no 1 on 07.02.2010 and the replacement of the knees was performed in the respondent no 1 with expenditure of Rs.4,00,000/- on treatment. However, there was continuous discharge of fluid (liquid substance) due to the negligence of the doctors from the left knee of appellant after the implantation. The appellant was readmitted in the respondent no 1 on 05.05.2010 where the appellant underwent another surgery which cost approximately Rs.70,000/-. The Discharge Summary mentioned the respondent no 3 as the treating doctor but the surgeries and treatment were actually performed by junior doctors in the presence of the respondent no 3 which was objected by the appellant and her husband i.e. the present appellant no 1. The problem of discharge from the left knee of the appellant continued despite second surgery besides acute pain and instability. The appellant again consulted the doctors of the respondent no 1 and the doctors started treatment of the appellant for tuberculosis without medical examination or confirmed diagnosis.

1.1 The appellant on 14.06.2010 consulted Inderprastha Apollo Hospital/ the opposite party no.6/the respondent No. 6 (hereinafter referred to as **‘the respondent no 6’**) where the doctors intimated her that the appellant was not suffering from tuberculosis and advised her for removal of implantation which

was causing problem to the appellant due to negligence of the treating doctors of the respondent no 1. The doctors at the respondent no 6 also opined that there was acute infection in the implant which was caused due to carelessness of the doctors of the respondent no 1. The appellant was admitted in the respondent no 1 on 26.09.2011 for removal of the infectious implant which was removed with cost of more than Rs.1,00,000/-. The doctors after removal of implant again advised implantation as the implant got infected due to unavoidable circumstances on previous occasion. The appellant again admitted in the respondent no 1 for the revision surgery. The knee of the appellant was still discharging fluid and the appellant due to this reason was sent for biopsy on 20.12.2011 but the wound after biopsy started to bleed. The appellant was discharged from the respondent no 1 and asked to come back after one month. The appellant further incurred expenditure of Rs. 50,000/- on this treatment.

1.2 The appellant due to negligence of the doctors of the respondent no 1 continued to discharge fluid and blood from the knee. The appellant thereafter consulted All India Institute of Medical Sciences/ the opposite party no 7/ the respondent no. 7 (hereinafter referred to as '**the respondent no 7**') in January, 2012 where the doctors performed grafting on the knee and also advised VAC dressing. The appellant spent approximately Rs.1,00,000/-. The discharge after VAC dressing stopped but the appellant was unable to walk properly. The appellant before implantation was able to walk and able to do her routine work besides running hospital. The appellant was forced to close her hospital. The appellant continued to incur additional expenses on follow-up treatment and medicines. The appellant alleged deficiency in service on the part of the respondents and being aggrieved has filed the present consumer complaint bearing C.C. No. 74 of 2014 titled as **Dr.Madhu Gupta V Medanta, The Medicity, Global Health Private Limited & others** before Haryana State Consumer Disputes Redressal Commission at Panchkula (hereinafter referred to

as 'the State Commission') alleging deficiency of service on the part of the respondents. The appellant prayed as under:-

**It is, therefore, respectfully prayed that the present complaint be accepted and the respondent No 1 to 5 be directed to compensate the complainant for their deficiency of service in terms below:-**

- a) A sum of Rs. 10,00,000/- alongwith interest of 18% be awarded in favour of complainant which she has to incurred on her treatment as wrong/negligent/deficient/improper treatment has been given to her by the doctors of Medanta.**
- b) The complainant be awarded another sum of Rs. 10,00,000/- for the physical damages and physical harassment occurred to her due to the negligent and improper treatment given by the doctors of Medanta Hospital.**
- c) The complainant be awarded another sum of Rs. 5,00,000/- for the mental agony suffered by her and her family members during her treatment period as the wrong and negligent treatment was given to her.**
- d) That the complainant be awarded another sum of Rs. 20,00,000/- for the loss of income and status occurred to her as due to the wrong treatment she is unable to practice as a doctor now and she has to close her maternity hospital and due to which he has to suffer a huge financial loss as she was earlier earning handsome amount from her profession.**
- e) The complainant be also awarded a sum of Rs. 2,00,000/- for this force litigation as for the want of proper care or deficient treatment given by the hospital she has to file the present complaint.**
- f) The complainant may also be awarded any another amount or any other relief may also be given to her which this Hon'ble Commission may deem fit and proper in the facts and circumstances of the case.**

2. The respondents except the respondent no 7 filed written statements/reply before the State Commission. The respondents no 1 to 4 in joint reply as reflected from the order passed by the State Commission submitted that the allegations as leveled by the appellant are false and baseless and the appellant was treated as per established and standard medical protocols. The respondents no 1 to 4 in

preliminary objections stated that the appellant was administered treatment at the respondent no 1 as per standard and prevailing medical practices and due care, caution and diligence were exercised in choosing the course of treatment for the appellant. The respondents no 1 to 4 on merits stated that the appellant had visited respondent no. 1 with complaints of pain in her knees and was carrying reports of investigations from outside including X-rays and blood tests reports. The respondent no 3 after examination advised Bilateral Total Knee Replacement (TKR) which was an elective/ planned procedure. The appellant was admitted in the respondent no 1 on 07.02.2010. The left knee of the appellant was more painful in comparison to the right knee. The appellant was on regular medication for hypertension and Rheumatoid Arthritis. The knees after further examinations were found to be severely deformed with dislocation of both patella (knee caps) and it was also revealed knock knee deformity of 10 degrees on the right knee and 20 degrees on the left knee along with gross instability on side-to-side movement of both knees.

**2.1** The appellant was prepared for TKR in view of the diagnosis of advanced degenerative joint disease secondary to Rheumatoid Arthritis of both knees. Thereafter pre-anesthetic check-up including cardiac evaluation was conducted and the requisite clearance was duly obtained. The appellant and her attendants were explained and counseled about the diagnosis, suggested surgery, possible outcomes along with known risks and complications including risks of infection, Pulmonary Embolism (PE), Deep Vein Thrombosis (DVT), Aseptic Loosening. The appellant on 08.02.2010 underwent TKR of both knees under Combined Spinal Epidural (CSE) anesthesia. The respondent no 3 performed the surgery and was assisted by Dr. Vivek Dahiya i.e. the respondent no. 4 and Dr. Himanshu Kochhar. The surgery was performed uneventful and without any complications. The appellant post-operative was received in the ICU at 04.15 pm in a stable and afebrile condition with pulse of 92/min, blood pressure of 160/92 mmHg, and SpO2 at

99%. The appellant was conscious, alert, and following verbal commands and was provided appropriate medications and supportive care. The dressings were changed on the second and fifth post-operative days and the wounds and stitch line were found to be healthy. The appellant commenced walking with support of a walker and wore a knee brace from the third post-operative day. The appellant was discharged on 12.02.2010 in a stable condition with vitals within acceptable range. The appellant at the time of discharge was able to perform Range of Motion (ROM) exercises with active assistance. The appellant's having ROM 0–75 in both knees degrees was able to walk using a walker and assistance and was advised to visit for follow-up on 18.02.2010.

**2.2** The appellant about three months after the surgery on or around 01.05.2010 observed discharge from the left knee surgical site. The appellant visited OPD on 04.05.2010 with a complaint of serous/watery fluid discharge from the left knee for last four days. The appellant on physical examination was found to be afebrile with mild swelling and tenderness around the left knee with no Distal Neuro Vascular Deficit (DNVD). The right knee was found to be healthy with no signs of inflammation. The appellant was admitted in the respondent no 1 on 05.05.2010 for dressing in the operation theatre. The debridement along with change of articular surface was performed by the respondent no. 3 with assistance of the respondent no. 4, Dr. Attique Vasdev and Dr. Vipin Tyagi and the discharge fluid as per standard protocol was sent for culture sensitivity. The procedure was uneventful and the appellant was hemodynamically stable, conscious and oriented post-surgery. The patients who are suffering from Rheumatoid Arthritis and on medication are at an increased risk for the development of deep post-operative infection and the infection rate among such patients being 1.6 times greater than in patients undergoing the same treatment for osteoarthritis. The stitch line at the time of discharge on 07.10.2010 was observed to be healthy and the appellant was discharged in a stable condition on

antibiotics and other supportive medication. The appellant was also advised for continuous exercises, physiotherapy and massage and to visit the respondent no 1 on 15.05.2010. The reports of culture sensitivity of pus and body fluids and histopathology sent on 05.05.2010 were received and findings did not mandate any change in the medication and treatment.

**2.3** The appellant improved after the debridement procedure but again visited the respondent no. 3 on 22.09.2011 with complaints of discharge from the left knee. Thereafter repeat aerobic culture and sensitivity test of pus was conducted and the report dated 25.09.2011 revealed infection with growth of organism *Staphylococcus Aureus* which is sensitive to Rifampicin. The appellant was admitted on 26.09.2011 for Stage-I Revision of the left knee which was performed on 27.09.2011. The surgery was uneventful and the appellant was discharged on 30.09.2011 in good condition. The appellant on 19.12.2011 was admitted for a biopsy of the left knee for assessing the status of infection. The biopsy of the knee along with debridement and change of antibiotic-impregnated cement spacer of the left knee was performed by the respondent no. 3 on 20.12.2011. The procedure was uneventful and the appellant remained stable throughout and was discharged on 21.12.2011 in a stable condition and was asked to follow up in OPD on 27.12.2011. The appellant failed to appear for follow-up appointment and did not visit the respondents no 1 & 3. The respondents no 1 & 4 prayed for dismissal of the complaint.

**3.** The respondent no 5 filed separate written statement/reply wherein denied the contents of the complaint. The respondent no 5 was earlier working as Attending Consultant in Radiology Department of the respondent no 1. The respondent no 5 stated that the appellant neither made any allegation nor alleged deficiency of service/negligence qua the respondent no. 5. The respondent no 5 was not part of the team which operated the appellant. The appellant visited the respondent no 1 with outside investigations including X-ray and blood tests

reports and thereafter the respondent no 3 advised Bilateral Total Knee Replacement (TKR of both knees). The complaint is time barred. The complainant has suppressed the material facts in the complaint which lacks material particulars. The patients who are suffering from Rheumatoid arthritis and on medication for Rheumatoid arthritis are at an increased risk for the development of deep post-operative infection. The opposite party no 5 on reply on merits stated that the appellant was provided with best care and treatment as per established medical practices. The appellant herself was a doctor. The allegations of medical negligence cannot be established merely on allegation of continuous discharge from the knees. TKR surgeries carry a known risk/complication of discharge from surgical site and infection in surgical site. The respondent no 5 denied allegations of deficiency of service or negligence on his part qua the appellant and also denied his liability to pay compensation. It was prayed that the complaint be dismissed.

4. The respondent no. 6 in written statement submitted that the appellant visited the respondent no 6 on 14.06.2010 as an OPD patient for seeking an opinion/treatment where Dr. Yash Gulati, the treating consultant gave his medical opinion based on the history as disclosed by the appellant. Dr. Yash Gulati prescribed treatment accordingly but did not make any remark or statement regarding the treatment provided at the opposite party no 1. The appellant after 14.06.2010 never visited the respondent no 6. The appellant did not make any allegation against the respondent no. 6. The respondent no. 6 prayed for dismissal of the complaint.

5. The respondent no.7 did not file any reply.

6. The appellant examined herself as CW1 and relied on documents Exhibit C1 to C59. The respondents no 1 & 2 tendered affidavit of Dr. Awadhesh Kumar Dubey, Medical Superintendent and authorized representative. The respondents no 3 to 5 have tendered their respective affidavit in evidence.

7. The State Commission after considering rival contentions and arguments of the contesting parties dismissed the complaint by order dated 27.01.2017 (hereinafter referred to as “**the impugned order**”). The State Commission after referring medical literature observed that replacement of knee joints of the appellant was under risk and re-implantation procedure after removal of an infected prosthesis carry a considerable risk of reinfection. The State Commission also observed that the appellant did not cross examined witnesses examined on behalf of the respondents no 1 to 5. The State Commission also opined that the appellant did not lead any expert witness to support her claim and as such claim of the appellant cannot be accepted on basis of bald statement of the appellant. The State Commission believed in evidence and medical literature relied on by the respondents no 1 to 5. The relevant portion of the impugned order is reproduced verbatim herein below:

**27. Undisputedly, the complainant has not led evidence of any expert witness in support of her claim. So, without support of any expert's opinion, the case of the complainant cannot be accepted only on the basis of her bald statement. On the other hand, the opposite parties have produced evidence and medical literature to show that due care and professional skill was exercised by the treating doctors in conducting operations of the complainant. The doctors were well qualified to do the treatment of the complainant and to contradict; no evidence has been led by the complainant. The treating doctor can only treat but cannot guarantee the success of a surgical operation which inevitably is fraught with risks.**

**28. It is equally significant that the complainant also took advice/treatment from other hospitals namely Inderprasath Apollo Hospital, Delhi and All India Institute of Medical Sciences, New Delhi but none of them observed adversely about the choice of treatment or any negligence in the operations.**

**29. In view of the above, this Commission does not think that any case of negligence has been made out by the complainant. The opposite parties have followed the most desirable and expected course of**

**treatment/operation; so they cannot be held liable merely on the allegation of the complainant. Hence, the complaint is dismissed.**

8. The appellant being aggrieved filed present First Appeal bearing F.A. No. 772 of 2017 titled as **Dr. Madhu Gupta V Medanta, The Medicity, Global Health Pvt. Ltd. & others**. The appellant challenged the impugned order primarily on grounds that the impugned order is illegal and against the record. The State Commission erroneously dismissed the complaint on the ground that no expert opinion was submitted by the complainant. The respondent no 3 performed operation in negligent manner and prescribed the medicines for tuberculosis for more than 9 months which is reflective of negligence. The respondent no 3 instead of performing revision surgery performed debridement and change of height. The respondent no 3 should have performed revision injury at earliest. The procedures on the appellant were performed by the junior doctors. The appellant was not given proper opportunity to cross examine the witnesses. The respondents failed to exercise reasonable care qua the appellant. It was prayed that the impugned order be set aside and the complaint be allowed.

9. We have heard Mr. Siddharth Mittal, Advocate and Mr. Sumit Kumar Sharma, Advocate for the present appellants, Mr. Madhukar Pandey, Advocate along with Mr. Umesh Kumar Singh, Advocate for the respondents no.1 to 5, Ms. Rasya Rawal, Advocate for the respondent no.6 and Anuj Jain, Advocate for the respondent no 7. We have also perused the record including impugned order and written submissions submitted on behalf the parties.

10. Mr. Siddharth Mittal, advocate for the appellant/present appellants advanced multifold arguments. Mr. Mittal stated that the State Commission erroneously dismissed the complaint solely on the ground that no expert opinion was placed on record and after referring the decision delivered by the Supreme Court in **V. Krishan Rao V Nikhil Super Specialty Hospital & another, (2010) 5 SCC**

513 argued that expert opinion is not mandatory in all cases of medical negligence and the State Commission should have formed the expert committee to examine medical negligence on the part of the respondents and further argued that the Supreme Court only held that when the case is complicated enough to require an expert's opinion or when the Forum cannot resolve it without such assistance, should expert opinion be insisted upon but the State Commission did not arrive at any such conclusion in the present case.

**10.1** The counsel further contended that the appellant was denied a proper opportunity to cross-examine the witnesses produced by the respondents. It was argued that the evidence by way of affidavit was filed on 23.01.2017 and the impugned order was passed on 27.01.2017 without granting adequate time for cross-examination. The counsel referred decision of the Orissa High Court passed in **Debaraj Sahoo & another V Union of India**, W.P. (C) No. 39597 of 2023 to argue that denial of cross-examination violates the principles of natural justice.

**10.2** The counsel referred doctrine of *res ipsa loquitur* and argued that it is clearly applicable in present case. The negligence is apparent from the facts that there was continuous discharge from the knee of the appellant despite multiple surgeries but the respondent no3 prescribed anti-tubercular medication including rifampicin, AKT, INH 300 mg and ethambutol for over nine months without any confirmed diagnosis of tuberculosis which is a clear case of negligence and aggravated physical condition of the appellant. The respondents and in particular the respondent no 3 are guilty of breach of care and did not address actual medical condition of the appellant. The counsel for the present appellants also referred medical literature on the toxic ocular effects of Ethambutol to show the potential for serious harm and also placed reliance on **Spring Meadows Hospital V Harjot Ahluwalia**, (1998) 4 SCC 39 and **Savita Garg V Director, National Heart Institute**, (2004) Supp. 5 S.C.R. 359.

11. The counsel for respondents no 1 to 5 advanced detailed arguments and also submitted comprehensive written arguments. It was stated that the appellant visited the respondent no 1 with complaint of pain in both knees and was advised Bilateral Total Knee Replacement (TKR of both knees) by the respondent no 3. The appellant was known case of hypertension and Rheumatoid arthritis. The appellant was admitted in the respondent no 1 on 07.02.2010 and was prepared for TKR in view of the diagnosis of advanced degenerative joint disease secondary to rheumatoid arthritis of both knees and was also explained diagnosis, suggested surgery and risk including risk of infection. It was further stated that the appellant underwent TKR of both knees on 08.02.2010 under Combined Spinal Epidural which was performed by the respondent no 3 with assistance of the respondent no 4 and Dr. Himanshu Kochchar. The appellant post-operation was stable and showed sign of improvement. The appellant was discharged on 12.02.2010 as post-operative period was uneventful. The appellant was advised to visit the respondent no 1 on 18.02.2010 for follow up advice and at that time the appellant was afebrile, healthy and the investigation did not reveal any infection. The appellant was actively walking with a walker with a good range of motion in her knees which indicated that the appellant was not having any infection.

The counsel for the respondents no 1 to 5 further stated that the appellant observed some discharge from left knee surgical side on or around 01.05.2010 and was admitted in the respondent no 1 on 05.05.2010 with complaint of serous/watery fluid discharge from left knee. The appellant was afebrile with mild swelling and tenderness around left knee. The appellant on 05.05.2010 was subjected to dressing in Operation Theater (OT). It was further stated that the appellant was explained and counselled that discharge and infection are known complications after TKR.

11.1 The counsel for the respondents no 1 to 5 in background of above stated facts argued that it is medically known that TKR (Total Knee Replacement) surgeries carry a known risk/complication of discharge from surgical side and infection in surgical site. The counsel for the respondents no 1 to 5 after referring medical literature as detailed in written arguments argued that patients who are suffering from Rheumatoid arthritis and on medication for Rheumatoid arthritis are at an increased risk for development of deep post-operative infection. It was further argued that the appellant was suffering from Rheumatoid arthritis and was on medication for Rheumatoid arthritis and accordingly the appellant was explained in detail about known risk of infection prior to surgery on 08.02.1010. It was further argued that the appellant after debridement procedure was kept on adequate coverage of IV antibiotics as per standard medical practice. The stitch line at the time of discharged on 07.05.2010 was observed to be healthy and the appellant was discharged in stable condition on antibiotics. The appellant was advised to visit to the Orthopedic OPD of the respondent no 1 on 15.05.2010 for review. The counsel for the respondents no 1 to 5 in respect of medicine Rifampicin argued that Rifampicin is a broad spectrum antibiotic administered in cases of post TKR infection with growth of Staphylococcus and Rifampicin in combination of other antibiotics is very effective for the treatment of Staphylococcus prosthetic joint infection. It is vehemently argued that Rifampicin is not only a TB drug. The counsel further referred Aerobic culture and sensitivity of Pus Report dated 07.05.2010 and Aerobic culture and sensitivity of Body Fluid Report dated 08.05.2010 which confirmed infection with growth of Coagulase negative Staphylococcus which is sensitive to Rifampicin. The Excision Biopsy Report dated 11.05.2010 also indicated infection. However these Reports did not mandate change in medication and treatment which were advised to the appellant at the time of discharge.

**11.2** The Counsel also stated that the appellant visited the respondent no 6 for further consultation and treatment on 14.06.2010 where the doctors advised the appellant to continue with same treatment and did not discontinue Rifampicin which confirmed that administration of Rifampicin was correct method of treatment. The doctors of the respondent no 6 continued with the treatment prescribed by the respondent no 3. The appellant was also advised to undergo removal of implant which was also prescribed by the respondent no 3. The counsel after referring relevant medical literature argued that as per accepted medical procedure where the patient post TKR suffers from acute infection in surgical site then the surgical site is dressed (open debridement and change of articular surface i.e. through cleaning of the joint and changing of plastic spencer) and thereafter the patient is put on broad spectrum antibiotic coverage pending receipt of culture report. It was further argued that as per accepted medical practice that where the infection in the surgical site persists and cannot be controlled even after debridement procedure, adequate antibiotics and supportive measures then the implant is removed and a thorough cleaning up of the joint is done. The counsel for the respondents no 1 to 5 vehemently argued that course of treatment which was followed in case of the appellant was not negligent but as per medical protocol.

**11.3** It was further stated that the appellant again visited the respondent no 1 on 22.09.2011 with complaints of discharge from the left knee and repeat Aerobic culture and sensitivity of Pus was conducted and Report dated 25.09.2011 revealed infection with growth of organism Staphylococcus Aureus and said organism is found to be sensitive to Rifampicin. The appellant was admitted under the respondent no 3 on 26.09.2011 for Stage-1 Revision of left knee as per medical procedure. The appellant after counselling gave informed consent which was conducted on 27.09.2011 by the respondent no 3 along with his team. The left knee joint was opened, implant was removed and thoroughly

washed/cleaned with sterile saline to remove infected tissues and antibiotic impregnated cement spacer was implanted. The appellant post-surgery was stable and at time of discharge on 30.09.2011 was on non-weight bearing walker aided ambulation and chair sitting and put on appropriate medicines including Rifampicin. It was further argued that the appellant was admitted for biopsy of the left knee to assess status of infection which was performed on 20.12.2011 along with debridement and change of antibiotic impregnated cement spacer by the respondent no 3 assisted by Dr. Attique Vasdev. The appellant was discharged on 21.12.2011 in stable condition and thereafter the appellant did not visit to the respondent no. 3. The appellant was provided with best possible treatment by experienced and qualified doctors with highest standard of care. The counsel emphatically denied allegations of medical negligence. The counsel for the respondents no 1 to 5 also refuted other allegations of the appellant and countered the arguments advanced on behalf of the present appellants.

**11.4** The counsel for the respondents no 1 to 5 also made legal submissions argued that every medical procedure is associated with known complications and if these complications occur during medical procedure then it is not medical negligence. It was also argued that the present appellants failed to discharge burden of proof of medical negligence on the part of the respondents and the present appellants did not lead any expert evidence to substantiate allegation of medical negligence. The counsel ultimately argued that the present first appeal be dismissed and cited **Aruna Trikha V Sehra Medical Centre**, I (2002) CPJ 75 (NC); **Dr. Anupama Nigam V Manish Kumar Sharma & others** , III (2015) CPJ 146 (NC); **Tilat Chaudhry & another V All India Institute of Medical Sciences & another** , IV (2012) CPJ 610 (NC); **Dr. C.P. Sreekumar V S. Ramanujam**, II (2009) CPJ 48 (SC); **Dr. Harkanwaljit Singh Saini V Gurbax Singh & another**; I (2003) CPJ 153 (NC); **Phillips India Ltd. V**

**Kunju Punnu and another**; AIR 1975 BOM 306; **Senthil Scan Centre V Shanthi Sridharan and another**, (2010) 15 SCC 193; **Nalini V Manipal Hospital & another**, IV (2011) CPJ 280 (NC); **Sukumari Sahu V Tata Memorial Hospital**, 3(2006) CPJ 293 (NC) besides other decisions rendered by the Superior Courts.

12. The counsel for respondent no. 6 argued that the present appeal against the respondent no 6 is baseless and deserves to be dismissed. The appellant did not make any allegation against the respondent no. 6 and as such no cause of action has accrued against the respondent no. 6. There was no negligence and deficiency in service on the part of the respondent no 6 qua the appellant. The appellant visited the respondent no 6 on 14.06.2010 as an OPD patient for seeking opinion/treatment and the treating consultant Dr. Yash Gulati did not make any remark or statement pertaining to the treatment given to the appellant at the respondent no 1. The present appeal against respondent no. 6 is an abuse of the process of law and is liable to be dismissed. The counsel relied on **Ravneet Singh Bagga V KLM Royal Dutch Airlines**, (2000) 1 SCC 66 to emphasize that the burden of proving deficiency in service is on the person who alleges it.

13. The counsel for respondent no. 7 argued that the appellant was provided best possible treatment and underwent the necessary procedure (debridement + cement spacer removal + SSG) as per standard protocol on 14.03.2012. The appellant was discharged on 24.03.2012 and advised to follow up in OPD. The appellant did not turn for follow up action. It was argued that no specific allegations of negligence were made against the respondent no. 7 and the present appeal against respondent no. 7 is liable to be dismissed.

14. It is relevant to refer relevant judicial pronouncement pertaining to medical negligence. The negligence comprises three important constituents which are i) a legal duty to exercise due care, ii) breach of the duty and iii) consequential

damages and medical negligence can be explained as a want of reasonable degree of care or skill or willful negligence on the part of the medical practitioner in the treatment of a patient with whom a relationship of professional attendant is established, so as to lead to bodily injury or to loss of life. The absence or lack of care that a reasonable person should have taken in the circumstance of the case is held to be negligent. The basic principle relating to negligence by professionals is known as the **Bolam Rule** which was laid down in **Bolam V Friern Hospital Management Committee, (1957) 1 WLR 582** as under:-

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

14.1 The Supreme Court of India also considered the magnitude of medical negligence in various pronouncements. The Supreme Court in an action for negligence in tort against a surgeon in **Laxman Balakrishna Joshi V Trimbak Bapu Godbole & another, 1969 (1) SCR 206** held that the duties which a doctor owes to his patient are clear and a person who holds himself out ready to give medical advice and treatment impliedly undertakes that he is possessed of skill and knowledge for the purpose. It was further held that such a person when consulted by a patient owes him certain duties which are a duty of care in deciding whether to undertake the case, a duty of care in deciding what treatment to give or a duty of care in the administration of that treatment and a breach of any of those duties gives a right of action for negligence to the patient. It was also held that the practitioner must bring to his task a reasonable degree

of skill and knowledge and must exercise a reasonable degree of care. The relationship between a medical practitioner and a patient carries within it certain degree of mutual confidence and trust. The Supreme Court also observed that section 14 of the Act indicates that the reliefs that can be granted on a complaint filed under the Act in respect of deficiency in service and the compensation can be awarded for loss or injury suffered by the consumer due to the negligence of the opposite party including medical negligence.

**14.2** The Supreme Court in **Achutrao Haribhau Khodwa V State of Maharashtra and others**, (1996) 2 SCC 634 held as under:-

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

**14.3** The Supreme Court in **Jacob Mathew V State of Punjab** extensively discussed negligence by professionals including doctors. The Supreme Court observed as under:-

**In the law of negligence, professionals such as lawyers, doctors, architects and others are included in the category of persons professing some special skill or skilled persons generally. Any task which is required to be performed with a special skill would generally be admitted or undertaken to be performed only if the person possesses the requisite skill for performing that task. Any reasonable man entering into a profession which requires a particular level of learning to be called a professional of that branch, impliedly assures the person dealing with him that the skill which he professes to possess shall be exercised and exercised with reasonable degree of care and caution. He does not assure his client of the result. A lawyer**

does not tell his client that the client shall win the case in all circumstances. A physician would not assure the patient of full recovery in every case. A surgeon cannot and does not guarantee that the result of surgery would invariably be beneficial, much less to the extent of 100% for the person operated on. The only assurance which such a professional can give or can be understood to have given by implication is that he is possessed of the requisite skill in that branch of profession which he is practising and while undertaking the performance of the task entrusted to him he would be exercising his skill with reasonable competence. This is all what the person approaching the professional can expect. Judged by this standard, a professional may be held liable for negligence on one of two findings: either he was not possessed of the requisite skill which he professed to have possessed, or, he did not exercise, with reasonable competence in the given case, the skill which he did possess. The standard to be applied for judging, whether the person charged has been negligent or not, would be that of an ordinary competent person exercising ordinary skill in that profession. It is not necessary for every professional to possess the highest level of expertise in that branch which he practices.

14.4 The Supreme Court also referred **Bolam** case and stated that it is cited and dealt with in several judicial pronouncements. It was observed that the classical statement of law in **Bolam's** case has been widely accepted as decisive of the standard of care required both of professional men generally and medical practitioners in particular. It has been applied to as touchstone to test the pleas of medical negligence. 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 a defendant charged with negligence acted in accord with the general and approved practice is enough to clear him of the charge. The Supreme Court further observed that a mere deviation from normal professional practice is not necessarily evidence of negligence. An error of judgment on the part of a professional is not negligence per se. The medical professional is often called upon to adopt a procedure which involves higher element of risk, but which he honestly believes as providing greater chances of success for the patient rather

than a procedure involving lesser risk but higher chances of failure. It was also observed that no sensible professional would intentionally commit an act or omission which would result in loss or injury to the patient as the professional reputation of the person is at stake. A single failure may cost him dear in his career.

**14.5** The Supreme Court also discussed rule of *res ipsa loquitur* and stated that it is not of universal application and has to be applied with extreme care and caution to the cases of professional negligence and in particular that of the doctors otherwise it would be counter-productive. The doctor cannot be held liable by applying doctrine of *res ipsa loquitur* because a patient has not favourably responded to a treatment given by a physician or a surgery has failed. The Supreme Court has summed up the 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 human affairs would do, or doing something which a prudent and reasonable man would not do.....Negligence becomes actionable on account of injury resulting from the act or omission amounting to negligence attributable to the person sued. The essential components of negligence are three: 'duty', 'breach' and 'resulting damage'.**

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

found to be sufficient; a failure to use special or extraordinary precautions which might have prevented the particular happening cannot be the standard for judging the alleged negligence. So also, the standard of care, while assessing the practice as adopted, is judged in the light of knowledge available at the time of the incident, and not at the date of trial. Similarly, when the charge of negligence arises out of failure to use some particular equipment, the charge would fail if the equipment was not generally available at that particular time (that is, the time of the incident) at which it is suggested it should have been used.

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

(4) The test for determining medical negligence as laid down in Bolam's case [1957] 1 W.L.R. 582, 586 holds good in its applicability in India.

14.6 The Supreme Court in **Neeraj Sud & another V Jaswinder Singh (minor) & another**, Civil Appeal No 272 of 2012 decided on 25.01.2024 after referring **Bolam** case and **Jacob Mathews V State of Punjab** in context to medical negligence held as under:-

11. Deterioration of the condition of the patient post-surgery is not necessarily indicative or suggestive of the fact that the surgery performed or the treatment given to the patient was not proper or inappropriate or that there was some negligence in administering the same. In case of surgery or such treatment it is not necessary that in every case the condition of the patient would improve and the surgery is successful to the satisfaction of the patient. It is very much possible that in some rare cases complications of such nature arise but that by

itself does not establish any actionable negligence on part of the medical expert.

14. It is well recognized that actionable negligence in context of medical profession involves three constituents (i) duty to exercise due care; (ii) breach of duty and (iii) consequential damage. However, a simple lack of care, an error of judgment or an accident is not sufficient proof of negligence on part of the medical professional so long as the doctor follows the acceptable practice of the medical profession in discharge of his duties. He cannot be held liable for negligence merely because a better alternative treatment or course of treatment was available or that more skilled doctors were there who could have administered better treatment.

15. A medical professional may be held liable for negligence only when he is not possessed with the requisite qualification or skill or when he fails to exercise reasonable skill which he possesses in giving the treatment. None of the above two essential conditions for establishing negligence stand satisfied in the case at hand as no evidence was brought on record to prove that Dr. Neeraj Sud had not exercised due diligence, care or skill which he possessed in operating the patient and giving treatment to him.

16. When reasonable care, expected of the medical professional, is extended or rendered to the patient unless contrary is proved, it would not be a case for actionable negligence. In a celebrated and very often cited decision in *Bolam v. Friern Hospital Management Committee (Queen's Bench Division)*<sup>3</sup>, it was observed that a doctor is not negligent if he is acting in accordance with the acceptable norms of practice unless there is evidence of a medical body of skilled persons in the field opining that the accepted principles/procedure were not followed. The test so laid down popularly came to be known as *Bolam's test* and stands approved by the Supreme Court in *Jacob Mathews v. State of Punjab and Another*.

17. In *Jacob Mathews (supra)* this Court held that a professional may be held liable for negligence if he is not possessed of the requisite skill which he supposes to have or has failed to exercise the same with reasonable competence.

18. In other words, simply for the reason that the patient has not responded favourably to the surgery or the treatment administered by a doctor or that the surgery has failed, the doctor cannot be held

**liable for medical negligence straightway by applying the doctrine of *Res Ipsa Loquitor* unless it is established by evidence that the doctor failed to exercise the due skill possessed by him in discharging of his duties.**

14.7 The Supreme Court in **Kusum Sharma V Batra Hospital**, (2010) CPJ 29 (SC) observed that medical science has conferred great benefits on mankind but these benefits are attended by considerable risks. Every surgical operation is attended by risks. It was further observed that the professional should be held liable for his act or omission, if negligent, is to make life safer and to eliminate the possibility of recurrence of negligence in future but at the same time courts have to be extremely careful to ensure that unnecessarily professionals are not harassed and they will not be able to carry out their professional duties without fear. The Supreme Court in **Martin F. D'Souza V Mohd. Ishfaq**, (2009) 3 SCC 1 observed that 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 straightway 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. It was also observed in this case that a medical practitioner is not liable to be held negligent simply because things went wrong from mischance or misadventure or through an error of judgment in choosing one reasonable course of treatment in preference to another. He would be liable only where his conduct fell below that of the standards of a reasonably competent practitioner in his field.

14.8 The Supreme Court in **Deep Nursing Home and another V Manmeet Singh Mattewal and others**, 2025 SCC OnLine SC1934 which is also referred by the counsel for the complainant, after referring **Jacob Mathew V State of Punjab** and **Martin F. D'Souza V Mohd. Ishfaq** observed as under:-

23. As pointed out in **Jacob Mathew vs. State of Punjab** and another<sup>6</sup>, simply because a patient did not favourably respond to the treatment given by a physician or if a surgery failed, the doctor cannot be held liable per se by applying the doctrine of *res ipsa loquitur*. This edict was reiterated in **Martin F. D'Souza vs. Mohd. Ishfaq** wherein, it was pointed out that no sensible professional would intentionally commit an act or omission which would result in harm or injury to a patient as the reputation of that professional would be at stake and a single failure may cost him or her dear in that lapse. It was also pointed out that sometimes, despite best efforts, the treatment by a doctor may fail but that does not mean that the doctor or surgeon must be held guilty of medical negligence, unless there is some strong evidence to suggest that he or she is. It was also pointed out that Courts and Consumer Fora are not experts in medical science and must not substitute their own views over that of specialists. While acknowledging that the medical profession had been commercialised to some extent and there were doctors who depart from their Hippocratic Oath for their selfish ends of making money, this Court held that the entire medical fraternity cannot be blamed or branded as lacking in integrity or competence just because of some bad apples.

24. On the same lines, in **Devarakonda Surya Sessa Mani and others vs. Care Hospital, Institute of Medical Sciences and others**, 2022 SCC OnLine SC 1608 it was held that unless a complainant is able to establish a specific course of conduct, suggesting a lack of due medical attention and care, it would not be possible for the Court to second-guess the medical judgment of the doctor on the line of treatment which was administered and, in the absence of such material disclosing medical negligence, the Court cannot form a view at variance, as every death in the institutionalised environment of a hospital does not necessarily amount to medical negligence on a hypothetical assumption of lack of due medical care.

14.9 The Supreme Court in **Jyoti Devi V Suket Hospital**, (2024) 8 SCC 655 observed as under:-

#### **The Law on Medical Negligence**

13. Three factors required to prove medical negligence, as recently observed by this Court in **M.A Biviji v. Sunita**, (2024) 2 SCC 242 following the landmark pronouncement in **Jacob Matthew v. State of Punjab**<sup>9</sup> are:

37. As can be culled out from above, the three essential ingredients in determining an act of medical negligence are:

- (1) a duty of care extended to the complainant,
- (2) breach of that duty of care, and
- (3) resulting damage, injury or harm caused to the complainant attributable to the said breach of duty.

However, a medical practitioner will be held liable for negligence only in circumstances when their conduct falls below the standards of a reasonably competent practitioner.”

14. To hold a doctor liable, this Court in *Dr. Mrs. Chanda Rani Akhoury v. Dr. M.A. Methusethupathi* observed:

“31.... a medical practitioner is not to be held liable simply because things went wrong from mischance or misadventure or through an error of judgment in choosing one reasonable course of treatment in preference to another. In the practice of medicine, there could be varying approaches of treatment. There could be a genuine difference of opinion. However, while adopting a course of treatment, the duty cast upon the medical practitioner is that he must ensure that the medical protocol being followed by him is to the best of his skill and with competence at his command. At the given time, medical practitioner would be liable only where his conduct fell below that of the standards of a reasonably competent practitioner in his field.”

(Emphasis supplied)

15. Observations in *Harish Kumar Khurana v. Joginder Singh*, (2011)10SCC291 are also instructive. Bopanna J., writing for the Court held:

11. “...It is necessary that the hospital and the doctors are required to exercise sufficient care in treating the patient in all circumstances. However, in unfortunate cases, though death may occur and if it is alleged to be due to medical negligence and a claim in that regard is made, it is necessary that sufficient material or medical evidence should be available before the adjudicating authority to arrive at a conclusion.”

(Emphasis supplied)

15. We shall examine the rival contentions and arguments of the appellant/present appellants and the respondents. The appellant attacked the impugned order passed by the State Commission by primarily pleading that it was illegal, arbitrary and contrary to facts and evidence on record. The counsel for the appellant/present appellant empathetically argued that expert opinion to substantiate medical negligence is not always required and the State Commission erroneously held about necessity of expert opinion to substantiate medical negligence on part of the respondent no 3 qua the appellant. It was also contended and argued on behalf of the appellant/the present appellants that the respondent no 3 prescribed anti-tubercular medications including rifampicin, AKT, INH 300mg and ethambutol to the appellant for nine months but there was no diagnosis of confirmed tuberculosis in the appellant which reflected beyond doubt medical negligence on the part of the respondent no 3 besides duty to take care. The counsel for the appellant/present appellants after referring doctrine of *res ipsa loquiter* argued that the respondent no 3 did not adequately address the post-operative complications in the appellant and deteriorating condition of the appellant was not properly managed.

16. The issue which needs consideration in the light of the contentions and arguments raised on behalf of the appellant/present appellants is that whether the respondents and in particular the respondent no 3 has committed medical negligence and breached the duty to take care during the treatment of the appellant. It is required to appreciate issue of medical negligence on the part of the respondent no 3 in particular qua the appellant to refer contentions of the respondents and medical documents/records prepared during the treatment of the appellant.

17. It is reflecting that the appellant was having past history of hypertension and Rheumatoid arthritis and was on medication for these diseases. The appellant was admitted in the respondent no 1 on 07.02.2010 with complaint of

pain in both knees and was treated by the respondent no 3. The left knee was more painful in comparison to the right knee. The respondent no 3 on basis of investigation advised Bilateral Total Knee Replacement (TKR of both knees). The counsel for the respondents no 1 to 5 after referring article titled as **Total Knee Arthroplasty in Rheumatoid Arthritis** authored by Jin Kyu Lee and Choong Hyeok Choi (Knee Surg Relat Res, Vol 24, No.1, Mar 2012) argued that in advanced disease when synovectomy is of no benefit, total knee arthroplasty (TKA) has proven to be most successful intervention that reduces knee pain and improves physical function in RA patients. It is also argued that TKR as advised by the respondent no 3 was right and appropriate treatment for the appellant. It is established from above article that the medical treatment i.e. TKR as suggested by the respondent no 3 after investigation was the right and appropriate procedure for the treatment of the appellant. It was further reported in the above article that TKA has been established as one of the most successful surgical interventions for reducing pain and enhancing physical function in RA patients. It was further mentioned that despite such complexities often encountered in RA patients, a well-timed, well executed TKA has been proven to improve overall function and quality of life of patients with disabling RA of the Knee. It is worth mentioning here that the appellant herself was a BAMS doctor and did not raise any objection for TKR as suggested and advised by the respondent no 3. We are in agreement with argument advanced by the counsel for the respondents no 1 to 5 that the respondent no 3 adopted appropriate procedure as per medical protocol in the treatment of the appellant. The appellant was discharged from the respondent no 1 on 12.05.2010.

**18.** The appellant as per Discharge Summary on basis of investigation was diagnosed with advanced degenerative joint disease secondary to Rheumatoid arthritis of both knees. The both knees of the appellant were observed to be severely deformed with both patellas (knee caps) dislocated. The pre-operative

examination also revealed knock knee deformity of 10 degrees on right knee and 20 degree on the left knee along with gross instability on both side to side movements of both knees. The Discharge Summary further reveals that Bilateral Total Knee Arthroplasty on the appellant was performed on 08.02.2010 under CSE (Combined Spinal Epidural) and after requisite anesthesia and cardiology clearance. The appellant as per Consent Form was explained and counselled about the diagnosis, suggested surgery, possible outcomes besides known benefits, risks and complications including risk of infection, PE (Pulmonary Embolism), DVT (Deep Vein Thrombosis), Aseptic Loosening etc. The appellant as per Discharge Summary tolerated the surgery and dressing was changed on second and fifth post-operative day. The stitch line was found to be healthy. The appellant at the time of discharge was able to do Range of Motion (ROM) exercises and her Rom in the knees was 0-75 degree B/L. The appellant was walking with the support of walker wearing knee braces on third post-operative day. The appellant at the time of discharge was also prescribed physiotherapy and requisite medicines. The appellant was advised to visit in Orthopedic OPD for review on 18.02.2010. The Discharge Summary further reflected and also submitted on behalf of the respondents no 1 to 5 that the appellant at time of discharge was not put on any antibiotic and TLC was normal indicating no infection in the appellant. The perusal of the Discharge Summary reflects that the appellant was subjected to the treatment as per established medical procedure and protocols and was not having any problem at the time of discharge from the respondent no. 1 on 12.02.2010. There is no evidence to establish that the respondent no 3 and his team was negligent in performing TKR on the appellant on 08.02.2010 and the respondent no 1 breached duty to take post-operative care of the appellant.

**19.** It is also reflecting that the appellant experienced some discharge from left knee surgical site and was readmitted in the respondent no 1 on 05.05.2010 with

complaint of serous/watery fluid discharge. The appellant on examination as per In-Patient and Physical Record, and Progress Sheet was found to be afebrile (without fever) with mild swelling, serous discharge and tenderness around left knee. There was no DNVD (Distal Neuro Vascular Deficit). The right knee of the appellant was found to be healthy and sutures were healed besides no sign of inflammation. The appellant as such was having problem only in left knee post operation. The appellant as per Discharge Summary was admitted in the respondent no 1 on 05.05.2010 for dressing in OT (debridement and change of articular surface) under the supervision of the respondent no 3. The appellant and her attendant stated to have been explained about discharge and infection as known complications post TKR. The respondent no 3 after informed consent of the appellant did procedure of debridement and change of articular surface i.e. surgery for thoroughly cleaning of the joint and changing of the plastic spacer which was uneventful. The Discharge Summary also reveals that the appellant was prescribed IV Fluids, analgesic, antibiotics and physiotherapy as treatment. The appellant tolerated surgery and dressings were changed on second day. The Stitch line was found to be healthy and the appellant was stable at the time of discharge on 07.05.2010. The discharge fluid was also sent for culture and sensitivity. PCR for mycobacterium tuberculosis and histopathology report were awaited at time of discharge. It is also worth mentioning here that the appellant was prescribed antibiotics such as Inj. Magnex, Tab. Ofloxacin and Tab. Rifampicin besides other supporting medicines.

20. The Aerobic culture and sensitivity of pus and Aerobic culture and sensitivity of body fluids Reports confirmed infection with growth of Coagulase negative Staphylococcus and said organism is sensitive to Rifampicin. The Excision Biopsy Report dated 11.05.2010 also indicated infection. The counsel for the respondents no 1 to 5 argued that TKR surgery carries a known risk/complication of discharge from surgical site and infection in surgical site

and further patients who are suffering from Rheumatoid arthritis and on medication for this are at an increased risk for the development of post-operative infection. It was also stated that infection rate among Rheumatoid arthritis patients is 1.6 greater than in the patients undergoing treatment for osteoarthritis. The counsel again referred article **Total Knee Arthroplasty in Rheumatoid Arthritis** to substantiate said argument and contention. The relevant part of the said article for sake of reference is reproduced as under:-

**Complications after TKA can be more frequent and serious in RA patient than OA patient because of poor healing nature of soft tissue, higher rate of deep wound infection, severe preoperative joint deformity and laxity, poor bone stock and involvement of other multiple joints precluding adequate rehabilitation. The most important complication affecting the results of TKA in RA patients could be deep wound infection. Rates of infection have been reported to be three times higher in RA patients compared to OA patients.**

20.1 It is established that Rheumatoid arthritis patients who are also on medication are more prone to infection after TKR (TKA). In present case the appellant was suffering from Rheumatoid arthritis and was on medication for Rheumatoid arthritis and as such the appellant was under high risk of infection after TKR. There is force in the argument as mentioned herein above and we are in agreement with said argument advanced by the counsel for the respondents no 1 to 5.

21. It is also appearing that the appellant on 14.06.2010 visited the respondent no 6 for further treatment and consultation where the appellant was consulted by Dr. Yash Gulati, Joint Replacement & Spine Surgeon, Orthopedic Surgery. Dr. Yash Gulati did not recommend change of Tab. Rifampicin but advised for removal of implant. The prescription of Dr. Yash Gulati from the respondent no 6 did not reflect any medical negligence on the part of the respondent no 3 in the treatment of the appellant.

22. The appellant again visited the respondent no 3 on 22.09.2011 with complaints of discharge from left knee and Aerobic culture and sensitivity of Pus was repeated. The culture & sensitivity Report dated 25.09.2011 revealed infection with growth of organism Staphylococcus Aureus and said organism was found to be sensitive to Rifampicin. The appellant accordingly was admitted in the respondent no 1 under the respondent no 3 for Stage-1 Revision of left knee. The Discharge Summary reflects that the respondent no 3 performed Stage-1 Revision on 27.09.2011 whereby implant was removed after opening of knee joint and joint was thoroughly washed/cleaned with sterile saline to remove all infected tissues and antibiotic impregnated cement spacer was implanted. The surgery was stated to be uneventful and tissue from infected site was taken for histopathological examination as per standard protocol to ascertain cause of infection. The appellant at time of discharge was on Non-weight bearing (NWB) walker aided ambulation and chair sitting. The appellant was also prescribed appropriate supportive medicines including Rifampicin. The appellant was advised to visit the respondent no 1 on 07.10.2011 for review. The appellant was again admitted in the respondent no 1 on 19.12.2011 for biopsy of the left knee to assess the status of infection in the joint as ESR (Erythrocyte Sedimentation Rate) and CRP (C-Reactive Protein) were not reducing in serial measurement. The respondent no 3 on 20.12.2011 performed biopsy of knee along with debridement and change of antibiotic impregnated cement spacer and tissue and frank pus from the joint as per standard medical protocol were sent for histopathological and culture and sensitivity. The appellant was discharged from the respondent no 1 on 21.12.2011 with medication prescription and thereafter the appellant did not visit the respondent no 1 or the respondent no 3.

23. The counsel for the respondents no 1 to 5 argued that if a patient post TKR suffers from acute infection in surgical site then the surgical site is dressed i.e.

open debridement and change of articular surface (thorough cleaning of the joint and changing of the plastic spacer) and the patient is then put on broad spectrum antibiotic coverage and antibiotic coverage may be modified on basis of culture report. It was further stated that as per settled medical practices if the infection still persists in the surgical site then the implant is removed with thorough cleaning up of the joint. The counsel referred article titles as **“Revision of Infected Total Knee Arthroplasty: Two-Stage Reimplantation Using an Antibiotic-Static Spacer”** authored by Antinio Silvestre, Fernando Almeida, Pablo Renovell, Elena Morante and Raul Lopez and published in Journal Clinics in Orthopedic Surgery, 2013. The perusal of said article reflects that two stage re-implantation is gold standard treatment for long lasting infection of Total Knee Arthroplasty i.e. TKA (TKR) and the technique of placing an antibiotic impregnated cement block after debridement and removal of the infected prostheses is being employed to chronically infected cases routinely with good results. It is also mentioned that said procedure is the best option to manage chronically infected knee prosthesis. It is further mentioned that first stage operation included surgical debridement, total synovectomy and removal of all the previous implants and cement and an antibiotic impregnated cement block be placed in the articular space. A follow-up is to be done after six weeks of surgery with a new assessment of ESR and CRP. The second stage surgery should not be undertaken until knees are free of any sign of clinical infection and the patient has normal ESR and CRP values. In the present case the respondent no 3 performed Stage -1 revision as per established medical procedure and protocols but raised level of ESR and CRP was found. The respondent no 3 performed the Stage-1 revision surgery as per settled medical norms and no medical negligence can be attributed to the respondent no 3 in the treatment of the appellatant.

24. We shall now consider the argument advanced by the counsel for the appellant/present appellants that the respondent no 3 prescribed anti-tubercular medicines including Rifampicin, AKT, INH 300 mg and ethambutol but without diagnosis of tuberculosis. The counsel for the respondents no 1 to 5 argued that Rifampicin is a broad spectrum antibiotic administered in cases of post TKR infection with growth of Staphylococcus in combination with other drugs and is very effective. It is also argued that Rifampicin is not only a TB drug. The counsel for the respondents no 1 to 4 referred article titled as **Treatment of staphylococcal prosthetic joint infections with debridement, prosthesis retention and oral rifampicin and fusidic acid** authored by C.A. Aboltinss, M.A. Page, K.L. Busing, A.W. J. Jenney, J.R. Daffy, P.F.M. Choong and P.A. Stanley. It is on record that the appellant was admitted in the respondent no 1 on 05.05.2010 for dressing in OT which was performed by the respondent no 3 and thereafter discharge fluid was sent for culture and sensitivity. The appellant was discharged on 07.05.2010 and at that time the appellant was prescribed combination of antibiotics including Tab. Rifampicin. The Aerobic culture and sensitivity of Pus Report dated 07.05.2010 and Aerobic culture and sensitivity of Body Fluids Report dated 08.05.2010 confirmed infection with growth of Coagulase negative Staphylococcus which is sensitive to Rifampicin. The Biopsy Report dated 11.05.2010 also indicated infection. It is reported in the above article that there is growing evidence of the efficiency of treating early staphylococcal infections of prosthetic joints with surgical debridement and prosthetic retention combined with oral antibiotic regiment that include Rifampicin in combination with a fluoroquinolone. It is also reported that debridement without prosthesis removal in combination with rifampicin and fusidic acid treatment was effective and should be considered for patients with early staphylococcal prosthetic joint infections. It is established that prescription of antibiotic Rifampicin in combination with other antibiotics by the respondent

no 3 was in consonance with established medical procedure and protocol for treatment of post-operative infection of the appellant. The respondent no 3 did not prescribe antibiotic for treatment of tuberculosis to the appellant as argued by the counsel for the appellant/present appellant rather it was prescribed for post-operation infection at the time of discharge after OP dressing on 07.05.2010. We are of considered opinion that argument as discussed above by the counsel for the appellant/present appellant are without any basis and is meritless. Medical literature submitted by the respondents no 1 to 5 clearly establishes that Rifampicin in combination with other antibiotics is an effective treatment for staphylococcal prosthetic joint infections.

25. It is also came on record that the appellant was admitted in the respondent no 7 with infected wound over left knee with cement spacer in situ and thereafter as per standard treatment protocol, debridement, cement spacer removal and SSG was done on the appellant on 14.03.2012. The appellant was discharged on 24.03.2012 and was advised for follow up in OPD. The appellant thereafter did not come to OPD for follow up. The appellant did not make any allegation of medical negligence against the respondent no. 7.

26. The State Commission in impugned order observed that the appellant did not lead any expert witness in support of her claim and the case of the appellant cannot be accepted only on basis of her bald statement without support of any expert opinion. The State Commission also observed that the respondents have produced evidence and medical literature to show that due care and professional skill was exercised by the treating doctors in conducting operations of the appellant. The counsel for the appellant attacked said observation of the State Commission in impugned order and argued that expert opinion is not necessary in all cases of medical negligence and cited **V. Krishan Rao V Nikhil Super Specialty Hospital & another** wherein it was observed by the Supreme Court that expert opinion is not necessary to establish medical negligence when the

medical negligence is apparent. The counsel for the respondents no 1 to 5 countered said argument and stated that medical evidence is required to be established by producing medical expert or medical literature and the medical negligence cannot be established by mere averments of the victim. The counsel for the respondents no. 1 to 5 cited **Senthil Scan Centre V Shanti Sridharan & another**, (2010) 15 SCC 193 where it was observed that medical negligence has to be proved by leading evidence. We are of considered opinion that the present case involved complicate medical issues as the appellant was chronic patient of Rheumatoid arthritis and was subjected to several surgical procedures. The appellant was required to lead expert evidence to substantiate claim of medical negligence on part of the respondents in particular the respondents no 1 & 3 qua the appellant. The Supreme Court in **Dr. C.P.Sreekumar V S. Ramanujam**, II (2009) CPJ 48 (SC) held that onus to prove medical negligence lies on the claimant and this onus can be discharged by leading cogent evidence. This Commission in **Nalini V Manipur Hospital & others**, IV (2011) CPJ 280 (NC) observed that appellant's case of alleged medical negligence cannot be accepted only on basis of affidavit without support of any expert opinion. We are considered opinion that argument advanced by the counsel of the appellant is without any merit. We are in agreement with the finding given by the State Commission to said affect.

27. The counsel for the appellant/present appellants also argued that the appellant was denied a proper opportunity to cross examine the witnesses examined by the respondents and the complaint was dismissed by the State Commission in haste. The evidence was filed on 23.01.2017 and the complaint was dismissed on 27.01.2017. It was argued that the right to cross examination is a valuable right and denial to cross examination violates principle of natural justice. We are of considered opinion that the appellant/present appellants cannot be allowed to take this objection at this belated stage in the Appeal and

the appellant should have raised this issue before the State Commission or otherwise by initiating appropriate legal proceeding. We are not impressed by the argument advanced by the counsel for the appellant.

28. It is established that the appellant was a chronic patient of Rheumatoid arthritis. The appellant was treated by the respondent no 3 in the respondent no 1. The appellant was subjected to surgery for Total Knee Replacement (TKR) which was performed on 08.02.2010. The appellant developed problem of discharge in left knee. The appellant for treatment of discharge from left knee after being admitted in the respondent no 1 underwent dressing in OT surgery on 05.05.2010. The appellant on 14.06.2010 also consulted Dr. Yash Gulati in the respondent no 6. The appellant was also diagnosed with infection in the left knee. The Appellant due to continuous problem of discharge and infection underwent Stage -1 Revision surgery on 27.09.2011 in the respondent no 1. The appellant was subjected to biopsy of knee on 20.12.2011 at the respondent no 1. The respondent no 3 performed all procedures/surgeries on the appellant in the respondent no 1. The appellant also underwent medical procedure at the respondent no 7. The counsel for the appellant/present appellants after referring doctrine of *res ipsa loquitur* argued that the State Commission neglected to apply this doctrine under the circumstances of the case and did not adequately responded to medical complications. The counsels for the respondents in counter argued that the appellant was provided with best possible treatment with highest standard of care and refuted allegations of medical negligence.

29. It was for the appellant/the present appellants to establish medical negligence on the part of the respondents no 1 & 3 in particular by leading cogent and convincing evidence and mere assertions in complaint or deposition in affidavit tendered in evidence are not sufficient to establish medical negligence as observed by this Commission in **Nalini V Manipur Hospital & others**. The appellant alleged negligence in her treatment and deficiency in

service but could not prove that the respondents and in particular the respondents no 1 & 3 were negligent in treatment of the appellant. The respondent no 3 treated the appellant and conducted various surgeries/procedures as discussed and detailed herein above as per established procedure and protocol. The respondent no 3 has acted like a reasonable man on considerations which ordinarily regulate the conduct of human affairs. There was no apparent or noticeable omission on the part of the respondent no 3 in the treatment of the appellant and the respondent no 3 has taken appropriate care in the treatment of the appellant.

30. The respondent no 3 as per **Bolam Rule** had exercised the ordinary skill of an ordinary competent man in the treatment of the appellant. The respondent no 3 while treating the appellant was possessing appropriate skill and knowledge. The Supreme Court in **Jacob Mathew V State of Punjab** clearly observed that a surgeon cannot and does not guarantee that the result of surgery would invariably be beneficial to the extent of 100% for the person operated on and the only assurance which can be given is that he is possessed of the requisite skill in that branch of profession which he is practicing.. The respondent no 3 followed those practices, protocols and procedures which are acceptable to the medical profession. The Supreme Court in **Neeraj Sud & another V Jaswinder Singh (minor) & another** observed that deterioration of the condition of the patient post-surgery is not necessarily indicative or suggestive of the fact that the surgery performed or the treatment given to the patient was not proper or inappropriate or that there was some negligence in administering the same. It is not always necessary that in every case the condition of the patient would improve and the surgery is successful to the satisfaction of the patient. It is not case of the appellant that the respondent no 3 was not possessing requisite qualification or skill for the treatment. There is no evidence to prove that the respondent no 3 has failed to exercise due diligence, care or skill while

performing surgery of the appellant on various occasions as detailed herein above.. The respondent no 3 cannot be held liable for medical negligence due to mere fact that the left knee of the appellant could not get the desired relief. There is no evidence that the respondent 3 has failed to exercise the due skill possessed by him in discharging of his duties i.e. during the treatment of the appellant. The respondent no 3 cannot be levelled with negligence as he performed his duties with reasonable skill and competence. The respondent no 3 conducted surgeries in good faith for the benefit of the patient i.e. the appellant and in accordance with recognized surgical practices and was not deviated from accepted medical standards or that the outcome was the result of any dereliction of duty by the opposite parties. The appellant/present appellants are not entitled to take benefit of doctrine of *res ipsa loquitur*. It is worth mentioning here that both knees of the appellant have been undergone for TKR by the respondent no 3 in the respondent no 1 but right knee did not develop any post-operative complication. There was no deficiency of service on the part of the respondents and in particular the respondents no 1 & 3. The appellant did not make any specific allegation of medical negligence against the respondent no. 2 and 4-7.

**31.** We have considered the arguments and rival contentions of the contesting parties. A doctor is under an obligation to provide high quality, ethical medical care to the patients which involves diagnosis of illness and its appropriate treatment. A doctor is supposed to perform recognized medical procedures with skill and care with follow up actions. The doctors must treat patients attentively and consciously. Simultaneously medical negligence should not be infer in casual manner rather it must be established with cogent, rational and convincing evidence by the person who is claiming negligence qua medical professional. It is established on record that the respondent no 3 had carried out all procedures during surgery and post-surgery with due diligence and in accordance with the prevailing medical standards. We in view of above discussion of the opinion

that the appellant/present appellants have failed to discharge the burden of establishing negligence or deficiency in service on the part of the respondents and in particular the respondents no 1 & 3. There is no reason to interfere in impugned order passed by the State Commission which is reasonably well articulated and the State Commission has considered the relevant issues rose on behalf of the contesting parties. We have also considered grounds taken by the appellant in the present appeal to challenge the impugned order but none of the ground is sustainable under facts and circumstances of the case as discussed herein above in detail. Accordingly, the present first appeal is dismissed as being devoid of merit and the impugned order passed by the State Commission is upheld. The pending applications, if any, also stand disposed of accordingly.

Sd/-

.....  
( DR. INDER JIT SINGH )  
PRESIDING MEMBER

Sd/-

.....  
( DR. SUDHIR KUMAR JAIN, J. )  
MEMBER

SSB/MS/C-3/reserved