Date of complaint filed :29.08.2017
Date of orders pronounced :28.02.2024

IN THE CIRCUIT BENCH OF THE TAMILNADU STATE CONSUMER DISPUTES REDRESSAL COMMISSION, MADURAI.

Present: THIRU. S.KARUPPIAH, PRESIDING JUDICIAL MEMBER

C.C.No.41/2017

WEDNESDAY, THE 28thDAY OF FEBRUARY 2024.

X. Sophilawrencia, aged 30 years,
W/o.KulandaiArockiasamy,
Kalpalayathanpatty,
Manapparai Taluk,
Trichy District, and presently,
Residing at Door No.R2/678,
BHEL Township, Kailasapuram,
Trichirappalli-620 014.

….Complainant.

-Vs-

1. Dr.Mrs.P.Dhas, M.B.B.S. D.G.O.
(Reg.No.20139)
Obstetrician and Gynecologist,
Retna Dhas Hospital,
No.2, Madurai Road,
Manapparai-621 306.

2. Dr.D.Dhas, B.Sc.M.B.B.S.M.S.
(Reg No.22894),
Consultant Surgeon,
Retna Dhas Hospital,
No.2, Madurai Road,
Manapparai-621 306.

…Opposite parties

Counsel for Complainant : M/s.T.Banumathy, Advocate.

Counsel for Opposite Parties 1 & 2 : M/s.AAV Partners.

This complaint came before me for final hearing on 26.02.2024 and upon perusing the material records this Commission made the following:-

ORDER

THIRU.S.KARUPPIAH, PRESIDING JUDICIAL MEMBER.

1. **The Facts :**

The complainant on 13.03.2016 had consulted the 1st opposite party at her hospital and the complainant was diagnosed as having Cyst problem in her ovary. Scan was also taken and as per the scan report it was diagnosed 'Primary sterility with Chocolate Cyst (R) Ovary' and the 1st opposite party advised the complainant to stay in the hospital for surgery. The complainant as per the advise got admitted in the opposite parties hospital on 15.03.2016 at 12.00 PM. Both opposite parties on the same day conducted the operation for removal of the Cyst at about 02.15 PM and the complainant was discharged from the hospital on 24.03.2016 at 11.00 AM. The complainant further submitted that in the discharge summary it has been mentioned as follows,

> *"Diagnostic Laparoscopy Done. Since the Chocolate Cyst (R) Ovary was very much adherent with the Uterine wall open method proceeded. D & C done & Endometrium sent for Biopsy" Closure: Wound Closed with a Drain".*

The complainant even after discharge, suffered continuous abdominal pain and also vomiting. So, she again consulted the 1st opposite party on 05.07.2016 and a scan was taken. In the scan, it has been sated that " Both Ovaries appear normal and The impression is normal sonograpy study of uterus and ovaries". The report was also signed by the 1st opposite party. Once again as per the advise a scan was taken on 02.08.2016 and the 1st opposite party diagnosed the problem as Peptic Ulcer. As pain subsisted on 31.08.2016 a scan was taken again for her abdomen and the sonography study of liver, GB, Pancreas, Spleen, Kidneys, Bladder, Uterus &

Ovaries impression is normal All the above scanning process were conducted by the 1st opposite party and reported were given by her. Though, the complainant consistently consulted the 1st opposite party for her ailments and the pain did not subsidized. So, she consulted BHEL Hospital. There a CT scan was taken on 22.12.2016 and the CT scan report revealed that

> *"The right ovary is not visualized. Impression: CT scan of pelvis done before and after oral and rectal contrast medium shows possibility of foreign hody in the mid abdomen displacing the bowel loops. The rest of the findings are normal".*

So, in the BHEL hospital on 26.02.2016 a surgery was conducted and the BHEL Doctors removed a foreign body a **MOP PAD** along with a part of bowel loops that were affected by the presence of the foreign body. So, the opposite parties not only treated the complainant with careless manner, they negligently performed the surgery and closed the wound by placing MOP PAD carelessly inside the abdomen. Further the opposite parties never disclosed that her ovary was also removed in the above surgery. It was came to her knowledge only at the time of treatment taken by her with BHEL Hospitals Doctor. So, alleged medical negligence and claiming Rs.99 lakhs towards compensation the complaint has been filed.

2. The opposite parties in the written version admitted the patient had approached the 1st opposite party on 11.03.2016 with complaints of primary infertility for 1 ½ years from marriage. The patient was advised to take ultrasound scan of the pelvis on 11.03.2016 and the scan report findings revealed that the patient had a cyst in the right adnexal area. An adnexal mass is a lump in tissue of the adnexa of uterus. The patient was diagnosed to have primary sterility with a

chocolate cyst in the right ovary. Chocolate cyst of the ovary is caused by endometriosis(Endometriosis is a painful disorder in which the tissue that normally lines the inside of the uterus(endometrium) grows outside the uterus and formed when a tiny patch of endometrial tissue (the mucous membrane that makes up the inner layer of the uterine wall) bleeds, sloughs off, becomes transplanted, and grows and enlarges inside the ovaries. As the blood builds up over months and years, it turns brown. When it ruptures, the material spills over into the pelvis and onto the surface of the uterus, bladder, bowel, and the corresponding spaces between. This can in the long run turn malignant. The patient was advised to undergo diagnostic scopy with right oophorectomy. An oophorectomy(oh-of-uh-REK-tuk-me) is a surgical procedure to remove one or both the ovaries. The 1st opposite party decided to perform a diagnostic laparoscopy to remove the chocolate cyst. When the diagnostic laparoscopy was done, it was found that there was a chocolate cyst adherent to the right ovary. As the same could become malignant consent was sought from the husband and procedure proceeded with. After obtaining informed consent from the patient and her attendees the opposite parties had performed the surgery on 15.03.2016 under general anesthesia. The right ovary was enlarged into a cyst of size 10*8 cm with no normal ovarian tissue present. It contained chocolate cyst. The cyst was adherent to the uterine wall. The normal anatomy of the pelvis was distorted and anatomical plane could not be separated. The adhesions were released with difficulty and the cyst was removed completely except for the base of the cyst which was adherent to the bowel was left. There was oozing from the place of diagnostic scopy POD throughout the procedure for which pack had to be kept. Homeostasis was achieved and drain was kept and abdomen was closed in layers.

The post operative period was uneventful and the patient was discharged on 24.03.2016, with advice to come back after 1 week for review to the opposite parties. The patient came back to the opposite parties on 28.03.2016 for review and suture were removed. The patient came back on 14.04.2016 and 16.05.2016. Inj. Lupride(Gn RH agonist) was administered. The patient back came on 05.07.2016 with amenorrhea and it was advised by the opposite party to take a scan and the scan report showed non pregnant uterus. On 02.08.2016 the patient came back with abdominal pain and again a scan was performed which showed tenderness over the epigastric region and peptic ulcer was suspected and the patient was treated for the same. The patient came back on 19.08.2016 with periods and was prescribed clomiphene for conceiving. Again she came back on 26.08.2016, 29.08.2016, 31.08.2016 and 02.09.2016. During this course it was found by the 1st opposite party that dominant follicles were seen in the left ovary. On 31.08.2016, the patient had complained of abdominal pain and the 1st opposite party had informed the patient that, the pain was due to impending rupture of follicles. The complainant never came back to the opposite parties after 02.09.2016 for review. Hence, alleging medical negligence against them is contrary to established principles. They were experienced and qualified doctors and there is no negligence on the part. Hence they prayed to dismiss the complaint.

3. In this case both sides filed proof affidavit and Ex.A1 to A17, B1 to B4 and C1 was also marked.

4. In this case learned counsel appeared for the opposite parties submitted that the complainant failed to prove any carelessness or negligence on the part of the opposite parties and the complainant failed to prove any foreign body by placing the

foreign body before this commission and no such foreign body was kept inside by the opposite parties. The counsel appeared for the opposite parties again further argued that the possibility for the complainant to underwent some other surgery after she underwent with the opposite parties was not ruled out in this case. In other words it his submission that the above foreign body even if it is found in the abdomen was not placed by them but it may be carelessly placed by some other doctors in doing surgery after her discharge from their hospital.

5. Now the points for consideration is:

1. Whether the opposite parties committed any medical negligence?

6. Points for discussion:-

It is an admitted fact that the complainant consulted with the 1st opposite party and opposite party suggested a surgery to remove Chocolate Cyst (R) Ovary and the Doctors have performed oophorectomy i.e. removed of ovary also. In this case, the first contention of the complainant is, she was not informed about removal of ovary and she was under an impression that cyst alone removed, by the surgery performed by the opposite parties. In this situation this commission perused the written version filed by the opposite parties. At one stage the Doctors admitted the patient was advised to undergo diagnostic scopy with right oophorectomy and in the later place they submitted that the "adhesions were released with difficulty and the cyst was removed completely except for the base of the cyst which was adherent to the bowel was left". So, from the above pleadings, it is not clear whether oophorectomy was actually performed or not.

7. In the Ex.A5 discharge summary under the heading ***operation notes diagnostic scopy with right oopherectomy with cyst endometriosis ,*** though

mentioned, in the same discharge summary under the heading ***procedure*** it has been mentioned `***Diagnostic Laparoscopy Done. Since the Chocolate Cyst (R) Ovary was very much adherent with the Uterine wall open method proceeded. D & C done & Endometrium sent for Biopsy" Closure: Wound Closed with a Drain.*** From the above notes it is clearly visualized by this commission that diagnostic scopy as well as oophorectomy were done simultaneously. This is not the case that they have performed diagnostic scopy i.e finding the nature of the abdomen was done on one time and later they performed surgery. When they really intended to remove the ovary a special consent and detailed informed consent, after explaining the necessity to remove the ovary must be obtained from the complainant. Because in this case the complainant approached the doctor for primary infertility for 1 ½ years. So, within two years of marriage the complainant approached the doctors for her problem. In such a situation removing ovary is some what minimizing the chances of pregnancy in future. It is utmost duty of the Doctors to enlight the complainant, the emergency for removing such ovary The doctor did not plead convincingly that they have explained the complainant about the necessity and emergency in removing the ovary. The consent form was marked in the case sheet Ex.B2. The consent is obtained in a printed form in which it has been mentioned primary sterility chocolate cyst right ovary diagnostic scopy might oopherectomy/laparotomy. The opposite party, initially wanted to perform only laprascopic surgery, since the cyst was in larger size open method was preferred. So, the initial planning of laprascopic surgery was converted into the open surgery. For the material procedural change, there is no consent obtained from the complainant that too in the middle of the surgical procedures. Furthermore in the same document, nurses daily record

endorsement of consent is available. In which it seems, the consent of the complainant was obtained on 15.03.2016 it was in the page No.32 and 35. Actual facts explained to the complainant was written in Tamil. In which, the proposed removal of ovary was not at all explained, informed to the complainant. On the other hand the complainant was simply informed as if, the complainant is having a small cyst (நீர்கட்டி) and it needs only a simple surgery. From this alone, it is inferred, that the complainant was informed only with regard to small cyst and removed of the above small cyst by simple surgery. Nothing more was explained about the above laprascopic or open method or removal of ovary etc., *At this juncture it is useful to refer the judgment of The Supreme Court of India in* ***Samira Kohli vs Dr. Prabha Manchanda & Anr*** *on 16 January, 2008 and the relevant portion is reproduced hereunder,*

> **We may also refer to the code of medical ethics laid down by the Medical Council of India (approved by the Central Government under section 33 of Indian Medical Council Act, 1956). It contains a chapter relating to disciplinary action which enumerates a list of responsibilities, violation of which will be professional misconduct. Clause 13 of the said chapter places the following responsibility on a doctor :**
>
> **"13. Before performing an operation the physician should obtain in writing the consent from the husband or wife, parent or guardian in the case of a minor, or the patient himself as the case may be. In an operation which may result in sterility the consent of both husband and wife is needed."**
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> **We may now summarize principles relating to consent as follows :**

(i) A doctor has to seek and secure the consent of the patient before commencing a 'treatment' (the term 'treatment' includes surgery also). The consent so obtained should be real and valid, which means that : the patient should have the capacity and competence to consent; his consent should be voluntary; and his consent should be on the basis of adequate information concerning the nature of the treatment procedure, so that he knows what is consenting to.

(ii) The 'adequate information' to be furnished by the doctor (or a member of his team) who treats the patient, should enable the patient to make a balanced judgment as to whether he should submit himself to the particular treatment as to whether he should submit himself to the particular treatment or not. This means that the Doctor should disclose (a) nature and procedure of the treatment and its purpose, benefits and effect; (b) alternatives if any available; (c) an outline of the substantial risks; and (d) adverse consequences of refusing treatment. But there is no need to explain remote or theoretical risks involved, which may frighten or confuse a patient and result in refusal of consent for the necessary treatment. Similarly, there is no need to explain the remote or theoretical risks of refusal to take treatment which may persuade a patient to undergo a fanciful or unnecessary treatment. A balance should be achieved between the need for disclosing necessary and adequate information and at the same time avoid the possibility of the patient being deterred from agreeing to a necessary treatment or offering to undergo an unnecessary treatment.

When applying those principles in this case the consent obtained from the complaint was not a proper consent. Moreover, as held by medical literature when a part of the body has to be removed a special consent for its necessity with explanation must be informed to the complainant. In this case the above consent was lagging. So, it

is the first negligent on the part of the opposite party doctors. Furthermore Page.15 in Ex.B2 , pre-anesthesia record, not filled up adequately, in the above record nothing has been mentioned about pre-surgical test and test for anesthesia etc.,. So it is the second negligence committed by the opposite parties.

8. It is the case of the complainant that she visited the opposite parties for her subsequent complaint on various dates. The surgery was performed on 15.03.2016 subsequently on 05.07.2016 in Ex.A6, another scan report was taken in which, it has been mentioned " ***both ovaries appear normal*** ". On seeing and perusing this, as dutiful Doctor can easily arrived at the conclusion that the report was mistaken one and informed the same to the complainant that when her ovary was already removed the finding in the scan is improbable one. But the Doctor failed to note this fact and failed to explain it to the complainant, rather the Doctor casually prescribed medicines. This is another negligence committed by the Doctor. Then again on 02.09.2016 a further scan report was taken in which also it is mentioned as uterus seems to be normal the uterus is filled with homogeneous myometrial echoes. Even in the scan report removal of ovary was not mentioned. It is the doctors duty to correct scan report and correlate with the earlier medical history or records. The scan was taken under the supervision of the opposite party have been signed by the doctor of the opposite parties hospital, and their qualifications in this aspect not explained. Either scan report were wrong or it was purposefully mentioned by the opposite parties to make the patient to believe that her ovaries were intact. So, having removed her ovary by the doctors and subsequently have a report as if both ovaries are normal amounted to medical negligence and unfair trade practice and this commission did not feel that the above mistake is an error of judgment.

9. Apart from that as per Ex.A8 it is evidenced about the consultation of the complainant with BHEL hospital and took scan on 22.12.2016. In this scan report it was revealed a foreign object was placed inside the abdomen. Further Ex.A9 is the treatment-cum-outpatient book reveals that the complainant periodically consulted the BHEL hospital doctor from the year 2015, that Is even before the surgery performed by the opposite parties and also after the surgery. As per records, Ex.A9 patient book, it is evidenced, that the complainant after the surgery consulted then only opposite parties till august 2016 and thereafter consulted the BHEL hospital. In the above book itself it has been further revealed that the complainant was admitted on 26.10.2016 and discharged on 06.01.2017. During the above period foreign body(MOP PAD) in abdomen eroding into bowel loop causing biflioentric- fistula subacute obstruction was removed adopting the procedure of laprotomy, retrieval of foreign body and resection of anesthomosis under general anesthesia was performed. Further one full MOP PAD in the lower abdomen was removed by the BHEL Doctors. So, it is clearly proved that at the time of surgery performed by the opposite parties they are carelessly placed MOP PAD inside the complainant. The opposite parties in their written version clearly admitted that they have used two MOP PAD at the time of surgery. From this admission it is concluded that one MOP PAD was carelessly kept inside the abdomen and the incision was closed by the opposite parties doctor. Further, the contention during argument about the possibility of keeping the MOP PAD by some other Doctors during some other surgery is not proved by the opposite parties and there is no pleadings to the effect.

10. This commission need no reference when a doctor wrongly mis-placed of carelessly placed a foreign particles like scissors, metal place, screw, MOP PAD, needle etc., inside the patients body while performing surgery is nothing but a gross negligence on their part. The due care expected from the doctor was not really taken by the above doctors. *The principle of 'Res ipsa loquitur' held has been explained :. In Spring Meadows Hospital v. Harjol Ahluwalia [(1998) 4 SCC 39] . The Apex Court was dealing with the case of medical negligence and held that in cases of gross medical negligence the principle of res ipsa loquitur can be applied. .in this case on hand the above principle will squarely applicable.*

To sum up the above discussions,

i. The above opposite parties did not inform the patient about the surgical procedure, whether it is laprascopic or open method.

ii. The opposite party prior to operation did not reveal about the removal of right ovary.

iii. Even after surgery they did not reveal the removal of one side ovary. Since, the complainant approached for her ailment of primary infirmity.

iv. After surgery even though they removed one ovary they gave scan report as if both ovaries are normal which in the opinion of this commission amounted to false representation to the complaint that their ovary was not removed.

v. Even though after surgery the complainant approached with complaints of pain it was not duly taken care.

11. The complainant further consulted the BHEL doctors and they found foreign body(MOP PAD) and removed the same by performing surgery. So, from the above carelessness, negligence ,wrong on the part of the opposite parties the complainant

suffered pain, mental agony family and financial problem. She also incurred monitory loss as well. Unnecessarily she was made to undergo another surgery and medical treatment. Considering the above pain and sufferings and the negligence committed by the opposite parties for morethan one occasions. This commission directed the opposite parties to pay Rs.25,00,000/- to the complainant towards compensation for pain and sufferings and compensation for mental agony and medical negligence.

12. In the result,

1. The complaint is partly allowed.

2. The opposite parties 1 & 2 jointly and severally are directed to pay a sum of Rs.25,00,000/-(Rupees Twenty Five Lakhs Only) towards compensation for mental agony and medical negligence to the complainant.

3. The above amount should be paid within a month from the date of receipt of order failing which it carries 6% interest per annum.

4. Further directed to pay Rs.10,000/- towards costs.

Dictated and pronounced in the open court to the Steno-typist transcribed and typed by her corrected and pronounced by us on this the 28th day of February 2024.

-Sd/-xxx
S.KARUPPIAH,
PRESIDING JUDICIAL MEMBER.

ANNEXURE
List of documents marked on the side of the Complainant

Ex.A1	11.03.2016	Pelvis ultrasonography report of the complainant.
Ex.A2	13.03.2016	Blood test report of the complainant.
Ex.A3	15.03.2016	Laparoscopy report of the complainant.

Ex.A4	22.03.2016	Histopathology report of the complainant.
Ex.A5	24.03.2016	The complainant's operation and discharge report.
Ex.A6	05.07.2016	Pelvis ultrasonography report of the complainant.
Ex.A7	02.08.2016	Abdomen and pelvis ultrasonography report of the complainant.
Ex.A8	22.12.2016	CT scan report of the complainant from trichy premier CT scans Pvt. Ltd., Trichy.
Ex.A9	---	BHEL Hospital outpatient book of the complainant from 11.03.2015 to 18.01.2017.
Ex.A10	---	The complainant's husband's BHEL ID card.
Ex.A11	---	The complainant's voter ID card.
Ex.A12	---	The complainant's family card.
Ex.A13	---	The complainant's educational qualification certificates
Ex.A14	---	The complainant's pay slip issued by National Public school, namakkal.
Ex.A15	23.01.2017	Copy of the legal notice issued to the opposite parties.
Ex.A16	25.01.2017	Acknowledgement cards.
Ex.A17.	---	Reply notice issued by the opposite parties.

List of documents marked on the side of the Opposite Parties.

Ex.B1	---	Copy of OP records.
Ex.B2	---	Copy of case sheet.
Ex.B3	---	Copy of Discharge Summary.
Ex.B4	---	Copy of Medical Literature.

List of documents marked on the Court side

Ex.C1	---	In-patient case sheet, BHEL Main Hospital, Tiruchy-14

-Sd/-xxx
S.KARUPPIAH,
PRESIDING JUDICIAL MEMBER.