IN THE HIGH COURT OF JUDICATURE AT MADRAS

Reserved On :	09.11.2022
Pronounced On:	31.01.2023

CORAM

THE HON'BLE Mr. JUSTICE G.CHANDRASEKHARAN

C.S.No.392 of 2014

Flora Madiazagane ...Plaintiff

Vs.

1.G.G.Hospital
Represented by its Director,
Dr.SFV Selvaraj (Deceased)
Dr.Kamala Selvaraj
No.6E, Nungambakkam High Road,
Chennai – 600 034.
(Substituted as per
order dated 22.02.2021 on memo)

2.D.SFV Selvaraj (Deceased)
(Defendants 3 to 5 are the
legal heirs of the deceased D2
as per order dated 22.02.2021 on memo)

3.Dr.Kamala Selvaraj

4.Dr.Deepu Raj Kamal Selvaraj

5.Dr.Priya Selvaraj ...Defendants

PRAYER: This is a suit filed under Order IV Rule 1 of the Original Side Rules Read with Order VII Rule 1 & 2 of the C.P.C.,

a)direct the defendants to pay jointly and severally the sum of Rs.1,50,00,500/- as the compensation to the plaintiff.

b)direct the defendants to pay the future interest at the rate of 24% for the unpaid amount from the date of plaint till the date of realization of the amount awarded.

c)to award the cost of the suit.

d)to pass such other order or orders as it deem fit and proper to the circumstances of the case.

For Plaintiff : Mr.V.Manohar

For Defendants : Mr.S.R.Rajagopal (Senior Advocate)

JUDGMENT

This suit is filed for seeking the defendants to pay jointly and severally a sum of Rs.1,50,00,500/- as compensation with a direction to pay future interest at the rate of Rs.24% for the unpaid amount from the date of plaint till the date of realization and for the costs.

2. The case of the plaintiff is that defendants are claiming to be the expert in the field of infertility treatment. They claim that they have much expertise, great reputation and have the assistance of able doctors. Based on the assured profile and medical services in the field of infertility treatment, plaintiff visited the first defendant hospital and consulted the third defendant for her infertility problem. Defendants 3 and 5 had taken up the treatment of the plaintiff after consecutive discussions and consultations. Plaintiff was subjected to various lab tests. They found that plaintiff has Fibroid in her uterus and has adhesion in her abdomen. Plaintiff was advised to undergo Laparoscopic surgery to remove adhesion in abdomen. Plaintiff accepted to undergo the Laparoscopic surgery to remove the Fibroid and adhesion. Plaintiff was admitted in the defendant's hospital on 14.05.2013 and team of doctors constituted by the defendants led by the fourth defendant performed the Laparoscopic surgery and Adhosiolysis surgery on 15.05.2013 to the plaintiff. Plaintiff and her relatives were informed that surgery was successful and plaintiff was kept under liquid diet on 16.05.2013. On 17.05.2013, the defendants provided the solid food to the plaintiff. Plaintiff experienced discomfort, breathing problem,

abdomen distension, vomiting and shooting pain. When it was brought to the attention of the defendants through the duty nurses, it was simply dismissed stating that it is the usual symptoms due to the nature of surgery. Only when the plaintiff expressed her unbearable condition and compelled the fifth defendant to attend her, it was taken to its gravity and even the duty nurses were pulled up for casual handling of the issue. Defendants continued to maintain that there could be some infection and advised her to undergo another surgery without revealing the reasons.

3. Defendants have not taken any consent from the plaintiff and obtained signatures of the plaintiff suppressing and without disclosing the true facts. On 18.05.2013, open surgery was done. The reason for the second surgery was that the faecal matter was coming through the hole in the abdomen. Colostomy bag was fixed outside to collect the faecal matter. Plaintiff was kept in I.C.U. till 21.05.2013. Defendants kept their fault under wrap. Plaintiff was shifted to Apollo First Med Hospital under emergency admission. It was made to appear that she was shifted to Apollo First Med Hospital for the purpose of further diagnosis and test. Doctor

Mr.Ravindran Kumaran lead by a team of doctors attended the plaintiff and only then they disclosed the truth that when the defendants performed Laparoscopic surgery, carelessly punctured and badly perforated the 'Sigmoid Colon' and not stopping with that, defendants had also removed the perforated area of 'Sigmoid Colon' in hurry and careless manner and connected the outlet of bowel system through a hole in abdomen with the bowel outside the body to collect the faeces, during the second surgery. The reason for the plaintiff developing serious infection in her abdomen and pelvis area was due to the said perforation. Therefore, plaintiff suffered irreparable injuries due to the irresponsible mishandling by the person who done the laparoscopic surgery in the defendant's hospital.

4. Fearing the exposure of their guilt, defendants approached the brother of the plaintiff namely Patric Rajan with an offer to pay a sum of Rs.5,00,000/- as a gift to cover up the issue. Plaintiff refused to budge to the designs of the defendants. Defendants damaged the entire system's function, inflicted permanent disability and scattered the hope of begetting the child. She was dumped in the high end hospital to fight for her

life for thirty-seven days. She had to undergo three different major and minor surgeries namely,

i)Laparotomy Drainage of Pelvic Abscess Rectosigmoid Resection and Refashioning of Colostomy on 30.05.2013.

ii)Eua and Secondary Suturing on 19.06.2013 and

iii)Abdominal Wound exploration and Evacuation of Hematoma on 26.06.2013 by the Apollo First Med Hospital.

5. As a result of corrective and repair treatments, plaintiff is left to live permanently with 'Colostomy Bag' to discharge the faeces. Her pelvic structure is completely damaged. She developed extensive adhesions on her intestine system and excretory system. The 'Colostomy Bag' was hanging outside the abdomen permanently. There is a big scare in the abdomen. These are the direct impact caused on the plaintiff due to the conduct and commission of medical negligence by the defendants. There are numerous indirect impact caused to the plaintiff and her near and dear ones. She has to carry the physical, emotional and other discomforts throughout her life. Plaintiff finds it uneasy to move around and mingle with the others.

She had to leave her job permanently and she is not even able to do her routine work. She depends upon others to carry out her natural needs and to see the comforts of the life. She is prone to suffer from ill-health often. She spent huge money for her treatment at First Med Apollo Hospital from 21.05.2013 to 03.07.2013. Plaintiff paid Rs.62,000/- to the defendants towards medical bill. She paid Rs.12,80,500/- for operation and medicine at Apollo First Med Hospital and Rs.4,00,000/- for further follow up treatment. She requires Rs.3,00,000/- for Hernia treatment. "Colostomy Bag" has to be changed every seven days and she may have to incur Rs.3,00,000/-. She required attendees and spent Rs.1,50,000/- so far, for attendees. Defendants are liable to compensate the plaintiff for permanent disability caused to her for a sum not less than Rs.75,00,000/-. Plaintiff's permanent disability, mental agony, though cannot be quantified, plaintiff tentatively and moderatively demand a sum of Rs.1,50,00,500/- as compensation. Plaintiff sent a notice dated 13.11.2013 and that was replied by the defendants on 30.12.2013. Defendants have not paid the amount. Therefore, this suit is for the aforesaid reliefs.

6. The case of the fourth defendant is that plaintiff is aged 44 years. She is a Srilankan Tamil settled in France and was suffering from infertility. On 08.01.2013, she approached the third defendant for treatment of primary infertility. After doing relevant investigations and ultrasound, it was found that plaintiff had Fibroid/Tumour in her uterus and she was advised to undergo a surgery to remove the Fibroids in the uterus before starting treatment for infertility. She had already undergone three surgeries in her uterus as follows:

i)Diagnostic Laparoscopy and Hysteroscopy

ii)Laparoscopic Salpingectomy

iii)Dilation and Curettage.

7. Plaintiff informed the third defendant that the above surgeries were performed in France. During the treatment, it was found that due to the three previous surgeries, the Uterus, Bowel/Intestine and certain other organs of the plaintiff were stuck/attached together and were affixed to the abdominal wall thereby causing a medical condition called “Adhesions”. “Adhesion” is basically a condition where different organs or

body parts stick together due to various medical conditions and sometimes get affixed to the abdominal wall following the previous history of surgery, ((a condition recognized as "Post-Operative adhesions"). The line of treatment advised to the plaintiff was "LAPAROSCOPY PROCEED ENDOSCOPIC MYOMECTOMY". The medical examination of the plaintiff revealed severe adhesions involving the bowels, omentum and anterior abdominal wall. The adhesions were so severe that the fourth defendant could not perform the proposed Fibroid removal from uterus without releasing the adhesions. Laparoscopic Adhesiolysis had to be performed followed by the Fibroid removal. Right fallopian tube of the plaintiff was found to be diseased and thus a right Salpingectomy also had to be performed to remove the right fallopian tube. Plaintiff was counselled and explained in detail the possibility of the above mentioned procedures in case of any difficulty during Laparoscopy, a conversion to open surgery would have to be performed. Plaintiff understood the various surgical procedures and on her own free will and accord, she signed the necessary consent forms for the aforesaid surgical procedures. Plaintiff's brother Mr.Patrice Rajan was also apprised of this.

8. On 14.05.2013, plaintiff was admitted as an inpatient and on 15.05.2013, fourth defendant performed the Laparoscopic Adhesiolysis on plaintiff to remove the adhesions followed by Laparoscopic Myomectomy to remove the Fibroid from the uterus followed by Laparoscopic Salpingectomy to remove the right fallopian tube on the plaintiff. After surgery, plaintiff was recuperating well and there was no evidence or symptoms of perforation or rupture in the Sigmoid Colon of the plaintiff due to the Laparoscopic Adhesiolysis surgical procedure. If there was any perforation or rupture in the Sigmoid Colon of the plaintiff during surgery,there would have been immediate emptying of the contents of the Colon through the opening in the Sigmoid Colon and that would have been seen by the surgical team. No such incident was reported on 15.05.2013 during the surgery. The adhesions encountered during the surgery is classified as post-operative adhesions due to the previous three surgeries, plaintiff had undergone. Those adhesions progressed to the severe status over the last decade or more. Sigmoid Colon of the plaintiff was affixed to the abdominal wall and after it was separated from abdominal wall by

Adhesiolysis, portion of the Sigmoid Colon which was attached to the abdominal wall was weak and exposed.

9. Plaintiff was started on oral liquids on 16.05.2013 and then she was given soft solids from 17.05.2013. After her oral feeds, due to the vigorous movement and expansion of the bowel, the portion of the Sigmoid Colon which was previously attached to the abdominal wall ruptured due to its inability to withstand the expansion pressure that follows bowel movements. That was a natural cause and not due to any medical negligence. Sigmoid Colon was not perforated or ruptured during the Laparoscopic Adhesiolysis surgery on 15.05.2013. Plaintiff was given best possible treatment. On 17.05.2013, about 7.30. p.m., she developed a swelling of the abdomen. Immediately, the services of Professor Dr.Deivanayagam, Senior Surgeon, then Head of Department of Surgery in Government General Hospital, Chennai was requestioned. As per his opinion, possibility of rupture of bowel had to be ruled out. Strict protocols were adhered like stopping oral feeds, inserting a ryles tube through the nose to empty out the stomach of its contents, administering IV fluids and

powerful antibiotics to curtail any possible infection setting in, as well as continuous monitoring of the plaintiff. On investigation, it was found that possibility of a bowel/Sigmoid colon rupture was very likely and the first defendant took immediate steps by informing the plaintiff and her brother the details of an open surgery by emergency surgical procedure. The condition developed on 17.05.2013 was due to the previous surgeries performed on the plaintiff.

10. On 18.05.2013, Dr.Deivanagayam, assisted by fourth defendant performed the Colostomy procedure on the plaintiff. The weakened and unhealthy Sigmoid Colon was removed and healthy Sigmoid Colon leading to the anus was taken out and connected to a colostomy bag attached to the left side of the body. Plaintiff was responding well to the surgery and was recovering. She seemed to be short of breath and therefore, it was decided to shift her to a centre which had facilities for assisted ventilation in case her condition worsened during the course of night. After taking the consent from the plaintiff and her brother, she was shifted to Apollo First Med Hospital for further monitoring. From 22.05.2013 to

24.05.2013 fourth defendant telephonically enquired with primary and secondary consultants Dr.Nirmala Jayashankar and Dr.Ravindran Kumeran in the Apollo First Med Hospital about the plaintiff's condition. He was informed that plaintiff's condition was normal. Fourth defendant also visited the plaintiff in Apollo First Med Hospital on two occasions and enquired about her health. He was informed by Dr.Nirmala Jayashankar that plaintiff would be shifted back to the first defendant hospital on 27.05.2013. When she enquired Dr.Nirmala Jayashankar on 29.05.2013, with regard to shifting of the plaintiff, she informed that there was some fluid collection in the plaintiff. Later, he was informed that plaintiff had undergone Laparotomy on 31.05.2013. Apollo First Med Hospital has not mentioned that Laparoscopic procedure conducted on the plaintiff by the first defendant hospital was defective. Plaintiff's medical condition was prone to adhesion formation. The allegations that plaintiff's sufferings was due to the surgery she had undergone in the first defendant hospital are not true and untenable. There is absolutely no cause of action for filing the suit against the defendants. Therefore, this suit is liable to be dismissed.

11. Defendants 1, 2, 3 and 5 have filed memo adopting the written statement filed by the fourth defendant.

12. On the basis of these pleadings, the following issues are framed:-

1) Whether there was formation of adhesion in the abdomen, prior to admission of the plaintiff in the 1st defendant hospital as contented by the defendants-3 & 5 and there was any necessity to undergo laparoscopic surgery to remove alleged adhesion in abdomen of the plaintiff?

2) Whether due to the previous surgeries, the plaintiff's medical condition required medical procedure and surgery?

3) Whether the plaintiff was clearly explained by the 1st defendant about the medical procedures and surgery to be undertaken by the plaintiff?

4) Whether the plaintiff signed the consent forms after proper counselling before the surgery was performed by the 1st defendant?

5) Whether or not the defendants had convinced the

plaintiff to undergo the laparoscopic surgery to become fit to conceive the child?

6) Whether the defendants acted in accordance to the expectation to conduct laparoscopic surgery and alleged adhosiolysis surgery with the skill and expertise?

7) Whether or not the defendants have given proper and appropriate care about the post surgery to the plaintiff?

8) Whether the subsequent open surgery conducted by the defendants was proper, warranted and done with necessary consent of the plaintiff or not?

9) Whether the defendants are liable to take responsibility for the consequences arisen due to such under skilled surgery on 18.05.2013?

10) Whether the plaintiff was shifted from the 1st defendant hospital to Apollo First Med Hospital after proper counselling to the plaintiff and her brother?

11) Whether or not the defendants negligence and improper handling resulted in damaging the sigmoid colon which resulted in leaking

of faecal matters (Motion/Human Waste) to give raise to the necessity to fix a colostomy bag outside the body to collect the discharge?

12) Whether or not there was lapse and deliberate negligence on the part of the defendants in giving due care to the post operation nursing after the surgery dated 18.05.2013?

13) Whether or not the plaintiff was made to suffer to the extreme condition due to the mishandling and deliberate negligence conduct of operation by the defendants made to be confined in ICU for consecutive periods?

14) The subsequent admission of the plaintiff in an advance medical house namely Apollo First Med Hospital by the defendants themselves only due to incapability consequences created due to the faulty conduct of the operation and mishandlings by the defendants or not?

15) Whether or not the plaintiff was inflicted with infection to her abdomen pelvic area only due to the lapse on the part of the defendants in not giving due medical care?

16) Whether or not the defendants offered the sum of Rs.5,00,000/-(Rupees five lakhs only) as one time settlement and attempted

to procure the undertaking from the plaintiff's brother not to proceed against the defendants for any reasons only due to the guilty of being committed medical negligence by the defendants?

17) Whether the plaintiff had a working colostomy and working stoma on admission to Apollo First Med Hospital on 21.05.2013 from the 1st defendant?

18) Whether or not the defendants caused the permanent disability to the plaintiff in the natural course of life style apart from scattering the hope of begetting the child for ever?

19) Whether or not the defendants are responsible and liable for the damage caused to the plaintiff's health, causing disability and that of future well being?

20) Whether or not the defendants are liable to compensate the said infliction of permanent disability for the expenses incurred to save the life of the plaintiff?

21) What is the quantum of damages for which the defendants are liable on each counts namely medical expense, permanent disability of plaintiff, pain and suffering, mental agony and that of

destroying the hope of begetting the child etc?

22) Whether or not the plaintiff is entitled to the reliefs claimed in the plaint?

23) Whether or not the defendants are liable to pay the interest for the amount to be quantified by this Court till the said amount is paid and discharged by the defendants?

24) What other relief the plaintiff is entitled to under the circumstances of the case explained?

13. On the side of the plaintiff, PW.1 and PW.2 were examined and Exs.P1 to P24 were marked and on the side of the defendants, DW.1 was examined and Exs.D1 to D14 were marked.

Issue Nos.1 to 20:-

14. The learned counsel for the plaintiff submitted that Ex.P20 discharge summary shows that plaintiff, an unfortunate lady, suffered due to inadvertent Sigmoid perforation and she had a stormy post-operative period. It indicates that the surgery performed at the first

defendant hospital by the fourth defendant was defective surgery and it led to all the complications faced by the plaintiff. Plaintiff approached the first defendant hospital after coming to know from the advertisements given, that first defendant hospital is a leading hospital for treating infertility. Third defendant is in the helm of affairs of the first defendant hospital. Plaintiff had provided all the necessary informations, including her past medical history of undergoing treatments for infertility. Only after going through her past medical treatment records, the defendants accepted to give treatment to the plaintiff and conducted the surgery. If they really felt that due to her past medical treatment, especially surgical treatment, adhesions and fibroids were formed and there is a possibility of encountering perforation or other harmful results, the defendants should have advised the plaintiff not to proceed with the treatment for infertility and should have avoided performing the surgery for removing adhesions and fibroids. After having known her medical conditions during the investigation and after deciding to perform surgery on her, the doctors in the first defendant hospital should have performed the surgery with utmost care. During the course of surgery, due to the mishandling and lack of care on the part of the fourth defendant,

he perforated the "SIGMOID COLON" resulting in plaintiff suffering unbearable pain and suffering as narrated above. Plaintiff came to India only to get treated by third defendant and not by other doctors at the first defendant hospital, especially by the fourth defendant. No consent was given for the fourth defendant to perform operation on her. The name of the fourth defendant is interpolated and consent form is fabricated. Fourth defendant is not an expert in treating/removing adhesions. He was not able to identify the plaintiff's problem after the surgery. Only after three days Dr.Deivanayagam, was called to attend the plaintiff and he only identified the problem of the plaintiff. The evidence of P.W.1 clearly proved the faulty surgery performed on the plaintiff by the fourth defendant. Only after taking treatment at Apollo First Med Hospital and undergoing three surgeries, plaintiff's life was saved. Therefore, she is entitled for compensation claimed. In support of his submissions, learned counsel for the plaintiff relied on the following judgements:-

(1) (2009) 6 SCC 1 (Nizam's Institute of Medical Sciences Vs. Prasanth S.Dhananka and others)

(2) (2010) 5 SCC 513 (V.Kishan Rao Vs. Nikhil Super Speciality

Hospital and another)

(3) *This Court judgment in* ***O.S.A.No.391 of 2003,*** *dated 11.03.2011* ***(M/s.Soni Hospital and two others Vs. Arun Balakrishnan Iyer and one another)***

(4) (2021) 10 SCC 291 (Dr.Harish Kumar Khurana Vs. Joginder Singh and others)

15. In response, learned counsel for the defendants submitted that during the course of preliminary tests, the presence of Fibroids were found and it was also found that right fallopian tube was already removed. There were adhesions and adhesions have also to be removed for commencing the infertility treatment. The Sigmoid Colon of the plaintiff was attached to other parts. Only during the surgery, it was found that adhesions was severe and the fourth defendant exercised all the necessary care and performed the surgery. There was no puncture caused to the Sigmoid Colon during the course of surgery. If the puncture/perforation had been caused during the course of surgery, the faecal matter would have been come out even when plaintiff was on the operation table. That was not

to be. Therefore, it is clear that the surgery was performed as planned and without any problem. Fourth defendant exercised due and reasonable care. It is not the case of the plaintiff that the surgery was performed not exercising reasonable degree of care and that there was a wilful misconduct on the part of the doctor who performed the surgery. There is absolutely no pleading with regard to negligence of the doctor. Plaintiff suppressed the past history of the treatment she had undergone and there is no pleadings in the plaint with regard to the past history of treatment. No credible evidence is produced to show that the treatment procedure adopted for the plaintiff is not correct. The consent form shows that plaintiff knew the course of treatment. P.W.2 is not an expert in the field and therefore, his evidence is not conclusive. There is no pleading with regard to unreasonableness in the professional conduct of the fourth defendant. There is no suggestion, no evidence to show that the Sigmoid Colon was punctured during the surgery. There is no pleading that fourth defendant failed to exercise due care and caution during the treatment. Neither the fourth defendant nor the doctors working in the first defendant hospital were responsible for the sufferings of the plaintiff. Her previous treatment, resulted in adhesions, weakened her

internal body part, alone were responsible for her condition. Therefore, plaintiff is not entitled for any relief and the suit is liable to be dismissed. In support of his submissions, he relied on the following judgments:-

(1) (2021) 10 SCC 291 (Dr. Harish Kumar Khurana Vs. Joginder Singh and others)

(2) (2019) 2 SCC 282 (S.K. Jhunjhuwala Vs. Dhanwanti Kaur and another)

(3) (2009) 9 SCC 709 (Ramesh Chandra Agrawal Vs. Regency Hospital Limited and others)

(4) (2020) 6 SCC 501 (Maharaja Agrasen hospital and others Vs. Master Rishabh Sharma and others)

(5) (1957) 1 WLR 582 (Bolam Vs. Friern Hospital Management Committee)

(6) (2019) 7 SCC 401 (Arun Kumar Manglik Vs. Chirayu Health and Medicare Private Limited and another)

(7) 2022 SCC OnLine SC 481 (Dr. (Mrs.) Chanda Rani Akhouri and others Vs. Dr.M.A.Methusethupathi and others)

16. We can understand from the case set out by the parties that there is no dispute with regard to the fact that the plaintiff was treated at the first defendant hospital for infertility treatment from 08.01.2013 till she was discharged from the first defendant hospital and transferred to Apollo First Med Hospital for further treatment on 21.05.2013. It is also admitted that during the course of treatment at first defendant hospital, two surgeries had been performed on the plaintiff on 15.05.2013 and on 18.05.2013. It is the case of the plaintiff that due to faulty surgery performed on 15.05.2013 'Sigmoid Colon' of the plaintiff was perforated resulting in severe pain and suffering to the plaintiff. Subsequently a corrective surgery was performed on 18.05.2013 and colostomy bag was attached to her body to collect the human waste. Even after the surgery on 18.05.2013, the condition of the plaintiff got worsened and she had taken treatment in Apollo First Med Hospitals for further medical treatment.

17. The allegations with regard to the faulty surgery on 15.05.2013 and 18.05.2013 are totally denied by the defendants. It is the case of the defendants that the treatment given to the plaintiff at first

defendant hospital, was in accordance with the protocol for treating the patient with similar complaints. It is the case of the defendants that the suit is filed only with a view to extract money from the defendants.

18. To understand the issues involved in this case and to decide the issues, it is necessary to appreciate the oral and documentary evidence produced in this case. Ex.P1 is the treatment record of the plaintiff. It is seen from Ex.P1 that she approached the fertility research centre of first defendant hospital on 08.01.2013. It has the details of plaintiff's obstetric history, previous treatment history. Ex.P2 notes dated 15.05.2013 reads as follows:

15/5/13

ut – NS, Ant & Post wall fib, Rt abd wall adhesions, Rt – severe HS, FF-RT-non communicating due to previous surgery, R.O – NS with adhesions, LT – mod salphingitis + free; L.O. - Normal, PoD – adhesions + spill

RT – X corneal block

LT - 1st flush

15/5/13

ut cav seen with normal.

Both ostia seen.

19. Preliminary investigation was conducted on her. Various test reports are produced as Ex.P3. Of these reports, the report dated 09.01.2013 for abdominal/pelvic ultra sonogram is important. This report indicates the presence of small fibroids in the uterus of the plaintiff in anterior and posterior walls of the uterus. Even in the written statement it is stated by the defendants that after doing the relevant investigations and ultrasound, it was found that the plaintiff had fibroids / tumor in her uterus and advised to undergo surgery to remove the fibroids in the uterus before starting treatment for infertility. It is the further case of the defendants that the plaintiff had informed the third defendant that she had already undergone three surgeries, namely, i)Diagnostic Laparoscopy and Hysteroscopy, ii)Laparoscopic Salpingectomy & iii)Dilation and Curettage.

20. Exs.P4 to P9 and P11 are the reports relating to various investigations conducted on the plaintiff prior to surgery. Ex.P10-admission form shows that plaintiff was admitted on 14.05.2013 for undergoing the surgery on 15.05.2013. Only after subjecting the plaintiff to various and necessary investigations and having satisfied that the plaintiff can be treated for infertility, defendants have scheduled the surgery on the plaintiff on 15.05.2013. She was advised to take only liquid diet ie., ice cold or hot beverage like tea, coffee and coconut water till 9 p.m and NIL by mouth after 9 p.m on 14.05.2013.

21. Ex.P2 shows that under general anaesthesia endo myomectomy + adhesiolysis + right Salpingectomy + Hystoscopy were done. The reason, according to the defendants, is that due to three previous surgeries performed, bowel/intestine and certain other organs of the plaintiff were stuck/attached together and were affixed to the abdominal wall, thereby causing a medical condition called adhesions. The adhesions involving the bowels, omentum and anterior abdominal wall were so severe that the 4th dependent could not perform the proposed fibroid removal from

the uterus without releasing these adhesions. It was found that the right fallopian tube of the plaintiff was found to be diseased and thus, right Salpingectomy had been performed to remove the right fallopian tube. Thus the fourth defendant performed laparoscopic adhesiolysis to remove the adhesions followed by laparoscopic myomectomy to remove the fibroids from the uterus and laparoscopic Salpingectomy to remove the right fallopian tube of the plaintiff.

22. What happened after these surgeries on 15.05.2013, as per the case of the plaintiff, is that the plaintiff was kept under liquid diet on 16.05.2013 and on 17.05.2013 she was provided with solid food. After consuming the solid food, she felt discomfort with difficulty in breathing, abdomen distention and vomiting with shooting pain. When it was brought to the notice of the defendants through the duty nurses, they simply dismissed her issue as the natural symptoms of the surgery. Only after the condition became unbearable, 5th defendant attended on the plaintiff and they realised the gravity of the problem. Thereafter the second surgery on 18.05.2013 was performed. Plaintiff seriously questioned the consent taken

for the second surgery and the surgery performed on her by the fourth defendant.

23. In Ex.P2, there is no notes recorded with regard to the condition of the patient, after surgery on 15.05.2013, 16.05.2013 and 17.05.2013 till the second surgery on 18.05.2013. The condition of the patient, after the surgery on 18.05.2013, is also not recorded in Ex.P2.

24. However, the defendants have produced Ex.D13-doctors' notes and D14-discharge summary of the plaintiff. They have also produced Exs.D1 to D12 documents. Ex.D1 is the copy of the letter from plaintiff's husband giving no objection for the laproscopy treatment to his wife as advised by the defendants. Ex.D2 is the consent taken for the surgery held on 15.05.2013. Exs.D6 and D7 are the consents taken for the surgery held on 15.05.2013 and for administering anesthesia. As already stated, plaintiff seriously disputed the consent given to 4th defendant for performing surgery on her and for the second surgery performed on 18.05.2013.

25. Ex.D3 is the checklist dated 14.05.2013. Ex.D4 is pre-operative form prior to the surgery performed on 15.05.2013. Ex.D5 is the pre-anesthetic evaluation of the plaintiff dated 14.05.2013. Ex.D8 is the checklist prepared prior to the surgery performed on 18.05.2013 for the plaintiff. Ex.D9 is pre-anesthetic evaluation dated 17.05.2013. Ex.D12 is the temperature reading dated 14.05.2013.

26. Ex.D13- Doctors' notes shows everything appears to be normal and there was no complaints from the plaintiff from 15.05.2013 to 17.05.2003 morning, contrary to the claim made by the plaintiff that she had complained of pain, breathlessness and discomfort. In Ex.D13, it is noted that plaintiff made some complaints at 6.30 p.m. on 17.05.2013. It was recorded that plaintiff complained of pain and swelling since last night. It was noted that there was a mild distention.

27. Nurses' notes dated 15.05.2013 shows that there was no specific complaint from the plaintiff at 07:00 a.m. and she was comfortable.

The notes recorded at 10:30 p.m. shows that there was some mild gastric pain. At 1:00 a.m. on 17.05.2013, plaintiff complained of severe gastric pain and breathlessness and she was given sedative. Thus, it is clear from Ex.D13 Doctors' and Nurses' notes that after surgery on 15.05.2013, plaintiff complained of pain and breathlessness.

28. Ex.D11- Doctors' notes relates to the treatment period from 18.05.2013 to 21.05.2013. It was noted at 9.00 a.m on 19.05.2013, plaintiff complained of breathlessness. Many writings in Ex.D11 had been erased with the help of whitener.

29. Ex.D14 is the discharge summary of the plaintiff for the treatment taken at the first defendant hospital from 14.05.2013 to 21.05.2013. It has details of the diagnosis done on the plaintiff, procedures undergone by the plaintiff at the first defendant hospital, past medical and surgical history etc.,. To be specific, she was diagonised with fibroid uterus / right hydro Salpingectomy / moderate PID and adhesions. She underwent laparoscopic myomectomy + adhesiolysis + right salpingectomy +

hystoscopy. It was found that, plaintiff had

(i) Multiple myeoma uterus in anterior and posterior wall (5 in numbers)

(ii) Right hydrosalphinx

(iii) Adhesions to lateral abdominal wall and uterus (omental)

(iv) Bilateral ovaries appeared normal.

30. The procedure notes for the surgery dated 14.05.2013 shows that Dense / severe adhesions to uterus and lateral abdominal wall released using harmonic scalpel. Uterus freed from adhesions. All myomas enucleated and sent for HPE using harmonic scalpel. Uterus repaired in two layers using 1-0 vicryl. Right salpingectomy done and tube sent for HPE. Haemostasis secured. Lavage given. Ports were closed subcuticularly with 3-0 caprosyn sutures. Wounds were cleaned and dressed.

31. Operation notes for the surgery dated 18.05.2013 shows the following findings:-

1. Sigmoid perforation with faecal peritonitis

2. Pockets of collection in the left paracolic gutter and pelvic areas

3. Rest of colon, small bowel loops normal and free

4. Rest of abdomen normal.

32. Procedure notes reads that, Findings noted on laparotomy. Thorough lavage given with betadine and normal saline complete wash of the abdominal cavity performed with normal saline. A formal left sided sigmoid colostomy was fashioned with the proximal loop. Distal end with perporation trimmed and closed in layers using 2-0 vicryl sutures/mersilk Colostomy fixed to skin with 2-0 vicryl sutures. Lavage repeated. Haemostasis secured. Left flank drain anchored. Abdomen closed in layers. Skin closed with 2-0 ethilon sutures. Wound cleaned and dressed.

33. It is seen from Ex.D14 that during the course of the treatment in the hospital after the surgery on 15.05.2013, the patient/plaintiff developed symptoms of peritonitis on the evening of 17.05.2013. She was managed conservatively with antibiotics and all

supportive measures until 18.05.2013. On suspicion of peritonitis diagnosed by Prof.S.Deivanayagam and Dr.Deepu Rajkamal Selvaraj, the patient and attenders were counseled for a laparotomy and proceeded (+/_temporary colostomy) and obtained a free and informed consent for the same. The second operation was carried out in the morning of 18.05.2013. Patient underwent a laparotomy and resection of perforated sigmoid colon and was fit with a temporary left sided colostomy. Patient/plaintiff was reviewed by the surgeon and anesthetist and the patient was responding well to the therapy until the evening of 21.05.2013. Patient found it difficult to breathe. A joint decision was taken to shift the Patient/plaintiff to a higher medical centre for ventilatory support/monitoring, in case of a deterioration in her pulmonary status. The patient and attenders were counselled for the same and consented freely for the temporary transfer. The patient was then discharged/transferred to Apollo First Med Hospital on 21.05.2013 at 8.30pm. Patient's vitals were stable at the time of transfer.

34. Exs.P12 to P16 are the reports of the investigations conducted on the plaintiff from 17.05.2013 to 21.05.2013. From these

documents, especially, Ex.P14 it is clear that plaintiff had undergone laproscopic endo myomectomy + adhesiolysis + right Salpingectomy + Hystoscopy surgeries on 15.05.2013. Thereafter, due to sigmoid perforation and peritonitis, she had to undergo laprotomy and temporary sigmoid colostomy on 18.05.2013. Whether the second surgery was the result of faulty first surgery, as claimed by the plaintiff is an issue to be considered now.

35. At this juncture, it is relevant to refer to the written statement of the defendants and the evidence of witnesses. In para 8 of the written statement, it is stated that "due to the previous history of adhesions in the plaintiff, the sigmoid colon of the plaintiff was affixed to the abdominal wall and after the sigmoid colon was separated from the abdominal wall on 15.05.2013 by Adhesiolysis, the portion of the sigmoid colon which was previously attached to the abdominal wall was weak and exposed. In simple terms it can be explained as follows, "if a postage stamp is stuck in an envelope for a prolonged period and if the postal stamp is removed from the envelope, a small portion of the stamp will continue to be

affixed on the envelope or vice versa." This part of the written statement of the of the defendants clearly show that only when performing the adhesiolysis the sigmoid colon which was attached to the abdominal wall was exposed.

36. PW1 reiterated her plaint averments in her proof affidavit. She has stated that a team of doctors led by the fourth defendant had performed Laproscopic surgery and Adhesiolysis surgery on 15.05.2013. She was provided solid food on 17.05.2013 and then developed discomfort, unable to breath, abdomen distension and vomiting with shooting pain. Only after her condition became unbearable, doctors had taken notice of her condition. Defendant's concealed the truth of the complications and advised the plaintiff to undergo a surgery without revealing the reasons. The plaintiff has not taken into confidence and signature was obtained by suppressing the true facts for the second surgery. She was shocked to know the reason for the second surgery was that faecal matter was coming through the hole in the abdomen and a colostomy bag was fixed outside to collect the faecal matter. Even thereafter, the plaintiff

suffered complications in breathing. Then she was shifted to Apollo First Med Hospital.

37. When cross examined, she admitted that she had undergone surgery for removal of right side fallopian tube in 1999 in France. She also admitted that she underwent D&C procedure in 2002 for an abnormal foetus and had a Diagnostic Laproscopy and Hysteroscopy in 2005 in France. She stated that she was advised by the Doctors in France to go for a test tube baby and she had also undergone the procedure in France in 2005. The test tube baby procedure was not successful. Her third pregnancy in 2009 ended in automatic abortion of the foetus. She stated that she went for fertility treatment at Roshani Hospitals in Cuddalore in 2011. She admitted having third D&C in 2012 in Roshani Hospitals, Cuddalore. She stated that she had 7 cycles of In Virtro Fertilisation (IVF), 6 in India and 1 in France. The IVF treatment was not successful. When she was suggested that due to two surgeries, three procedures of D&C and 7 cycles of IVF, the uterus, bowel/intestine and other organs were stuck/attached together and they were fixed in the abdominal wall, she

denied the suggestion and added that Dr.Kamala Selvaraj told that, after conducting all tests, all are normal. She denied that she was informed about the adhesions during the medical examination done in the first defendant's hospital. When she was confronted with Ex.P2 that there is a mention in Ex.P2 that she had a medical condition call adhesions, she answered in the affirmative. She further stated that she did not know that adhesions is a medical condition, where, different organs or body parts stick together due to various medical conditions and some times gets fixed to the abdominal wall following a previous history of surgeries. She admitted that after relevant investigation and ultrasound, it was found that she had fibroid in the uterus, before starting treatment for infertility.

38. When she was asked as to whether Dr.Kamala Selvaraj advised her the treatment “Laproscopy Proceed Endoscopic Miomectomy”, she answered that she was advised to undergo Laproscopy, but was not advised to undergo Endoscopy and was not informed about the Myomectomy. She answered in the affirmative when she was asked that in order to remove/release adhesions, Laproscopic Adhesiolysis had to be

performed followed by the removal of the fibroid. She denied the suggestion that she was given counselling and explained the details of the procedures and in case of any difficulty during laproscopy, a conversion to open surgery would be performed. When she was suggested that she understood the various surgical procedures and on her own free Will and accord signed the consent forms, she answered in the affirmative and continued to state that consent was obtained for Laproscopic surgery.

39. She stated that she regained conciousness in the early morning of 16.05.2013 and she was shifted to the regular ward in the evening. She was normal when she was shifted to the general ward. When she was suggested that due to previous history of adhesions, her sigmoid colon was affixed to the abdominal wall and after the sigmoid colon was separated from the abdominal wall on 15.05.2013, a portion of the sigmoid colon, which was previously attached to the abdominal wall was weak and exposed, she answered that she did not know. She stated that she was given solid food from the evening of 16.05.2013 and within ten minutes, she had discomfort. When she was suggested that after she had oral feeds, due to

movement and expansion of the bowel, the portion of the sigmoid colon, which was previously attached to the abdominal wall ruptured due to the inability to withstand the expansion pressure that follows bowel movements, she denied the suggestion. When she was suggested that sigmoid colon was not perforated or ruptured during Laproscopic Adhesiolysis surgery performed on 15.05.2013, she answered that she did not know. She stated that she developed swelling in abdomen in the morning of 17.05.2013. She stated that oral feeds were stopped and ryles tube was inserted on the instructions of Dr.Deepu and she was conscious then.

40. When she was suggested that she and her brother Mr.Patrick Rajan were informed that an option of open surgery will be required immediately, she denied the suggestion and stated that she was again advised to undergo another Laproscopy surgery on 17.05.2013. When she was suggested that on 18.05.2013, Dr.Deivanayagam assisted by Dr.Deepu performed the colostomy procedure, she answered that she did not know. When she was asked that due to the weakened condition of

sigmoid colon, it was not possible to reconnect the sigmoid colon immediately and the best possible option was to connect the sigmoid colon to the colostomy bag, she answered in the affirmative. She stated that she was in ICU from 18.05.2013 to 21.05.2013 and she was not unconscious on 21.05.2013, but was suffering from breathlessness. Due to her condition of breathlessness, though she was aware of the things happened on 21.05.2013, she was unable to communicate.

41. She denied that an informed consent was taken from her and her brother that she has to be shifted to Apollo First Med Hospital on 25.02.2013. When she was suggested that she was shifted to Apollo First Med Hospital to ensure that she was provided with adequate facilities for intensive monitoring and ventilator support in case of her condition worsens, she denied the suggestion. She had stated that the condition of breathlessness subsidised after providing ventilation treatment in Apollo First Med Hospital. She stated that she did not know whether Dr.Deepu met Doctors of the Apollo First Med Hospital and enquired about her well being. She stated that she underwent three surgeries in Apollo First Med

Hospital on 30.05.2013, 19.06.2013, 23.06.2013. She stated that in the operation done on 30.05.2013, in Apollo First Med Hospital, the colostomy bag was kept in the same position as done in G.G.Hospital and adhesions were also released. She admitted that during the Laparatomy procedure performed by the Apollo First Med Hospital on 30.05.2013, it was found that there were very dense vascular adhesions of the small bowel, which resulted in Apollo First Med Hospital making three punctures in the small bowel.

42. She denied the suggestion that her condition stabilised after she was shifted to Apollo First Med Hospital on 25.05.2013 when she was put on ventilator support and it shows that there was no negligence on the part of Dr.Deepu or G.G.Hospital with regard to the sigmoid colon operation conducted on 18.05.2013 or the Laproscopy surgery conducted on 15.05.2013. She also denied the suggestion that the operation done in Apollo First Med Hospital on 30.05.2013 cannot be considered as a rectification operation for the reason that it was not done immediately after her admission, but, done nearly 12 days after the second operation done in

G.G.Hospital. She stated that the colostomy bag was removed in August 2014. But it was not mentioned in her proof affidavit. She stated that she had taken Hernia treatment during 2014, but did not produce any medical records in support of this claim. She denied the suggestion that she paid only Rs.40,000/- at G.G.Hospital and she has to pay Rs.1,22,962/- towards fees to G.G.Hospital.

43. DW.1 is the 4th defendant in this case and he has given evidence on his behalf and on behalf of other defendants. He reiterated the defendants' case set out in the written statement in the proof affidavit. During the course of cross examination, he stated that written statement was filed by him on behalf of all the defendants. Third defendant Dr.Kamala Selvaraj is the senior OBGYN, who specialized in sub fertility and IVF and she is the sole proprietrix. He admitted that only on that attraction, patients are coming to her for consultation. Plaintiff visited first defendant hospital on 08.01.2013 and she consulted with the third defendant. She approached the hospital for third defendant's consultation. He admitted collecting medical history and procedures underwent by the plaintiff and detailed that

she had four previous procedures in the years 1999, 2002, 2005 and 2009. However he stated that plaintiff had not furnished the discharge summary for the treatment taken on these occasions. He stated that he was not aware of the conversations transpired between the plaintiff and the third defendant, when the plaintiff met third defendant. He can only assume that it was to offer a solution to plaintiff's pathology. He performed the surgery as per the direction of the third defendant. But admitted that his name is not indicated in Exs.D1 and D2. He continued to state that Ex.D2 consent was given to authorise the third defendant to perform or authorise the person/persons to perform the same under the authorisation of the third defendant.

44. He stated that plaintiff had multiple fibroid uterus + right Salpingectomy + moderate Pelvic inflammatory disease adhesions. Ex.P11 report shows that there were more than one fibroid. Ex.P3 shows there were atleast 2 fibroids. He stated that plaintiff was suffering hydro Salpinge and PAD adhesions and was operated for the same. This issue has contributed to her sub-fertility status and operation addressed all the above issues. All the three procedures were carried out simultaneously by him.

Prof.Dr.Deivanayagam suspected peritonitis and therefore, second operation was conducted on 18.05.2013. He admitted that operation notes in Ex.P14 dated 18.05.2013 envisaged that there was perforation with peritonitis. He explained that in the course of releasing the uterus from PAD adhesions, sigmoid colon which was added to the uterine wall may have been weekend. This can only be surmised and presumed to be the cause for subsequent perforation. There is no reference about the release of adhesions in the discharge summary, when the patient was transferred to Apollo First Med hospital. He stated that plaintiff required higher surgical and intensive care and since the same was not available at the first defendant hospital, with the consent of the plaintiff, defendants facilitated her transfer to Apollo First Med Hospital.

45. He admitted that plaintiff developed complications during post operative period. That was diagonised immediately and effectively and she was allowed to recover from it. Only due to her poor immunity and healing power, she developed peritonitis secondary to perforation of Colon. He reiterated that first surgery was performed

perfectly and meticulously, but plaintiff's poor immunity and healing power and previous surgeries, could have contributed to the perforation of the colon. When he was asked as to whether the complication was the result of the operation done on 15.05.2013, he answered that "No. Not directly, but may be indirectly."

46. He further stated that if there was any puncture of a hollow viscous, the contents of the viscous will spill on the operative field. If the puncture happened to the plaintiff during the operation, the entire operation field would have been covered with feacal matter, but this did not happen in this case. When the plaintiff had undergone surgery at Apollo hospital, 3 perforations were made inadvertently, but they were identified and rectified subsequently in the same sitting. This part of the evidence of DW.1 that if there had been perforation to sigmoid colon, feacal matter would have been spilled on the operation field is doubtful for the reason that before surgery the intake of solid substance had been stopped and the digested food left in the bowel would have been removed by administering enema. It is seen from Ex.P10 that plaintiff was given only liquid diet from

14.05.2013. Therefore, this part of evidence of DW.1 that if there was puncture caused in the sigmoid colon during the operation, the faecal matter would have been spilled on the operation field cannot be accepted.

47. He admitted that peritonitis was confirmed and the reason for peritonitis was the cause of bowel perforation. During the second operation, it was noticed that the entire pelvic area was spoiled with the liquid feacal material, there was leaking from operation site ie., the sigmoid colon region. The corrective surgery was done to repair the puncture. The surgeon, who performed second surgery, was of the opinion that the plaintiff will require intensive monitoring/ventilatory support. Ventilatory support was not available in the first dependent hospital and that was the reason for transferring the plaintiff to Apollo First Med Hospitals. He stated that there is no intensive care available in first defendant hospital. The reason for transferring the plaintiff temporarily to a higher surgical centre was to safeguard her best interest. Plaintiff paid the expenses at Apollo First Med hospitals.

48. With regard to payment of Rs.5,00,000/- (Rupees five lakhs only), he stated that because of the fact that the plaintiff was subjected to trauma by three unintentional perforations made on her small intestine in addition to, standard revision of her colostomy, the patient and her relations are ethnic origin of Sri Lanka, third defendant volunteered to release solatium of Rs.5,00,000/- on compassion and humanitarian ground. When he was confronted with Ex.P19, he denied having anything to do with this document. He also stated that plaintiff is a native of Karaikal. When he was asked as to whether plaintiff would be able to give birth to a child, he answered that he is not qualified to assess it and she needs to be assessed by a Gynecologist. He stated that the plaintiff underwent surgeries on her digestive system and not on her reproductive system and therefore, she should be technically fit to conceive. He stated that primary operation done at first defendant hospital is nothing to do with the reproductive system. He admitted that the bills produced by the plaintiff are original and genuine bills. The bills for the treatment at Apollo First Med Hospital, discharge summary of Apollo First Med Hospitals are produced as Exs.P17 and P20. Ex.P18 is the receipt for stay at hotel. Ex.P19 is the copy of the declaration

of gift with an offer to pay Rs.5,00,000/- by the third dependent. However, this offer was not accepted by the plaintiff and it is not acted upon.

49. Ex.P20 is the discharge summary of Apollo First Med Hospitals. This is an all important document. Ex.P20 and the evidence of PW2 would shed light on the treatment given to the plaintiff at Apollo First Med Hospitals. Ex.P24 is also the discharge summary of the Apollo First Med Hospitals. Ex.P20- discharge summary for the treatment given to plaintiff at Apollo First Med Hospitals from 21.05.2013 to 03.07.2013 reads as follows:-

> *"Date of Admission : 21.05.13*
> *Date of Discharge : 03.07.13*
>
> *SUMMARY:*
>
> *This 45 year old unfortunate lady was admitted as an Emergency in Apollo First Med Hospitals on the 21 of May after being shifted from G.G. Hospitals in Chennai.* ***She had history of having had laparoscopic myomectomy and adhesiolysis on 15 May as part of her investigations and treatment for infertility. Unfortunately during the post. operative period patient developed***

peritonitis and had to undergone emergency laparotomy on the 18th of May where she was diagnosed to have an inadverent sigmoid perforation. *The patient had toileting and an attempted wedge resection of the perforated site. She had end colostomy fashioned and the distal sigmoid was sutured and left in as a redundant loop. Patient was shifted to Apollo First Med Hospital on the 21" as she had ongoing fever and breathlessness which required treatment at a higher facility. On admission patient was clinically febrile, dyspnoeic and tachycardia. No anaemic or jaundiced. She was admitted in HDU under the care of Dr. Nirmala Jayashankar, Consultant Gynaecologist and Surgical opinion was obtained from the Surgical Gastroenterology team. Clinically patient had wound infection in her lower midline laparotomy scar with a functioning colostomy. There was a tube drain in the left lumbar region which had minimal fluid come through and routine investigations revealed a leucocytosis with hypoalbuminemia. Pus culture from the wound reported Klebsiella growth of ESBL pattern Patient was given supportive treatment in HD and was started on broad spectrum IV antibiotics.*

Since the stoma was working the patient was initiated on diet. Over the next few days patient had an evidence of blood stained fluid discharge from the wound site and started having increasing leucocytosis. ***As part of the investigations to evaluate her leucocytsosis CT Abdomen was done which revealed evidence of pelvic abscess along with free fluid in her left iliac fossa region. Patient was taken up for theatre on 30th of June for a suspected wound dehiscence and drainage of pelvic abscess. Per operatively it was also discovered the end colostomy stoma was retracting and thus the patient had to have a formal laparotomy.*** *During laparotomy patient had evidence of very dense vascular adhesions of the small howel which resulted in three enterotomies while dissection was proceeding.* ***With great difficulty anatomy was delineated and the following findings were noted. Patient had full thickness wound dehiscence. In addition to having a pelvic abscess there was evidence of stump blow out of distal sigmoid redundant loop and LIF end colostomy was retracting.*** *Enterotomies were closed and left colon was mobilized after splemic flexure mobilization and*

end colostomy was refashioned. Hartmann's procedure was done with resection of distal sigmoid up to the level of pelvic prim and rectal stump was sutured and left in place Pelvic abscess was drained and patient had copius warm saline wash and the dehisence was closed with mass tension sutures. Skin and subcutaneous layer was not closed. ***The patient had stormy post operative period but made very gradual progress and was started on total parenteral nutrition. Patient had evidence of prolonged illeus which was investigated by CT of her abdomen which showed evidence of possible minor sub clinical anastomotic leak.*** *Patient was initiated broad spectrum intravenous antibiotics and TPN was continued.* ***As patient was making slow progress, on the 6th of June patient suddenly desaturated and was immediately shifted to ICU and an urgent CT pulmonary angiogram was done which reported evidence of pulmonary thromboembolism.*** *This necessitated anticoagulation which was initiated and patient later was stabilised and was shifted to the ward. The patient's wound which was left open in the theatre had a regular vacuum dressings done and was making good progress with healthy granulation*

tissue. When the wound was ready patient was taken up for secondary suturing which was performed on 19th of June.

Meanwhile the patient had been initiated on oral feeds and over a period of time TPN and Enteric feeds were complimenting each other. As the patient was tolerating oral feeds, was discontinued the patient was started on oral anticoagulation. ***Patient was almost ready to be discharged when she suddenly developed evidence of bleeding from her abdominal wound drain site. In addition to drop in haemoglobin and patient was also found to have mild renal impairment probably secondary to Inj. Polymixen 'B' which she was getting as part of her broad spectrum antibiotic cover.*** *This renal impairment probatily augmented the anticoagulation effects of low molecular weight heparin.* ***Therefore LMWH was withdrawn and the patient was taken to theatre for formal haemotoma evacuation from her abdominal wound site this was done on the 26th of June. Post operatively patient was monitored in HOU and her anaemia corrected with blood transfusion.*** *Patient was latter shifted to the ward*

and was initiated on oral diet which she tolerated well and the patient was discharged home after restarting her oral anticoagulation medications. INR was within Theraputic range. Patient was able to have a normal warfarin diet and her serum albumin had considerably improved at the time of discharge. At discharge patient was wound was found to be healthy and patient was discharged with in situ corrugated wound drain. The patient was ask to review with INR level in 3 days time.

OPERATION NOTES: LAPAROTOMY
DRAINAGE OF PELVIC ABSCESS
RECTOSIGMOID RESECTION AND
REFASHIONING OF COLOSTOMY (30.05.13)

Findings:

1) Retracting sigmoid end colostomy
2) Burst abdomen
3) Sigmoid stump blow out
4) Pelvic abcess
5) Dense bowel adhesions.

Procedure:

1) Release of adhesions and closure of iatrogenic enterotomy sites

2) Splenic flexure mobilisation and refashioning of end colostomy

3) Sigmoid stump resected upto the level of rectosigmoid junction

4) Pelvic abcess drainage done

5) Meticulous normal saline wash out

6) Mass closure of burst abdomen.

OPERATION NOTES: EUA AND SECONDARY SUTURING (19.06.13)

- *Under GA, supine position, EUA done*
- *Good granulating raw area*
- *Small cavity on either sides in the lower wound noted*
- *Raw area including the cavities curetted thoroughly*
- *Linea further narrowed by tightening the loop ethilon*
- *Corrugated drain placed to drain the cavities*
- *Wound margins freshened*
- *Skin closed with 2-0 ethilon*
- *Haemostasis ensured.*

OPERATION NOTES: ABDOMINAL WOUND EXPLORATION AND EVACUATION OF HEMATOMA (26.06.13)

- *| GA, part painted and draped*
- *All sutures removed*
- *200ml blood clots removed*
- *No fresh bleeding noted*
- *Previous corrugated drain removed and new 2 x corrugated drain placed*
- *Thorough lavage with Hydrogen peroxide and saline done*
- *Hemostasis secured*
- *Skin closed with 2-0 ethilon."*

50. Subsequently, she was again treated from 11.08.2014 to 22.08.2014 for reversal of hotmon's procedure and anatomical repair of left Salpingectomy.

51. PW2 is a Doctor, who treated the plaintiff at Apollo First Med Hospital. He is a Gastro intestinal specialist. He treated the plaintiff at Apollo First Med Hospital between 21.05.2013 to 03.07.2013.

Exs.P20 and P24 are the discharge summaries given by the Apollo First Med Hospital. According to him, G.G.Hospital had rightly diagnosed her problem and tried to perform a corrective operation. During the operation to remove fibroid, they inadvertently injured/punctured the sigmoid colon. G.G.Hospital took up the patient for corrective surgery. During the post operative period, the patient became sick and was shifted to Apollo First Med Hospital. The patient had to go through a big ordeal and had to suffer lots of complications. The chances of her having complications because of the surgeries are more. When cross examined, he stated that the colostomy fashioned on the plaintiff was functioning. He stated that the plaintiff Mrs.Flora had multiple surgeries. Most of the previous surgeries were related to the infertility management. When he was asked as to whether he was aware that Mrs.Flora was suffering from a condition medically known as adhesions, he answered that adhesions is not a medical condition. It is a surgical finding. Adhesions merely denotes scared tissue. Any patient who had any form of surgery can develop adhesions. He found adhesions when he operated on Mrs. Flora at the places were surgery was already conducted. Adhesiolysis is performed as and when one encounter

adhesions. It may have to be done any time during the surgery. If the faecal is not diagnosed and appropriate treatment is not given, patient progressively deteriorates and will eventually die. On some occasions, colostomy is a life saving procedure. He stated that during the procedures which happened in G.G.Hospital, an Enterotomy happened, probably inadvertently. Enterotomy means opening of the intestine. He stated that when a part of the bowel is removed, it is referred to as resection. When two ends of bowel are brought together, it is referred to as anastomosis. These procedures were done twice on Mrs.Flora, first in G.G.Hospital, where a part of the large bowel was leaking stools. Secondly, at Apollo First Med Hospital on 30.05.2013 when again the large intestine stump was found leaking.

52. From the evidence of PW1, it is clear that she had undergone Laproscopic Salpingectomy for removing right fallopian tube in France and Diagnostic Laproscopy, three procedures of D&C and 7 cycles of IVF. She was about 43 years when she came to infertility treatment at the first defendant's hospital. After failing in her previous pregnancy

attempts, including 7 IVF treatment, she had approached the first defendant's hospital for her infertility treatment.

53. It is seen from Ex.P2 that there is mention that the plaintiff had adhesions and it is known to her. Though she claimed that she was advised to undergo Laproscopy but was not advised to undergo Endoscopy and not informed about Miomectomy, Ex.D2 consent form shows that she had given consent for Laproscopy, Hysteroscopy, Endomiomectomy and right Salpingectomy. Of course, the word Salpingectomy, it appears that, it was inserted later. Though she denied the suggestion that she was informed that in case of any difficulty during the Laproscopy, a conversion to open surgery would be performed, Ex.D2 consent form, speaks otherwise.

54. Ex.D2 consent form shows that it has details of Laproscopy, Hysteroscopy and Endoscopic Surgery. It has also the details of the after effects of the surgery and possible complications. In case of complications or discovery of life threatening abnormalities, major

abdominal surgery might be necessary. Possible injury to the Stomach and intestine and other complications are also mentioned. It is even stated in the consent form that very rarely some of the complications can even cause death. It is mentioned that the Doctor does not and cannot guarantee the success of the procedure, but the procedure is in the best interest of the patient. It is mentioned that, it is explained to her that during the course of operation, unforeseen conditions may be discovered requiring an extension of the original procedure or different procedures from that described above and therefore, the plaintiff authorised the above named Surgeon and any other person or persons authorised by him to perform such other Laproscopic surgical procedures and if necessary, Laparotomy as are necessary or advisable and desirable in his professional judgment, including treatment of conditions unknown to him at the time of commencement of the operation.

55. Ex.D6 consent form shows that the plaintiff had been fully explained about the nature of the surgical procedures and she was answered her questions about her condition and procedures to her

satisfaction. She was also explained the risk involved in the procedures, she understood the risk and was willing to undergo the procedures. It further reads that no guarantee was given to her by the Doctor about the results of the procedures and during the course of surgery or treatment, unforeseen conditions may be revealed, requiring the extension of the original procedures or different procedures than those are specifically disclosed. Thus, she authorized the surgeon Dr.Kamala Selvaraj or her associate to perform such surgical procedures and to remove any tissue or organs that may be necessary or medically desirable as determined by the Surgeon's judgment. This authority shall extend to the treatment of conditions not previously known to her Doctor. This surgery was planned for Laparotomy + Colostomy (Temporary) for Sigmoid perforation.

56. Though it is claimed by the plaintiff that no informed consent was taken before two surgeries, consent form speaks otherwise. As explained above, the consent form refers about the surgical procedures, possible complications and results. Most importantly, it is stated in the consent form that the surgeon does not guarantee the success of the surgery

and very rarely, surgery may lead to loss of life also.

57. It is seen from Exs.D2, D6 and D7 consent forms, plaintiff had signed in all these forms. Plaintiff's claim is that no informed consent was obtained and the consent was primarily given for the purpose of operation by third defendant Dr.Kamala Selvaraj and not by fourth defendant. Consent forms read that Dr.Kamala Selvaraj can perform the operation or the operation can be performed by such person / persons authorised by her. The consent forms are in English. It is not known whether the plaintiff knew how to read and understand English. The Doctors who explained about the procedural aspects of the surgery and possible complications to the plaintiff have not been examined as witnesses in this case. Therefore, we cannot completely ignore the plaintiff's claim that she was not fully informed about the procedural aspects of the surgery and its complications.

58. From the evidence of PW2, we can gather that during

the operation to remove the fibroid, G.G.Hospital Doctors had inadvertently injured/punctured the sigmoid colon. It is also seen from the evidence of PWs 1 and 2 that three surgeries had been performed at Apollo First Med Hospital.

59. We will now advert to the judgments relied by the learned counsel appearing for the parties on medical negligence. The learned counsel for the plaintiff relied on the following judgments:

(1) Nizam's Institute of Medical Sciences Vs. Prasanth S.Dhananka and others reported in ***(2009) 6 SCC 1*** for the proposition as to what amounts to an informed consent; ingredients of medical negligence and burden of proof and onus of proof in case of medical negligence. The relevant portion of the judgment is extracted hereunder:

> *43. The two issues in Samira Kohli case [(2008) 2 SCC 1] which are relevant for our purpose and raised before the Bench were: (SCC p. 15, para 17)*
> *"(i) Whether informed consent of a patient is necessary for surgical procedure involving removal of reproductive organs? If so, what is the nature of such consent?*

(ii) When a patient consults a medical practitioner, whether consent given for diagnostic surgery can be construed as consent for performing additional or further surgical procedure—either as conservative treatment or as radical treatment—without the specific consent for such additional or further surgery?"

These two questions were answered in the following terms: (SCC pp. 16-18, paras 18 & 21)

"18. Consent in the context of a doctor-patient relationship, means the grant of permission by the patient for an act to be carried out by the doctor, such as a diagnostic, surgical or therapeutic procedure. Consent can be implied in some circumstances from the action of the patient. For example, when a patient enters a dentist's clinic and sits in the dental chair, his consent is implied for examination, diagnosis and consultation. Except where consent can be clearly and obviously implied, there should be express consent. There is, however, a significant difference in the nature of express consent of the patient, known as 'real consent' in UK and as 'informed consent' in America. In UK, the elements of consent are defined with reference to the patient and a consent is considered to be valid and 'real' when (i) the patient gives it voluntarily

without any coercion; (ii) the patient has the capacity and competence to give consent; and (iii) the patient has the minimum of adequate level of information about the nature of the procedure to which he is consenting to. On the other hand, the concept of 'informed consent' developed by American courts, while retaining the basic requirements of consent, shifts the emphasis on the doctor's duty to disclose the necessary information to the patient to secure his consent. 'Informed consent' is defined in Taber's Cyclopedic Medical Dictionary thus:

'Consent that is given by a person after receipt of the following information: the nature and purpose of the proposed procedure or treatment; the expected outcome and the likelihood of success; the risks; the alternatives to the procedure and supporting information regarding those alternatives; and the effect of no treatment or procedure, including the effect on the prognosis and the material risks associated with no treatment. Also included are instructions concerning what should be done if the procedure turns out to be harmful or unsuccessful.'
(emphasis supplied)

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21. The next question is whether in an action for negligence/battery for performance of an unauthorised surgical procedure, the doctor can put forth as defence the consent given for a particular operative procedure, as consent for any additional or further operative procedures performed in the interests of the patient. In Murray v. McMurchy [(1949) 2 DLR 442 : (1949) 1 WWR 989] the Supreme Court of British Columbia, Canada, was considering a claim for battery by a patient who underwent a caesarean section. During the course of caesarean section, the doctor found fibroid tumours in the patient's uterus. Being of the view that such tumours would be a danger in case of future pregnancy, he performed a sterilisation operation. The Court upheld the claim for damages for battery. It held that sterilisation could not be justified under the principle of necessity, as there was no immediate threat or danger to the patient's health or life and it would not have been unreasonable to postpone the operation to secure the patient's consent. The fact that the doctor found it convenient to perform the sterilisation operation without consent as the patient was already under general anaesthesia, was held to be not a valid defence. A somewhat similar view was expressed by the Court of Appeal in England in F. (Mental Patient:

Sterilisation), In re [(1990) 2 AC 1 : (1989) 2 WLR 1025 : (1989) 2 All ER 545 (HL)] , and the Supreme Court of Nova Scotia, Canada in Marshall v. Curry [(1933) 3 DLR 260 : 60 CCC 136] . It was held that the additional or further treatment which can be given (outside the consented procedure) should be confined to only such treatment as is necessary to meet the emergency, and as such needs to be carried out at once and before the patient is likely to be in a position to make a decision for himself. Lord Goff observed: (AC pp. 76 H-77 B)

'... Where, for example, a surgeon performs an operation without his consent on a patient temporarily rendered unconscious in an accident, he should do no more than is reasonably required, in the best interests of the patient, before he recovers consciousness. I can see no practical difficulty arising from this requirement, which derives from the fact that the patient is expected before long to regain consciousness and can then be consulted about longer term measures.' "

44. The Court in Samira Kohli case [(2008) 2 SCC 1] also considered the possibility that had the patient been conscious during surgery and in a position to give his

consent, he might have done so to avoid a second surgery but observed that this was a non-issue as the patient's right to decide whether he should undergo surgery was inviolable. This is what the Court had to say: (Samira Kohli case [(2008) 2 SCC 1] , SCC pp. 18-19, para 23)

"23. It is quite possible that had the patient been conscious, and informed about the need for the additional procedure, the patient might have agreed to it. It may be that the additional procedure is beneficial and in the interests of the patient. It may be that postponement of the additional procedure (say removal of an organ) may require another surgery, whereas removal of the affected organ during the initial diagnostic or exploratory surgery, would save the patient from the pain and cost of a second operation. Howsoever practical or convenient the reasons may be, they are not relevant. What is relevant and of importance is the inviolable nature of the patient's right in regard to his body and his right to decide whether he should undergo the particular treatment or surgery or not. Therefore at the risk of repetition, we may add that unless the unauthorised additional or further procedure is necessary in order to save the life or preserve the health of the patient and it would be unreasonable (as contrasted

from being merely inconvenient) to delay the further procedure until the patient regains consciousness and takes a decision, a doctor cannot perform such procedure without the consent of the patient."

45. It is clear from the evidence in the case before us that there was no urgency in the matter as the record shows that discussions for the deferment of the proposed excision biopsy had taken place between the complainant, his parents and Dr. Satyanarayana in the OPD and the consent for the procedure had been obtained. Also in the light of the observations in the cited cases, any implied consent for the excision of the tumour cannot be inferred.

46. The broad principles under which medical negligence as a tort have to be evaluated, have been laid down in the celebrated case of Jacob Mathew v. State of Punjab [(2005) 6 SCC 1 : 2005 SCC (Cri) 1369] . In this judgment, it has been observed that the complexity of the human body, and the uncertainty involved in medical procedures is of such great magnitude that it is impossible for a doctor to guarantee a successful result and the only assurance that he "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." (SCC p. 18, para 18)

47. The Bench also approved in Jacob Mathew case [(2005) 6 SCC 1 : 2005 SCC (Cri) 1369] (at SCC p. 19, para 19) the opinion of McNair, J. in Bolam v. Friern Hospital Management Committee [(1957) 1 WLR 582 : (1957) 2 All ER 118] , in the following words: (WLR p. 586)

"... 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 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; it is well-established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art." [Charlesworth & Percy, ibid., Para 8.02]

48. The Bench finally concluded its opinion as follows: (Jacob Mathew case [(2005) 6 SCC 1 : 2005 SCC (Cri) 1369] , SCC pp. 32-33, para 48)

"48. We sum up our conclusions as under:

(1) Negligence is the breach of a duty caused by omission to do something which a reasonable man guided by those considerations which ordinarily regulate the conduct of human affairs would do, or doing something which a prudent and reasonable man would not do. The definition of negligence as given in Law of Torts, Ratanlal & Dhirajlal (edited by Justice G.P. Singh), referred to hereinabove, holds good. Negligence becomes actionable on account of injury 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 the 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 case [(1957) 1 WLR 582 : (1957) 2 All ER 118] holds good in its applicability in India."

77. We are also cognizant of the fact that in a case involving medical negligence, once the initial burden has been discharged by the complainant by making out a case of negligence on the part of the hospital or the doctor concerned, the onus then shifts on to the hospital or to the attending doctors and it is for the hospital to satisfy the

court that there was no lack of care or diligence.

78. In Savita Garg v. National Heart Institute [(2004) 8 SCC 56] it has been observed as under: (SCC pp. 69-70, para 16)

"16. ... Once an allegation is made that the patient was admitted in a particular hospital and evidence is produced to satisfy that he died because of lack of proper care and negligence, then the burden lies on the hospital to justify that there was no negligence on the part of the treating doctor or hospital. Therefore, in any case, the hospital is in a better position to disclose what care was taken or what medicine was administered to the patient. It is the duty of the hospital to satisfy that there was no lack of care or diligence. The hospitals are institutions, people expect better and efficient service, if the hospital fails to discharge their duties through their doctors, being employed on job basis or employed on contract basis, it is the hospital which has to justify and not impleading a particular doctor will not absolve the hospital of its responsibilities."

(2) V.Kishan Rao Vs. Nikhil Super Speciality Hospital and another reported in ***(2010) 5 SCC 513*** for the proposition as to the standard norms for medical negligence in Bolam Test is not a rule of law; where negligence is evident prima facie, the burden of proof is on the respondent to prove otherwise. The relevant portion of the judgment is extracted hereunder:

> *23. Even though Bolam [(1957) 1 WLR 582 : (1957) 2 All ER 118] test was accepted by this Court as providing the standard norms in cases of medical negligence, in the country of its origin, it is questioned on various grounds. It has been found that the inherent danger in Bolam [(1957) 1 WLR 582 : (1957) 2 All ER 118] test is that if the courts defer too readily to expert evidence medical standards would obviously decline. Michael Jones in his treatise on Medical Negligence (Sweet and Maxwell), 4th Edn., 2008 criticised the Bolam [(1957) 1 WLR 582 : (1957) 2 All ER 118] test as it opts for the lowest common denominator. The learned author noted that opinion was gaining ground in England that Bolam [(1957) 1 WLR 582 : (1957) 2 All ER 118] test should be restricted to those*

cases where an adverse result follows a course of treatment which has been intentional and has been shown to benefit other patients previously. This should not be extended to certain types of medical accidents merely on the basis of how common they are. It is felt "to do this would set us on the slippery slope of excusing carelessness when it happens often enough" (see Michael Jones on Medical Negligence, para 3-039 at p. 246).

24. With the coming into effect of the Human Rights Act, 1998 from 2-10-2000 in England, the State's obligations under the European Convention on Human Rights (ECHR) are justiciable in the domestic courts of England. Article 2 of the Human Rights Act, 1998 reads as under:
"Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law."

25. Even though Bolam [(1957) 1 WLR 582 : (1957) 2 All ER 118] test "has not been uprooted" it has come under some criticism as has been noted in Jackson & Powell on Professional Negligence (Sweet and Maxwell), 5th Edn., 2002. The learned authors have noted (see para 7-047 at

p. 200 in Professional Negligence) that there is an argument to the effect that Bolam [(1957) 1 WLR 582 : (1957) 2 All ER 118] test is inconsistent with the right to life unless the domestic courts construe that the requirement to take reasonable care is equivalent with the requirement of making adequate provision for medical care. In the context of such jurisprudential thinking in England, time has come for this Court also to reconsider the parameters set down in Bolam [(1957) 1 WLR 582 : (1957) 2 All ER 118] test as a guide to decide cases on medical negligence and specially in view of Article 21 of our Constitution which encompasses within its guarantee, a right to medical treatment and medical care.

26. In England, Bolam [(1957) 1 WLR 582 : (1957) 2 All ER 118] test is now considered merely a "rule of practice or of evidence. It is not a rule of law" (see para 1.60 in Clinical Negligence by Michael Powers QC, Nigel Harris and Anthony Barton, 4th Edn., Tottel Publishing). However, as in the larger Bench of this Court in Jacob Mathew v. State of Punjab [(2005) 6 SCC 1 : 2005 SCC (Cri) 1369] Lahoti, C.J. has accepted Bolam [(1957) 1 WLR 582 : (1957) 2 All ER 118] test as correctly laying down the standards for judging cases of medical

negligence, we follow the same and refuse to depart from it.

> *50. In a case where negligence is evident, the principle of res ipsa loquitur operates and the complainant does not have to prove anything as the thing (res) proves itself. In such a case it is for the respondent to prove that he has taken care and done his duty to repel the charge of negligence.*

(3) M/s. Soni Hospital and two others Vs. Arun Balakrishnan Iyer and one another in ***O.S.A. No.391 of 2003, dated 11.03.2011 on the file of this Court*** for the proposition that once negligence is evident, *Res ipsa loquitur* comes into operation and burden shifts on the hospital to prove there was no negligence on its part. The relevant portion of the judgment is extracted hereunder:

> *50. In a case where negligence is evident, the principle of res ipsa loquitur operates and the complainant does not have to prove anything as the thing (res) proves itself. In such a case it is for the respondent to prove that he has*

taken care and done his duty to repel the charge of negligence.

126.In Nizam Institute of Medical Sciences v. Prasanth S. Dhananka and others, [2009 (7) SCALE 407] : (2009 AIR SCW 3563) this Court held as under:-

"32.We are also cognizant of the fact that in a case involving medical negligence, once the initial burden has been discharged by the complainant by making out a case of negligence on the part of the hospital or the doctor concerned, the onus then shifts on to the hospital or to the attending doctors and it is for the hospital to satisfy the Court that there was no lack of care or diligence. In Savita Garg (Smt.) v. Director, National Heart Institute (2004 AIR SCW 5020) (Para 16) it has been observed as under:

Once an allegation is made that the patient was admitted in a particular hospital and evidence is produced to satisfy that he died because of lack of proper care and negligence, then the burden lies on the hospital to justify that there was no negligence on the part of the treating doctor or hospital. Therefore, in any case, the hospital is

in a better position to disclose what care was taken or what medicine was administered to the patient.

60. For the same preposition, he also relied on the judgment in ***Dr. Harish Kumar Khurana Vs. Joginder Singh and others*** reported in ***(2021) 10 SCC 291.*** The relevant portion of the judgment is extracted hereunder:-

> *27. .... when there was no medical evidence available before Ncdrc on the crucial medical aspect which required such opinion, the mere reliance placed on the Magisterial enquiry would not be sufficient. Though the opinion of the civil surgeon who was a member of the committee is contained in the report, the same cannot be taken as conclusive since such report does not have the statutory flavour nor was the civil surgeon who had tendered his opinion available for cross-examination or seeking answers by way of interrogatories on the medical aspects. Therefore, if all these aspects are kept in view, the correctness or otherwise of the line of treatment and the decision to conduct the operation and the method followed were all required to be considered in the background of the medical evidence in the particular*

facts of this case. As indicated, the mere legal principles and the general standard of assessment was not sufficient in a matter of the present nature when the very same patient in the same set up had undergone a successful operation conducted by the same team of doctors. Hence, the conclusion as reached by Ncdrc is not sustainable.

61. The learned counsel for the defendants relied on the following judgments:

(1) ***Dr. Harish Kumar Khurana Vs. Joginder Singh and others*** reported in ***(2021) 10 SCC 291*** for the proposition that medical negligence must be proved based on material evidence available on record and not just on legal principles. The relevant portion of the judgment is extracted hereunder:

25. The extracted portion would indicate that the opinion as expressed by Ncdrc is not on analysis or based on medical opinion but their perception of the situation to arrive at a conclusion. Having expressed their personal opinion, they have in that context referred to the principles declared regarding Bolam test and have arrived at the conclusion that the second surgery should not have been

taken up in such a hurry and in that context that the appellants have failed to clear the Bolam test and therefore, they are negligent in performing of their duties. The conclusion reached to that effect is purely on applying the legal principles, without having any contra medical evidence on record despite Ncdrc itself observing that the surgeon was a qualified and experienced doctor and also that the anaesthetist had administered anaesthesia to 25,000 patients and are not ordinary but experienced doctors.

26. On the aspect relating to the observation of poor tolerance to anaesthesia and the period of performing the second operation from the time of first operation was conducted it was a highly technical medical issue which was also dependant on the condition of the patient in a particular case which required opinion of an expert in the field. There was no medical evidence based on which conclusion was reached with regard to the medical negligence. The consequential issues with regard to the preparation that was required and the same not being in place including of having a cardiologist in attendance are all issues which was dependant on the aspect noted above on Issues 2 and 3. The observations of Ncdrc in their

opinion appears to be that the second operation ought not to have been conducted and such conclusion in fact had led to the other issues also being answered against the appellants which is not backed by expert opinion.

27. In the above circumstance, when there was no medical evidence available before Ncdrc on the crucial medical aspect which required such opinion, the mere reliance placed on the Magisterial enquiry would not be sufficient. Though the opinion of the civil surgeon who was a member of the committee is contained in the report, the same cannot be taken as conclusive since such report does not have the statutory flavour nor was the civil surgeon who had tendered his opinion available for cross-examination or seeking answers by way of interrogatories on the medical aspects. Therefore, if all these aspects are kept in view, the correctness or otherwise of the line of treatment and the decision to conduct the operation and the method followed were all required to be considered in the background of the medical evidence in the particular facts of this case. As indicated, the mere legal principles and the general standard of assessment was not sufficient in a matter of the present nature when the very same patient in the same set up had undergone a successful

operation conducted by the same team of doctors. Hence, the conclusion as reached by Ncdrc is not sustainable.

(2) ***S.K. Jhunjhuwala Vs. Dhanwanti Kaur and another*** reported in ***(2019) 2 SCC 282*** for the proposition that, to prove medical negligence, direct nexus must be there between ailment after injury and Doctor's negligence. The relevant portion of the judgment is extracted hereunder:

> *42. In our opinion, there has to be a direct nexus with these two factors to sue a doctor for his negligence. Suffering of ailment by the patient after surgery is one thing. It may be due to myriad reasons known in medical jurisprudence. Whereas suffering of any such ailment as a result of improper performance of the surgery and that too with the degree of negligence on the part of the doctor is another thing. To prove the case of negligence of a doctor, the medical evidence of experts in the field to prove the latter is required. Simply proving the former is not sufficient.*

(3) ***Ramesh Chandra Agrawal Vs.Regency Hospital Limited and others*** reported in ***(2009) 9 SCC 709*** for the proposition that, evidence

of expert on a subject without specific data for his assertion has to be excluded from consideration. The relevant portion of the judgment is extracted hereunder:

> *20. An expert is not a witness of fact and his evidence is really of an advisory character. The duty of an expert witness is to furnish the Judge with the necessary scientific criteria for testing the accuracy of the conclusions so as to enable the Judge to form his independent judgment by the application of these criteria to the facts proved by the evidence of the case. The scientific opinion evidence, if intelligible, convincing and tested becomes a factor and often an important factor for consideration along with other evidence of the case. The credibility of such a witness depends on the reasons stated in support of his conclusions and the data and material furnished which form the basis of his conclusions. (See Malay Kumar Ganguly v. Dr. Sukumar Mukherjee [(2009) 9 SCC 221 : (2009) 10 Scale 675] , SCC p. 249, para 34.)*
>
> *21. In State of Maharashtra v. Damu [(2000) 6 SCC 269 : 2000 SCC (Cri) 1088 : AIR 2000 SC 1691] , it has been laid down that without examining the expert as a witness in court, no reliance can be placed on an opinion alone. In*

this regard, it has been observed in State (Delhi Admn.) v. Pali Ram [(1979) 2 SCC 158 : 1979 SCC (Cri) 389 : AIR 1979 SC 14] that "no expert would claim today that he could be absolutely sure that his opinion was correct, expert depends to a great extent upon the materials put before him and the nature of question put to him".

22. In the article "Relevancy of Expert's Opinion" it has been opined that the value of expert opinion rests on the facts on which it is based and his competency for forming a reliable opinion. The evidentiary value of the opinion of an expert depends on the facts upon which it is based and also the validity of the process by which the conclusion is reached. Thus the idea that is proposed in its crux means that the importance of an opinion is decided on the basis of the credibility of the expert and the relevant facts supporting the opinion so that its accuracy can be crosschecked. Therefore, the emphasis has been on the data on the basis of which opinion is formed. The same is clear from the following inference:

"Mere assertion without mentioning the data or basis is not evidence, even if it comes from an expert. Where the experts give no real data in support of their opinion, the evidence even though admissible, may be excluded from consideration as affording no assistance in arriving at the

correct value."

(4) ***Maharaja Agrasen hospital and others Vs. Master Rishabh Sharma and others*** reported in ***(2020) 6 SCC 501*** for the proposition that expert evidence is only advisory in nature and also with regard to degree of skill and care required by the practitioner. The relevant portion of the judgment is extracted hereunder:

> *12.3.2. It is well settled that a court is not bound by the evidence of an expert, which is advisory in nature. The court must derive its own conclusions after carefully sifting through the medical records, and whether the standard protocol was followed in the treatment of the patient. The duty of an expert witness is to furnish the court with the necessary scientific criteria for testing the accuracy of the conclusions, so as to enable the court to form an independent opinion by the application of this criteria to the facts proved by the evidence of the case. [Ramesh Chandra Agrawal v. Regency Hospital Ltd., (2009) 9 SCC 709 : (2009) 3 SCC (Civ) 840; State of H.P. v. Jai Lal, (1999) 7 SCC 280 : 1999 SCC (Cri) 1184] Whether such evidence could be accepted or how*

much weight should be attached to it is for the court to decide. [Malay Kumar Ganguly v. Sukumar Mukherjee, (2009) 9 SCC 221 : (2009) 3 SCC (Civ) 663 : (2010) 2 SCC (Cri) 299; V. Kishan Rao v. Nikhil Super Speciality Hospital, (2010) 5 SCC 513 : (2010) 2 SCC (Civ) 460]

12.3.3. We accept the view taken by the National Commission in disregarding the opinion of the Medical Board constituted by AIIMS.

12.3.4. The complainants have discharged the initial burden of proof [Nizam's Institute of Medical Sciences v. Prasanth S. Dhananka, (2009) 6 SCC 1 : (2009) 2 SCC (Civ) 688; Savita Garg v. National Heart Institute, (2004) 8 SCC 56] by making out a case of clear negligence on the part of Appellant 1 Hospital and the Paediatric doctors under whose care the baby was admitted, as also Appellant 4 Dr S.N. Jha, the Senior Ophthalmologist attached to Appellant 1 Hospital. Appellant 1 Hospital and Appellants 2-4 doctors have failed to satisfy the Court that ROP tests were conducted at any point of time, or that the complainants were even advised to get the ROP test done.

12.4. Medical Negligence and Duty of Care

12.4.1. Medical negligence comprises of the following constituents:

(1) A legal duty to exercise due care on the part of the medical professional;

(2) failure to inform the patient of the risks involved;

(3) the patient suffers damage as a consequence of the undisclosed risk by the medical professional;

(4) if the risk had been disclosed, the patient would have avoided the injury;

(5) breach of the said duty would give rise to an actionable claim of negligence.

12.4.2. The cause of action for negligence arises only when damage occurs, since damage is a necessary ingredient of this tort. In a complaint of medical negligence, the burden is on the complainant to prove breach of duty, injury and causation. The injury must be sufficiently proximate to the medical practitioner's breach of duty. In the absence of evidence to the contrary adduced by the opposite party, an inference of causation may be drawn even though positive or scientific proof is lacking. [Postgraduate Institute of Medical Education & Research v. Jaspal Singh, (2009)

7 SCC 330 : (2009) 3 SCC (Civ) 114 : (2009) 3 SCC (Cri) 399]

12.4.3. Medical negligence is the breach of a duty of care by an act of omission or commission by a medical professional of ordinary prudence. Actionable medical negligence is the neglect in exercising a reasonable degree of skill and knowledge to the patient, to whom he owes a duty of care, which has resulted in injury to such person. The standard to be applied for adjudging whether the medical professional charged has been negligent or not, in the performance of his duty, would be that of an ordinary competent person exercising ordinary skill in the profession. The law requires neither the very highest nor a very low degree of care and competence to adjudge whether the medical professional has been negligent in the treatment of the patient. [Laxman Balkrishna Joshi v. Trimbak Bapu Godbole, (1969) 1 SCR 206 : AIR 1969 SC 128; Kusum Sharma v. Batra Hospital, (2010) 3 SCC 480 : (2010) 1 SCC (Civ) 747 : (2010) 2 SCC (Cri) 1127]

12.4.4. The degree of skill and care required by a medical practitioner stated in Halsbury's Laws of

England [3rd Edn., Vol. 26, pp. 17-18; 4th Edn., Vol. 30, para 35.] is as follows:

"22. Negligence : Duties owed to patient. A person who holds himself out as ready to give medical 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. A breach of any of these duties will support an action for negligence by the patient."

"35. Degree of skill and care required.—... To establish liability on that basis it must be shown (1) that there is a usual and normal practice; (2) that the defendant has not adopted it; and (3) that the course in fact adopted is one no professional man of ordinary skill would have taken had he been acting with ordinary care."
(emphasis supplied)

(5) ***Bolam Vs. Friern Hospital Management Committee*** reported in ***(1957) 1 WLR 582*** on the principles as to what is in law we mean by "Negligence". The relevant portion of the judgment is extracted hereunder:

> *Before I turn to that, I must tell you what in law we mean by "negligence." In the ordinary case which does not involve any special skill, negligence in law means a failure to do some act which a reasonable man in the circumstances would do, or the doing of some act which a reasonable man in the circumstances would not do; and if that failure or the 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 you judge it by the action of the man in the street. He is the ordinary man. In one case it has been said 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 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 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; it is well established law that it is sufficient if he exercises*

the ordinary skill of an ordinary competent man exercising that particular art. I do not think that I quarrel much with any of the submissions in law which have been put before you by counsel. Counsel for the plaintiff put it in this way, that in the case of a medical man, negligence means failure to act in accordance with the standards of reasonably competent medical men at the time. That is a perfectly accurate statement, as long as it is remembered that there may be one or more perfectly proper standards; and if he conforms with one of those proper standards, then he is not negligent. Mr. Fox-Andrews also was quite right, in my judgment, in saying that a mere personal belief that a particular technique is best is no defence unless that belief is based on reasonable grounds. That again is unexceptionable. But the emphasis which is laid by the defence is on this aspect of negligence, that the real question you have to make up your minds about on each of the three major topics is whether the defendants, in acting in the way they did, were acting in accordance with a practice of competent respected professional opinion. Mr. Stirling submitted that if you are satisfied that they were acting in accordance with a practice of a competent body of professional opinion, then it would be wrong for you to hold that negligence was established. In a recent Scottish case,

Hunter v. Hanley, which dealt with medical matters, where the Lord President said this:

> *"In the realm of diagnosis and treatment there is ample scope for genuine difference of opinion and one man clearly is not negligent merely because his conclusion differs from that of other professional men, nor because he has displayed less skill or knowledge than others would have shown. The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of, if acting with ordinary care."*
>
> *If that statement of the true test is qualified by the words "in all the circumstances," Mr. Fox-Andrews would not seek to say that that expression of opinion does not accord with the English law. It is just a question of expression. I myself would prefer to put it this way, that he is not 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. I do not think there is much difference in sense. It is just a different way of expressing the same thought. Putting it the other way round, a man is not negligent, if he is acting in accordance with such a practice,*

merely because there is a body of opinion who would take a contrary view. At the same time, that does not mean that a medical man can obstinately and pig-headedly carry on with some old technique if it has been proved to be contrary to what is really substantially the whole of informed medical opinion. Otherwise you might get men today saying: "I do not believe in anaesthetics. I do not believe in antiseptics. I am going to continue to do my surgery in the way it was done in the eighteenth century." That clearly would be wrong.

(6) ***Arun Kumar Manglik Vs. Chirayu Health and Medicare Private Limited and another*** reported in ***(2019) 7 SCC 401*** for the proposition that, the threshold to prove unreasonableness is associated risks and the conditions under which practitioner perform. The relevant portion of the judgment is extracted hereunder:

43. Our law must take into account advances in medical science and ensure that a patient-centric approach is adopted. The standard of care as enunciated in Bolam [Bolam v. Friern Hospital Management Committee, (1957) 1 WLR 582] case must evolve in consonance with its subsequent interpretation by English and Indian courts.

Significantly, the standard adopted by the three-Judge Bench of this Court in Jacob Mathew [Jacob Mathew v. State of Punjab, (2005) 6 SCC 1 : 2005 SCC (Cri) 1369] includes the requirement that the course adopted by the medical professional be consistent with "general and approved practice" and we are bound by this decision.

44. In adopting a standard of care, Indian courts must be conscious of the fact that a large number of hospitals and medical units in our country, especially in rural areas, do not have access to latest technology and medical equipment. A two-Judge Bench of this Court in Martin F. D'Souza v. Mohd. Ishfaq [Martin F. D'Souza v. Mohd. Ishfaq, (2009) 3 SCC 1 : (2009) 1 SCC (Civ) 735 : (2009) 1 SCC (Cri) 958] held thus : (SCC p. 17, para 37)

"37. The standard of care has to be judged in the light of knowledge available at the time of the incident and not at the date of the trial. Also, where the charge of negligence is of failure to use some particular equipment, the charge would fail if the equipment was not generally available at that point of time."

45. In the practice of medicine, there could be varying approaches to treatment. There can be a genuine difference

of opinion. However, while adopting a course of treatment, the medical professional must ensure that it is not unreasonable. The threshold to prove unreasonableness is set with due regard to the risks associated with medical treatment and the conditions under which medical professionals function. This is to avoid a situation where doctors resort to "defensive medicine" to avoid claims of negligence, often to the detriment of the patient. Hence, in a specific case where unreasonableness in professional conduct has been proven with regard to the circumstances of that case, a professional cannot escape liability for medical evidence merely by relying on a body of professional opinion.

(7) ***Dr. (Mrs.) Chanda Rani Akhouri and others Vs. Dr.M.A.Methusethupathi and others*** reported in ***2022 SCC online SC 481*** with regard to the principles to be kept in mind while considering negligence of a practitioner. The relevant portion of the judgment is extracted hereunder:

24. The term "negligence" has been defined in Halsbury Laws of England (Fourth Edition) para 34

and as settled in Kusum Sharma v. Batra Hospital and Medical Research Centre2 as under:

> *"45. According to Halsbury's Laws of England, 4th Edn., Vol. 26 pp. 17-18, the definition of negligence is as under:*
>
> *"22. Negligence.—Duties owed to patient. A person who holds himself out as ready to give medical 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. A breach of any of these duties will support an action for negligence by the patient."*

25. In para 89 of the judgment in Kusum Sharma (supra), the tests of medical negligence while deciding

whether the medical professional is guilty of medical negligence, varied tested principles have to be kept in view, this Court held as under:

"89. On scrutiny of the leading cases of medical negligence both in our country and other countries specially the United Kingdom, some basic principles emerge in dealing with the cases of medical negligence. While deciding whether the medical professional is guilty of medical negligence following well-known principles must be kept in view:

I. Negligence is the breach of a duty exercised 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.

II. Negligence is an essential ingredient of the offence. The negligence to be established by the prosecution must be culpable or gross and not the negligence merely based upon an error of judgment.

III. The medical professional is expected to bring 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.

IV. A medical practitioner would be liable only where his conduct fell below that of the standards of a reasonably competent practitioner in his field.

V. In the realm of diagnosis and treatment there is scope for genuine difference of opinion and one professional doctor is clearly not negligent merely because his conclusion differs from that of other professional doctor.

VI. 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. Just because a professional looking to the gravity of illness has taken higher element of risk to

redeem the patient out of his/her suffering which did not yield the desired result may not amount to negligence.

VII. Negligence cannot be attributed to a doctor so long as he performs his duties with reasonable skill and competence. Merely because the doctor chooses one course of action in preference to the other one available, he would not be liable if the course of action chosen by him was acceptable to the medical profession.

VIII. It would not be conducive to the efficiency of the medical profession if no doctor could administer medicine without a halter round his neck.

IX. It is our bounden duty and obligation of the civil society to ensure that the medical professionals are not unnecessarily harassed or humiliated so that they can perform their professional duties without fear and apprehension.

X. The medical practitioners at times also have to be saved from such a class of complainants who use criminal process as a tool for pressurising the medical professionals/hospitals, particularly private hospitals or

clinics for extracting uncalled for compensation. Such malicious proceedings deserve to be discarded against the medical practitioners.

XI. The medical professionals are entitled to get protection so long as they perform their duties with reasonable skill and competence and in the interest of the patients. The interest and welfare of the patients have to be paramount for the medical professionals."

62. The following propositions would emerge from the aforesaid judgments:

1. What is relevant and of importance is the inviolable nature of the patient's right in regard to his body and his right to decide whether he should undergo the particular treatment or surgery or not.

2. The essential components of negligence are three: 'duty', 'breach' and 'resulting damage'.

3. In a case of medical negligence, once the initial burden has been discharged by the complainant, the onus then shifts on to the hospital or to the attending doctors and it is for the hospital to satisfy the court that there was no lack of care or diligence.

4. Bolam test is now considered merely a rule of practice or of evidence and not a rule of law. Hon'ble Apex court of India, in Jacob Mathew v. State of Punjab has accepted Bolam test as correctly laying down the standards for judging cases of medical negligence.

5. In a case where negligence is evident, the principle of res ipsa loquitur operates and the complainant does not have to prove anything as the thing (res) proves itself. In such a case it is for the respondent to prove that he has taken care and done his duty to repel the charge of negligence.

6. To sue for medical negligence, there has to be a direct nexus between suffering of ailment by the patient after surgery and such suffering must be as a result of improper performance of the surgery and that too with the degree of negligence on the part of the doctor.

7. To prove the case, the medical evidence of experts in the field to prove the latter is required.

8. Simply proving the former is not sufficient. An expert is not a witness of fact and his evidence is really of an advisory character. Where the experts give no real data in support of their opinion, the evidence, even though admissible, may be excluded from consideration as affording no assistance in arriving at the correct value.

9. Further, without examining the expert as a witness in court, no reliance can be placed on an opinion alone.

10. Constituents of Medical Negligence :-

(a) legal duty to exercise due care on the part of the medical professional;

(b) failure to inform the patient of the risks involved;

(c) the patient suffers damage as a consequence of the undisclosed risk;

(d) if the risk had been disclosed, the patient would have avoided the injury;

(e) breach of the said duty would give rise to an actionable claim of negligence.

11. In the case of medical negligence, the burden is on the complainant to prove breach of duty,

injury and causation. In the absence of evidence to the contrary adduced by the opposite party, an inference of causation may be drawn even though positive or scientific proof is lacking.

12. The term "Negligence" with specific reference to duties owed to patient as defined in Halsbury's Laws of England is as follows:

> ***Negligence : Duties owed to patient****. A person who holds himself out as ready to give medical 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.*** *A breach of any of these duties will support an action for negligence by the patient."*

13. The test for negligence, is the standard of the ordinary skilled man exercising and professing to have that special skill. In the case of a medical man, negligence means failure to act in accordance with the standards of reasonably competent medical men at the time. However, it should be remembered that there may be one or more perfectly proper standards; and if he conforms with one of those proper standards, then he is not negligent.

14. The standard of care has to be judged in the light of knowledge available at the time of the incident and not at the date of the trial, further the court must be conscious of the fact that a large number of hospitals and medical units in our country, especially in rural areas, do not have access to latest technology and medical equipment.

15. The threshold to prove unreasonableness is set with due regard to the risks associated with medical treatment and the conditions under which medical professionals function.

63. In operation notes for the surgery dated 18.05.2013, it was recorded that there was sigmoid perforation. In all probability the sigmoid perforation was the cause of apparent negligence on the part of the fourth defendant while performing adhesiolysis. It is not as though the defendants especially the fourth defendant did not aware of the plaintiff's past medical and surgery history. Only after knowing that she had undergone 3 procedures earlier and there were fibroids in her uterus and adhesions, defendants proceeded with the treatment, through surgical means. If the adhesions were so severe and possibility of causing harm/injury to the other body parts, while removing adhesions, is unavoidable defendants should have avoided to proceed further with adhesiolysis and other treatments. No proper precautions were taken to avoid damage to other body part, especially, sigmoid colon, while

performing adhesiolysis. Defendants had taken unnecessary risk and in the process, risked the life of plaintiff. Therefore, it is apparent that the second surgery dated 18.05.2013 was the result of faulty first surgery performed on 15.05.2013.

64. It is pertinent to reiterate the definition of term 'negligence' as per Halsbury's Laws of England.

> ***Negligence : Duties owed to patient****. A person who holds himself out as ready to give medical 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.*** *A breach of any of these duties will support an action for negligence by the patient."*

65. As per this definition, a Doctor owes the duty to patient in deciding whether to undertake the case; the duty of care in deciding what treatment to give; and the duty of care in his administration of that treatment.

66. Plaintiff was aged about 43 years when she came for treatment in the first defendant hospital. Before coming to the first defendant hospital, she had undergone two surgeries, 3 DNC procedures and 7 IVF procedures. After failing in all her attempts to get childbirth, she had chosen the first defendant hospital mainly based on the popularity of the third defendant in infertility treatment, with the fond hope that she would get positive result this time. The investigation prior to the treatment revealed that plaintiff had fibroid and adhesions. The Doctors at first defendant hospital knew better the complications that may arise while removing the adhesions. Ex.D2 consent form is general in nature and it is a printed format consent form. There is no specific mention in Ex.D2 consent form about informing the plaintiff the possible complications that may arise while removing the fibroids, adhesions etc. As already indicated, the

Doctors, who had explained the terms in the consent form, are not examined before this Court to find out what exactly the information they provided to the plaintiff. The Doctors at first defendant hospital, especially, fourth defendant, who performed the surgery and who knew pretty well about the plaintiff's previous treatment history, including surgical treatment and that the plaintiff had fibroids and adhesions, should have anticipated the complications associated with adhesiolysis surgery and taken adequate precautionary measures.

67. The Doctors at first defendant hospital, who have conferred with the plaintiff, considering her advanced age, previous surgical histories and other treatment histories and the definite/possible complications that may arise due to adhesions and other surgeries, should have even discouraged the plaintiff to go ahead with infertility treatment. However, they have not advised the plaintiff not to go ahead with the treatment, but rather found the plaintiff fit to undergo the surgery. Having found the plaintiff fit to undergo the surgery, the Doctors should have taken extra caution while performing the surgery to find out whether adhesions

were properly removed and whether any injury was caused to other body parts, during the course of surgery. If any injury is caused to other body parts, like in this case, perforation to sigmoid colon, immediate steps should have been taken to plug/to close the perforation. Unfortunately, that was not done in this case. When the plaintiff had undergone surgery at Apollo First Med Hospitals, inadvertently three punctures were made, however that issue was addressed in the same sitting. That sort of care and caution was not taken in this case by fourth defendant at GG hospital. It is the admitted case of the defendants that since the plaintiff had undergone previous surgeries, her uterine and sigmoid colon were attached with each other and when adhesiolysis was done, a portion of the sigmoid colon was stuck with uterus and that become weak. After consuming solid food, the weak spot got exposed leading to leakage of feacal matters. When the fourth defendant admitted that during adhesiolysis, a portion of sigmoid colon was stuck with uterus and become weak, it was expected that the fourth defendant should have taken all the necessary steps to correct/find the alleged weak part of sigmoid colon so as to prevent any further complications. That was not done in this case.

68. It appears that plaintiff has not informed about 7 IVF treatment procedures undergone by her. She had also taken the risk of getting pregnancy after her previous attempts failed, at the age of 43 years, normally considered too old to go for pregnancy. Even in normal old age pregnancy, the following risk factors are associated:-

(i) High Blood Pressure

(ii) Gestational diabetics

(iii) Birth defects, such as down syndrome, miscarriage, low birth weight. Even with advanced scanning techniques, the scan investigation report will not give 100% accurate findings.

69. In the light of the evidence available and discussed above, this Court is of the view that the risk taken by the plaintiff at the age of 43 years after all her previous attempts to get childbirth failed; failure on the part of the Doctors at first defendant hospital to give proper advice, even to discourage the plaintiff to go ahead with pregnancy plans in view of her failed attempts and advance age; failure on the part of the fourth defendant

to take all the necessary precautionary measures to avoid any damage to other body parts, especially, sigmoid colon of the plaintiff while performing adhesiolysis; failure on the part of the fourth defendant to find out the perforation of sigmoid colon in the same sitting and address the issue, all contributed to the perforation of sigmoid colon leading to the necessity of performing the second surgery on 18.05.2013. The second surgery, by the medical standards and protocol, was absolute necessary for saving the life of plaintiff. That was also admitted by PW.2.

70. Even as per the admitted case of the defendants, no facilities available at the first defendant hospital to treat the plaintiff's breathlessness problem after the second surgery. The reason for shifting the plaintiff to the Apollo First Med Hospital was that it had no facilities for assisted ventilation treatment and therefore, plaintiff was shifted to Apollo First Med Hospital for assisted ventilation support in case plaintiff's condition worsened. When the first defendant hospital had taken the risk of performing surgery, it is expected that the facility for assisted ventilation treatment should also be in place in the first defendant hospital. Without

having such a basic facility, the very idea of conducting surgery on plaintiff and going ahead with the surgery is itself a questionable decision taken by the Doctors at first defendant hospital. After plaintiff was transferred to Apollo First Med Hospital, we have seen that she underwent three surgeries there. She had to undergo a lot of pain and suffering from the date of first surgery at first defendant hospital on 15.05.2013 till she completely recovered and became normal. Therefore, this Court is of the view that the Doctors at first defendant hospital, especially, defendants 3 and 4 had failed in properly advising the plaintiff about the possible complications/risks that may arise while removing fibroids/adhesions and failed in properly administering the treatment when they were performing adhesiolysis.

71. In view of the discussions held above, this Court answers the Issue Nos.1 to 20 as follows: -

i. There was formation of adhesion in the abdomen prior to the admission of the plaintiff in the first defendant hospital as contended by the defendants 3 and 5 and there was necessity to undergo laproscopic surgery to remove the adhesion for infertility treatment

for Issue No.1.

ii. Due to previous surgeries and plaintiff's medical conditions, plaintiff required medical procedures and surgery for Issue No.2.

iii. Though the consent form shows about the explanation about the medical procedures, in the absence of examination of Doctors, who explained the medical procedures and surgery to be performed on the plaintiff, it is not possible to answer the issue as to whether plaintiff was clearly explained about the medical and surgical procedures to be performed on her and then she signed consent forms for Issue Nos. 3 and 4. Obviously defendants convinced the plaintiff to undergo laproscopic surgery to become fit to conceive the child for Issue No.5.

iv. Defendants, especially, fourth defendant had not performed laproscopic surgery and adhesiolysis surgery with the skill and expertise required from an expert and due to his negligence, he perforated the sigmoid colon of plaintiff, while performing adhesiolysis surgery for Issue No.6.

v. After the first surgery, plaintiff's complaint was not immediately

addressed by the defendants and only after her condition worsened, Doctors attended on her, for issue No.7.

vi. Subsequent open surgery by the Doctors on the plaintiff on 18.05.2013, under the then prevailing circumstances, was proper and necessary. However, in the absence of examination of Doctors who explained the consent form, it is not possible to give a finding that an informed consent was taken from the plaintiff. Accordingly, issue No.8 is answered.

vii. Second surgery was necessitated because of the faulty first surgery. Therefore, Doctors are liable to take responsibility for the second surgery and its consequences. Accordingly, issue No.9 is answered.

viii. Plaintiff was first operated on 15.05.2013 and then on 18.05.2013 and she was facing pain and sufferings. Therefore, it is not possible to say that she was shifted to Apollo First Med Hospitals after proper counselling to her and her brother. Accordingly, issue No.10 is answered.

ix. Defendant's negligence, especially, fourth defendant's negligence and improper handling resulted in damaging the sigmoid colon, which

resulted in leaking the feacal matters to give raise to the necessity of fixing the colostomy bag outside the body to collect the discharge. Accordingly, issue No.11 is answered.

x. After the second surgery on 18.05.2013, despite given care, plaintiff developed discomfort, especially, difficulty in breathing. Accordingly, issue No.12 is answered.

xi. The faulty first surgery was responsible for the plaintiff's condition, the second surgery at G.G. Hospital and subsequent surgeries at Apollo First Med Hospitals for Issue No.13.

xii. Even as per the case of the defendants, first defendant hospital has no facility for treating plaintiff's breathlessness problem ie., first defendant hospital has no ventilatory support system and that was the reason for shifting the plaintiff to Apollo First Med Hospitals, for Issue No.14.

xiii. The faulty first surgery was responsible for the infection to plaintiff's abdominal pelvic area, for Issue No.15.

xiv. Defendants offered a sum of Rs.5,00,000/- (Rupees five lakhs only) as one time settlement, for Issue No.16.

xv. Plaintiff had working colostomy and working stoma on her admission at Apollo First Med Hospitals on 21.05.2013, for Issue No.17.

xvi. Though there was a faulty first surgery performed by the defendants, the evidence produced in this case is inconclusive to find out the nature of permanent disability caused to the plaintiff. The reason is no expert was examined on the aspect of permanent disablement suffered by the plaintiff. PW.2 gave evidence only in respect of treatment aspects. He did not give any evidence on the permanent disability suffered by the plaintiff and its extent and percentage. He stated that, as regards child birth, he is not commenting any thing. He also said that the chances of plaintiff getting complications, because of surgeries, are more. Though it is certain that plaintiff suffered permanent disability because of multiple surgeries, due to the faulty first surgery, it is not possible to fix the nature and extent of permanent disability. Thus, Issue No.18 is answered.

xvii. At the risk of repetition, it is reiterated that first surgery held on 15.05.2013 resulted in perforation of Sigmoid Colon and that was the cause for second surgery on 18.05.2013 at first defendant hospital,

followed by other surgeries at Apollo First Med Hospital. These repeated surgeries had affected enormously the plaintiff's health causing her lot of pain and untold sufferings during the period of treatment. Possibly, plaintiff could never give childbirth again; she suffered other disabilities related to repeated surgeries. Therefore, defendants are liable to compensate plaintiff for the pain and sufferings and disablement caused to her. Thus, Issues 19 and 20 are answered.

Issue Nos.21 to 24:

72. These issues are answered in the light of the findings reached in Issue Nos.1 to 20.

It is not in dispute that the plaintiff had undergone treatment at first defendant hospital and Apollo First Med Hospital. Therefore, no doubt that she had spent money at first defendant hospital and Apollo First Med Hospital for treatment. The faulty first surgery was responsible for successive surgeries and related treatment. Plaintiff has produced Exs.P17 and P18 Bills to show the treatment and other incidental expenses. DW.1

admitted the veracity of these documents. As per plaintiff's claim, she paid Rs.62,000/- at first defendant Hospital. It is also claimed that she paid the following sums at Apollo First Med Hospital:-

1) for operation and medicines ... Rs.12,80,500/-

2) for Follow up treatment ... Rs. 4,00,000/-

She also claimed Rs.3,00,000/- for treating Hernia, Rs.3,00,000/- for maintaining colostomy bag and Rs.1,50,000/- towards attender's charges.

73. The medical records produced by the plaintiff, especially, medical bills show that she spent Rs.12,80,500/- for operation and other charges at Apollo First Med Hospital. There is no medical records and bills produced in support of the claim of Rs.4,00,000/- towards further follow up treatment charges and the claim of Rs.3,00,000/- towards Hernia treatment. In the absence of medical records and bills, this claim cannot be allowed. It is admitted by the plaintiff that colostomy bag was removed at Apollo First Med Hospital. Therefore, her claim of Rs.3,00,000/- for change of colostomy bag once in seven days is not correct and therefore, this claim is rejected. It is no doubt that during the course of

treatment, somebody might have taken care of plaintiff, leaving the attender's other commitments and in the process, plaintiff should have paid the attendee a reasonable charge. Thus, this Court is of the view that the plaintiff is entitled for Rs.1,50,000/- as claimed in the plaint towards attendee charges. Thus, taking into consideration the amount spent on medical expenses and supported by receipts, the attendee charges and other incidental charges, this Court is of the view that the plaintiff is entitled for a sum of Rs.15,00,000/- (Rupees Fifteen Lakhs only) towards medical expenses, attendee charges and other incidental charges.

74. As discussed above, plaintiff might have undergone severe pain and untold sufferings from the date of first surgery on 15.05.2013, during the period of treatment at first defendant hospital and Apollo First Med Hospital, when she had undergone surgeries on 18.05.2013, 30.05.2013, 19.06.2013 and 26.06.2013 till she completely recovered to lead a normal life. It is also certain that she suffers from permanent disability associated with these surgeries. This permanent disablement would impact her day-to-day functioning/activities in her daily

routine, preventing her from performing her activities as a normal person. Taking these aspects into consideration, this Court orders a lumpsum compensation of Rs.25,00,000/- (Rupees Twenty Five Lakhs only) towards pain and sufferings and the disability suffered by the plaintiff due to faulty first surgery resulting in successive surgeries.

75. In the result,

(i) The suit is decreed in part with costs.

(ii) This Court directs the defendants to pay jointly and severally a sum of Rs.40,00,000/- (Rupees Forty Lakhs only) as compensation to the plaintiff with interest at the rate of 12% per annum from the date of plaint till the date of decree and at the rate of 6% per annum from the date of decree till the date of realisation.

Mra 31.01.2023

List of Witnesses examined on the side of the plaintiff:

PW.1 - Mrs. Flora Madiazagane

PW.2 - Dr.Ravindran Kumeran

List of Exhibits marked on the side of the plaintiff:

Exhibits	*Date*	*Particulars of Document*
Ex.P1	08.01.2013	Original Diagnostic Notes by GG Hospital
Ex.P2	08.01.2013	Original Diagnostic report by GG Hospital
Ex.P3	09.01.2013	Original Diagnostic report by Cardio Diagnostic Care, GG Hospital Complex.
Ex.P4	15.01.2013	Original Diagnostic report by G.G.Hospital
Ex.P5	19.02.2013	Original X-ray Mammography report of plaintiff
Ex.P6	05.04.2013	Original Diagnostic report by Cardio Diagnostic Care, GG Hospital Complex.
Ex.P7	11.04.2013	Xerox copy of G.G.Hospital Report
Ex.P8	27.04.2013	Original report of Karai Labs
Ex.P9	29.04.2013	Original report of Hitech diagnostic centre
Ex.P10	02.05.2013	Original Admission form of GG Hospital with report
Ex.P11	15.05.2013	Original Diagnostic report by Cardio Diagnostic Care, GG Hospital Complex.
Ex.P12	16.05.2013	Original report of A.A.Lab Services
Ex.P13	20.05.2013	Original Diagnostic report by Cardio Diagnostic Care, GG Hospital Complex.
Ex.P14	19.05.2013	Original Diagnostic report by Cardio Diagnostic Care, GG Hospital Complex.
Ex.P15	17.05.2013	Original Diagnostic report by Cardio Diagnostic Care, GG Hospital Complex.

Exhibits	*Date*	*Particulars of Document*
Ex.P16	21.05.2013	Original Diagnostic report by Cardio Diagnostic Care, GG Hospital Complex.
Ex.P17 (series)	-	Statement of expenses with Bills & receipts-Originals
Ex.P18 (series)	-	Statement of expenses with Bills & Expenses (other than Hospital)
Ex.P19	25.06.2013	Xerox copy of Declaration of Gift (without signature of the donee/plaintiff)
Ex.P20	03.07.2013	Original Discharge Summary issued by Apollo First Med Hospitals
Ex.P21	18.11.2013	Office copy of Legal Notice issued by plaintiff's counsel to the defendants
Ex.P22	27.11.2013	Reply by defendants' counsel to the plaintiff's counsel (Original)
Ex.P23	30.12.2013	Reply by defendants' counsel to the plaintiff's counsel (Original)
Ex.P24	22.08.2014	Original Discharge Summary issued by Apollo First Med Hospitals

List of Witnesses examined on the side of defendants:

DW.1 - Dr.Deepu Raj Kamal Selvaraj

List of Exhibits marked on the side of defendants:

Exhibits	*Date*	*Particulars of Document*
Ex.D1	03.05.2013	Xerox copy of the No Objection Certificate obtained from the plaintiff's husband, Mr.Madizagane
Ex.D2	14.05.2013	Xerox copy of the consent for Diagnostic Laparoscopy / Hysteroscopy / Endoscopic Surgery
Ex.D3	14.05.2013	Original check list of the plaintiff by GG Hospital
Ex.D4	14.05.2013	Original Pre-Operative Form of GG Hospital with regard to plaintiff
Ex.D5	15.05.2013	Original Anaesthesia Record of the plaintiff by GG Hospital
Ex.D6	18.05.2013	Xerox copy of the Consent of the Plaintiff to Surgery and other procedures by GG Hospital
Ex.D7	18.05.2013	Xerox copy of the Consent of the Plaintiff for Anaesthesia by GG Hospital
Ex.D8	18.05.2013	Original check list of the plaintiff by GG Hospital
Ex.D9	18.05.2013	Original Anaesthesia Record of the plaintiff by GG Hospital
Ex.D10	21.05.2013	Original Consent from Mr. Patrick Rajan
Ex.D11	18.05.2013 (7 sheets)	Original Doctors' Notes of GG Hospital
Ex.D12	14.05.2013 (2 sheets)	Original Temperature Chart of the plaintiff by GG Hospital from 14.05.2013 to 21.05.2013
Ex.D13	(8 sheets)	Originals Doctors' Notes of GG Hospital
Ex.D14	(6 sheets)	Original Discharge Summary by GG Hospital

Sli/Mra

31.01.2023

Internet: Yes
Index : Yes
Speaking/Non speaking order

C.S.No.392 of 2014

G.CHANDRASEKHARAN, J.,

mra

Judgment in
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31.01.2023