NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION
NEW DELHI

CONSUMER CASE NO. 65 OF 2005

1. MRS. SEHEHERAZEDE JAVERI
W/O. LATE S.H. JAVERI, R/O. 8-2-326/2, ROAD NO.3, BANJARA HILLS
HYDERABAD
A.P.
2. AALIM JAVERI, S/O. SEHEHERAZEDE JAVERI,
R/O. 8-2-326/2, ROAD NO.3, BANJARA HILLS
HYDERABAD
A.P. .....Complainant(s)

Versus

1. CARE HOSPITAL (QUALITY CARE INDIA)
REP BY ITS M.D., 5-4-199, JAWAHARLALNEHRU ROAD,
NAMAPALLY
HEDERABAD.
2. DR. GOPI CHAND, CARDIO THORASIC SURGEON,
C/O. CARE HOSPITAL, 5-4-199, JAWAHARLALNEHRU ROAD,
NAMAPALLY,
HYDERABAD
3. DR. SRI RAMULU, ANESTHETIST
C/O. CARE HOSPITAL, 5-4-199, JAWAHARLAL NEHRU ROAD,
NAMAPALLY,
HYDERABAD
4. UNITED INDIA INSURANCE CO.
REP. BY ITS MANAGER, D.O.7, P.B. NO. 1089, BASEER BAGH
HYDERABAD - 29. .....Opp.Party(s)

BEFORE:

HON'BLE MR. JUSTICE A. P. SAHI,PRESIDENT

FOR THE COMPLAINANT :	FOR THE COMPLAINANT : MR. SUKUMAR PATTJOSHI, SR. ADVOCATE
	MR. ANSHUMAN GUPTA, ADVOCATE
	MR. PRASHANT ALAI, ADVOCATE
	MR. GAURAV KHATRI, ADVOCATE
	MR. RAM RAO KRISHNA, ADVOCATE
FOR THE OPP. PARTY :	FOR THE OPPOSITE PARTY : MR. M. SRINIVAS R. RAO, ADVOCATE
	MR. SASWAT ADHYAPAK, ADVOCATE FOR OP-1 TO 3
	MR. AMIT KUMAR SINGH, ADVOCATE FOR OP-4

Dated : 10 April 2024

ORDER

1. This is a claim of medical negligence by the widow and the son of late Mr. S.H. Javeri who is described in paragraph 2 of the complaint as a sixth generation leading jeweller of Hyderabad. He is stated to have been a person of considerable means and high social stature and used to reside in India for six months and remain abroad the other six months travelling to Switzerland and other countries in connection with his business affairs.

2. The complaint was argued by Mr. Sukumar Pattjoshi, learned Senior Counsel, who advanced his submissions on 10.01.2024 that is gainfully extracted herein under:

> *"Heard Mr. Sukumar Pattjoshi, learned Senior Counsel for the Complainant.*
>
> *This is a medical negligence allegation claim arising out of the treatment undertaken by late Mr. S.H. Javeri at Care Hospital (Quality Care India) Nampally, Hyderabad. The* ***treatment at the hospital was for a coronary surgery*** *that was performed by the Opposite Party No. 2 Dr. Gopi Chand with Dr. Sri Ramulu as anaesthetist.*
>
> *Even though the said treatment was a* ***planned surgery that is stated to have been conducted successfully****, but the* ***post-operative care and management of the patient undertaken by the hospital as well as the attending doctors resulted in negligence on their part.*** *This ultimately culminated into the patient getting infected and then succumbing to the said infection due to absence of following the correct medical protocol by the Opposite Parties.*
>
> *The arguments of Mr. Pattjoshi even though advanced was on the issue of not giving an informed consent regarding the post-operative complications that could arise or could affect the patient adversely, but his main argument was with regard to* ***the post-surgery mismanagement and negligence by the Opposite Party No. 1 causing the patient to be infected with Hospital Associated infections as well as other infections*** *which ultimately according to him are substantiated by the pathological and microbiological reports that are on record.*
>
> *He has also urged that* ***the hospital*** *even though has advertised of being possessed of all the best facilities, in fact* ***was totally deficient and the facilities were inadequate*** *which also added and compounded the aforesaid mismanagement.*
>
> *He then contended that the hospital in spite of best efforts* ***did not disclose the original documents*** *and rather withheld them which resulted in denial of the claim by the Insurance Company to the Complainant.*

It is on these broad parameters that he has handed down a written synopsis of the arguments that have been advanced by him coupled with the indications of the evidence and pleadings on record, a copy of which has also been handed over to the learned Counsel for the Opposite Party. To note some of the documents which may need a reply on the part of the Opposite Party, ***there are six reports on which reliance has been placed. The first report*** *relating to the infection is from the Global Hospital dated 05.08.2002 and is contained at page 142 of part 3 of the paper book. The said report recites as under:*

"INVESTIGATIONS CULTURE & SENSITIVITY:- BAL FLUID-4 (Right middle lobe)

DEPARTMENT OF MICROBIOLOGY

Culture: Pseudomonas aeruginosa isolated.

Semiquantitative culture colony count:-10 orgs/ml

ANTIMCROBIAL SUSCEPTIBILITY PROFILE FOR PSEUDOMONAS

PIPERACILLIN-R	*CEFPODOXIME: R*
CEFTAZIDIME:R	*CEFPIROME:R*
CEFTIZOXIME:R	*CEFEPIME-R*
OFLOXACINE:R	*IMIPENEM:S*
CIPROFLOXACIN:R	*MEROPENEM:S*
GENTAMICIN:R	*TAZOBACTAM-PIPERACILLIN:S*
AMIKACIN:R	*CEFOPERAZONE-SULBACTAM:R*
NETILMICIN:R	*TICARCILLIN-CLAVULANATE-R*

CEFOPERAZONE:R

TOBRAMYCIN;R

MEZLOCILLIN-R

R-Resistant IM-Intermediate Susceptibility S-Susceptible

Remarks: This isolate would be significant with a colony count as cited above."

Learned Counsel submitted that this was the first report which goes on to substantiate the allegations regarding the infections that set in and was followed by the ***second report which is dated 10.08.2002*** *at page 224 of part 3 of the*

*paper book. Learned Counsel submits that this report indicates **another form of bacteria** having set in adding to the existing infection, the heading of the said report is as follows:*

"Antimicrobial Susceptibility Profile of Gram Positive Cocci"

*Learned Counsel pointed out to the **third report** dated 17.08.2002 with regard to the **specimen of the CVP tip that** was sent for examination. This report was tendered after examination by the Care Hospital itself in its laboratory. It is pointed out that this was another form of infection that was discovered on the said culture report.*

*Simultaneously, another report with regard to **ET Secreation** was also tendered on the same date by the hospital itself which according to the Complainant is the fourth type of infection adding to the said three other infections referred to above.*

*Learned Counsel then pointed out the **fifth report** regarding an infection known as **tube ICD Tube Tip report** which is at page 152 of part 3 of the paper book.*

*Finally, it is pointed out that a report was tendered on 17.08.2002 in respect of another test carried out titled as **ET SECREATION FOR GRAM STAIN** and which again confirms a certain form of bacterial infection. It is with the aid of these six documents that Mr. Pattjoshi contends that it is established that the hospital was running with such infected equipments that were administered to the deceased that directly resulted in the infections and ultimately caused his death.*

*He then submits that even the line of treatment which was adopted does not appear to be in accordance with **medical protocols particularly with regard to the Tracheostomy** that was to be carried out and had been advised by an expert Dr. Vigg. He submits that the advice was tendered on 05.08.2002 whereas the same was not adhered to and ultimately was attempted on 17.08.2002 during the last stages of the patient.*

He has also referred to the typed case sheets, which are in a purple coloured spiral compilation titled as part I of volume II of the paper book, to indicate that these symptoms of infections and the deteriorating condition of the patient had been noted from time to time which confirms the manner in which the infection was caused and was being observed yet the protocols were not followed.

*Ultimately the hospital also resorted to administering a **medicine Xigris which was medically not permissible** as per rules as the said drug was not a licensed drug to be marketed in India and even otherwise after the death of the patient the said drug was also banned in 2011. He therefore submits that administering of such a drug that too even without informing the patient that it was not approved or was not licensed was yet another negligence on the part of the Opposite Party.*

He has then urged that looking to the evidence which has been brought on record, the death summary which was prepared by the Opposite Party No. 2 is contrary to the confirmed Hospital Associated Infection and the resulting causes, and it is strange that the said ***summary does not refer to it or honestly records it.*** *Thus, according to him the death summary is not a genuine disclosure of the status of the infections and this also is compounded on account of the incorrect statement made in the medical certificate which was issued where the cause of death was incorrectly shown as a complication arising out of the coronary surgery which was conducted. Learned Counsel submits that this sort of misinformation tendered was presumably to shield themselves from the real cause of death which according to the learned Counsel for the Complainant were the deficiencies that have been broadly referred in the arguments advanced.*

Mr. Pattjoshi has also relied on certain publications, copies whereof have been handed over to the learned Counsel for the Opposite Party to highlight as to what are hospital associated infections and the protocols that need to be observed in this respect.

He has also placed before the Bench a couple of publications with regard to the status of the medicine namely 'Xigris' that was administered at last to contend that the said medicine did not have any medical approval and therefore its administering has compounded the ultimate cause of death of the patient.

He has also handed over the compilation of judgments which he proposes to place before the Bench after the arguments are concluded on the issues so raised and after the response is given by the learned Counsel for the Opposite Party.

Learned Counsel for the Opposite Party had already handed over a brief note of facts, copy of which had been given to the learned Counsel for the Complainant indicating the chronology of events and some explanation regarding medical terminologies. Learned Counsel for the Opposite Party prays that he may be granted some time to answer the submissions made and proceed with the case.

As agreed between the parties, list this matter on 29.02.2024 at 2.00 p.m."

3. In support of his submissions Mr. Pattjoshi on 29.02.2024, when the arguments concluded, cited the following decisions, primarily on hospital associated infection, lack of informed consent and on the principles of medical negligence that are attracted on the pleadings, evidence and arguments advanced in this case:

"1.*Savita Garg (Smt) Vs. Director, National Heart Institute, (2004) 8 SCC 56 at paragraph 10.*

2.Samira Kohli Vs. Dr. Prabha Manchanda & Anr., (2008) 2 SCC 1 at paragraph 49 (ii).

3.Nizam Institute of Medical Sciences & Prashant S. Dhanaka & Ors., (2009) 6 SCC 1 at paragraphs 42, 51 & 77.

4.Malay Kumar Ganguly Vs. Dr. Sukumar Mukherjee & Ors., (2009) 9 SCC 221 at paragraphs 93, 95 & 154.

5.V. Kishan rao Vs. Nikhil super Speciality Hospital & Anr., (2010) 5 SCC 513 at paragraphs 45 & 50.

6.Maharaja Agrasen Hospital & Ors. Vs. Pooja Sharma & Ors., (2020) 6SCC 501 at paragraphs 12.4.1 to 12.4.4.

7.Minor EBY Vs. GEM Hospital & Ors., 2004 SCC OnLine NCDRC 32 at paragraph 17.

8.Apollo Emergency Hospital Vs. Dr. Bommakanti Sai Krishna & Anr., 2013 SCC OnLine NCDRC 119 at paragraphs 6,7 & 8

9.Comtrust Eye Hospital Vs. V. Sirajudeen and & ANr., 2013 SCC OnLine NCDRC 131 at paragraph 7.

10. Prasanna Lakshmi Vs. Maxivision Laser Center Pvt. Ltd., 2019 SCC OnLine NCDRC 451 at paragraphs 33."

4. Mr. M. Srinivas R. Rao, learned counsel for the opposite parties advanced his submissions with the help of short notes that were tendered earlier indicating the chronology of events and also gave a description of the medical terminologies on which he proposed to rely on during the course of submissions.

5. While advancing his submissions on the date when the arguments concluded, that is on 29.02.2024, he handed down another brief note of arguments with a copy of the same to other side that have been perused by me. The brief notes narrate the previous medical history of patient, particularly, his genetic history, indicating diabetic and cardiac disorders that were there in other family members as well. He then invited the attention to the fact that in 1995, the patient suffered Transient Ischamic Cerebral Attack, which was on account of his smoking habits, obesity, drinking alcohol and other symptoms that led to slurred speech and weakness. He then urged that the surgeries were performed thrice in 1999, one for prostrate, one for intestine and then the third one also in the abdominal region. It is also stated that in 1995 another surgery of piles was also performed. With all this past medical history of the patient, it was submitted that he was a person of very weak immunity that was severely compromised on account of his habits and his past medical history. According to the learned

counsel, this weak constitution reduces the body immunity to fight with various bacteria and viruses. He then pointed out that the patient was severely diabetic which further made him susceptible to weaknesses and infections. It was urged that since he was a heavy smoker and was also known to have drinking habits, the same also increased his risks and infections and illnesses including pneumonia and other respiratory problems, which led to complications, whenever such a patient is subjected to a surgery or such medical treatment. He further submitted that the patient also suffered from acid peptic disease, which is a group of gastrointestinal disorder caused by alcohol and regular use of medicines like aspirin, inflammatory drugs and also chewing tobacco and smoking cigarettes. The sum and substance of this argument of Mr. Rao is to emphasize that the patient was not only weak in constitution but was suffering from very serious deficiencies of immunity and was also carrying a very high risk for infections. To substantiate his submissions, Mr. Rao has invited the attention of the Bench to the fact that the patient had visited the Apollo Hospital in Hyderabad, where he was diagnosed with Acute Coronary Syndrome on 03.06.2002. He was discharged from the said hospital on 05.06.2002 and the symptoms that have been indicated above with regard to his medical history were also noted in the discharge summary stating that he had a family history of CAD and was a smoker. His history of present illness was also noted with chest pain of 2-3 episodes associated with sweating, radiating to the left arms and relieved by Sorbitrate. He was however put on a Holter monitor and at the time of discharge, he was advised for surgery, but he expressed to undertake the same at a later date. He was called upon to get him reviewed after one week. But it appears that Mr. Zaveri travelled abroad to London, where again he visited the King's College Hospital in London and he was examined by Dr. David Jewitt in the cardiac department, who tendered his medical report dated 11.07.2002. The same is extracted herein under:

"DAVID JEWITT

Phone/fax 0207 428 0675

e.mail david.jewittcardiol@btinternet.com

Cardiac Department	*London Bridge Hospital*
King's College Hospital	*27 Tooley Street*
London	*London*
SE5 9RS	*SE1 2PR*
0207 346 3379	*207 407 3100*
	Secretary mobile 07956942714

11 July 2002

Medical report on Sadruddin Javeri dob 24 12 38

This 64 year old Jeweller from Hyderabad, India, consulted me during a recent visit to London

His history is that on 3rd June 2002 he experienced left sided chest pain with sweating lasting for 20 minutes and this responded to 5mgs of Isosorbide dinitrate in the form of Sorbitrate.

He was investigated in hospital in Hyderabad and a diagnosis of unstable angina was made. His cardiac enzymes and troponin were apparently normal. He was found to have a raised cholesterol at 248mgs/100mls and a raised triglyceride at 232mgs/100mls. He was also noted to have a raised glucose at 142mgs/dl.

He smokes 15-16 cigarettes a day and drinks modest quantities of alcohol.

In 1995 he apparently underwent a hernia operation and this was subsequently complicated by transient ischaemic cerebral attack in the post operative period lasting for 48 hours and associated predominantly with speech difficulty. He underwent a transurethral resection of the prostate in 2001 in Australia.

At the time of his admission to hospital in Hyderabad in June he was noted to have frequent ventricular extra systoles on 24 hour tapes and monitoring and was started on Amiodarone and is currently taking this in a dose of 400 mgs a day. He is also taking Atenolol 50 mgs a day, aspirin 150 mgs a day, Clopidogrel 75 mgs a day, Imdur 60 mgs a day and a statin

He has not had a treadmill stress test

In his family history his father died at the age of 89 from myocardial infarct. His mother at the age of 68 from myocardial infarct. One brother has had

coronary artery bypass surgery in 1982 and one sister has coronary artery disease.

On examination he looked his age. He was comfortable at rest. Pulse was regular in sinus rhythm, but there were a number of ventricular extra systoles. Heart sounds were normal with no cardiac murmurs. Blood pressure was 125/85 Chest was clinically clear

Resting ECG showed unifocal ventricular extra systoles and ***shallow ST segment depression in leads 3 and VF with T wave flattening in V6 suggesting possible inferior wall ischaemia.***

In the light of the above history I proceeded to diagnostic coronary angiography on Wednesday 10th July 2002 at the Cromwell Hospital

Left ventricular angiography left ventricular function was well preserved, ejection fraction greater than 60%, left ventricular end diastolic pressure 12.

Coronary angiography, the coronary tree was right dominant.

Right coronary artery is totally occluded at its origin with filling only of a sinus node and a conal branch. The posterior descending part of the right coronary artery is seen to fill retrogradely from the left coronary injection.

Left main coronary artery is normal.

Left anterior descending coronary artery has two proximal 80-90% stenoses.

The vessel filling out to the apex beyond these.

An intermediate coronary artery is seen to be diseased.

Left circumflex coronary artery is totally occluded proximally filling with a delay via collaterals its first and second obtuse marginal branches.

Conclusion

*This patient has **critical three vessel coronary artery** disease and despite his recent onset of symptoms, is **recommended to undergo early coronary artery surgery with grafting to all three coronary vascular territories. I have referred him to my colleague Mr Jatin Desai for this procedure which I hope will be undertaken within the next week.***

Kind regards

Yours sincerely

Sd/-

David Jewitt FRCP

Consultant Cardiologist"

6. During his stay there he had been referred to Dr. Jatin Desai for carrying out coronary artery bypass graft surgery at the Cromwell Hospital, but he was not admitted because he had not been able to transfer appropriate financial support. This fact is recorded in the follow-up medical reported dated 16.07.2002, which is recorded herein under:

"DAVID JEWITT

Phone/fax 0207 428 0675

e.mail david.jewittcardiol@btinternet.com

Cardiac Department *London Bridge Hospital*

King's College Hospital *27 Tooley Street*

London *London*

SE5 9RS *SE1 2PR*

0207 346 3379 *207 407 3100*

Secretary mobile 07956942714

16 July 2002

Follow up medical report on Sadruddin Javen dob 24 12 38

This patient who was due to have coronary artery bypass graft surgery on 16 July at the Cromwell Hospital by my colleague Mr Jatin Desai, has not been admitted because todate he has not been able to transfer the appropriate financial support During the last week he has been free of chest pain and stable

Carotid Doppler examination had shown heterogeneous plaque in the right internal carotid but the maximum stenosis was 30% and the common carotid and external carotid were free of disease. The left internal carotid, common carotid and external carotid were all normal, both right and left vertebral arteries were freely patent and normal

Haematological screening has shown a haemoglobin of 15.9g/dl, white count 9.3 x 10^9/1, platelets 161 x 10%, ESR 2 mm in the first hour.

Renal function is normal with a urea of 5.8mmol/l, creatinine 127umol/l. Liver function tests were normal. Cholesterol was within the normal range at 4.06mmol/l, triglycerides. 1.88mme. Random glucose is elevated at 10mmol/l with a haemoglobin alc 1 of 8.3. normal range 4.2 10 6 4

Clinically this patient is stable but his angiogram showed critical three vessel disease and he requires early coronary artery surgery. He should also start on oral hypoglycaemic therapy for his diabetes and I would recommend he starts on Glibenclamide 5 mgs in the first instance, increasing if necessary to 5 mgs bd.

We remain happy to arrange his coronary artery surgery in London. If he insists on returning to India, air travel is not contraindicated but is certainly not desirable. I would repeat my view that early coronary artery surgery is required.

Yours sincerely

Sd/-

David Jewitt FRCP

Consultant Cardiologist"

7. Mr. Rao, therefore emphasized that these two reports further confirm that status of health of the patient and after returning to India he got himself admitted to the opposite party no. 1 - Hospital on 29.07.2002. During his admission at the Hospital he was examined and his past history and present status of illness was all recorded in the case sheet dated 29.07.2008, the typed copy whereof has been provided along with spiral compilation captioned as Part-I (Vol-II). Learned counsel inviting the attention of the Bench urged that on 30.07.2002 at about 8 p.m. in the hospital, it was found that his breath was smelling of tobacco and he was advised to abstain from smoking.

8. The coronary artery bypass graft surgery was done on 31.07.2002 that was successfully carried out and he was extubated after six hours of ventilation. However, on 02.08.2002, since his breathing was high he was re-intubated.

9. Learned counsel submits that an infection was detected which is pneumonia on 02.08.2002 and in order to find out the cause of the infection, a culture and sensitivity test of fluids was sent for investigation to M/s. Global Hospital on 03.08.2002. The report was received later on 05.08.2002 and has been placed on record. The same is extracted herein under:

"NAME: MR. S.H. JHAVERI AGE: 64 YRS SEX: MALE

REF. BY. DR. SHARAT TALLURI LABNO:OPD DATE R: 3.8.2002

DATE D:5.8.2002

INVESTIGATIONS CULTURE & SENSITIVITY:- BAL FLUID-4 (Right middle lobe)

DEPARTMENT OF MICROBIOLOGY

Culture: Pseudomonas aeruginosa isolated.

Semiquantitative culture colony count:-10 orgs/ml

ANTIMCROBIAL SUSCEPTIBILITY PROFILE FOR PSEUDOMONAS

PIPERACILLIN-R *CEFPODOXIME: R*

CEFTAZIDIME:R *CEFPIROME:R*

CEFTIZOXIME:R *CEFEPIME-R*

OFLOXACINE:R *IMIPENEM:S*

CIPROFLOXACIN:R *MEROPENEM:S*

GENTAMICIN:R *TAZOBACTAM-PIPERACILLIN:S*

AMIKACIN:R *CEFOPERAZONE-SULBACTAM:R*

NETILMICIN:R *TICARCILLIN-CLAVULANATE-R*

CEFOPERAZONE:R

TOBRAMYCIN;R

MEZLOCILLIN-R

R-Resistant IM-Intermediate Susceptibility S-Susceptible

Remarks: This isolate would be significant with a colony count as cited above.

Sd/-

Dr. Iyer R. N.

Consultant Microbiologist. ”

10. He was examined by Dr. Sarat Talluri on 03.08.2002, who indicated the cause of this infection to be unclear, but recorded Sepsis (HA Pneumonia). He also advised that the patient shall be treated for Sepsis related infection unless proved otherwise.

11. While recording the active investigations it was also observed that Sepsis had again become active with low grade fever and increased TLC. For the first time the case sheet also records infection source as catheter related and accordingly, the catheter was changed.

12. On 04.08.2002, it is again recorded that Sepsis was continuing with low grade fever and the TLC was still high. The change of catheter a day before was also noted with a further advice that there was a need for a chest tube.

13. It is also pointed out by the learned counsel that the patient also called for the advice and examination by Dr. Ajit Vigg on 05.08.2002, who also examined the patient and indicated the infection of pneumonia and Sepsis and advised early tracheostomy. This is recorded in the case sheet dated 05.08.2002. Learned counsel has also invited the attention to

the affidavit of Dr. Ajit Vigg, which has been filed before this Commission dated 28.11.2007, particularly to the contents of paragraph 5 and 9 thereof that shall be discussed later on. The submission is that there was no shortfall in the line of treatment and consequently the said affidavit of Dr. Vigg that had been pressed into service by the learned counsel for the complainant to attribute negligence, does not support their contention.

14. He has then with the help of the case sheet dated 07.08.2002, pointed out that the Sepsis seemed to be under control with a low grade fever and the TLC count had not increased. Followed by this is the report of 12.08.2002, which demonstrates Sepsis with a low grade fever but the TLC count had decreased with an advice to change catheter.

15. It is also submitted that every step of precaution at every stage was being taken by the attending doctors and there was not even an iota of negligence in taking care of the patient.

16. It is also submitted that prior to discharge on 31.07.2002, consent was taken from the patient, which is recorded in the case sheet of the said date. It is urged that there was no objection nor any indication of not taking consent prior to the performance of the surgery. It is also urged that there is no complaint with regard to the surgery which was conducted.

17. Coming to the issue of administering the drug Xigris, he has invited the attention of the Bench to the article publication in the newspaper, the Telegraph, stating that the company dealing in the said drug, namely, Indian subsidiary had already obtained approval from the Drugs Comptroller General of India for importing and marketing the said drug. Thus as on the date, the drug was administered, the same was being introduced and he has also invited the attention to another communication from the company, Lilly, demonstrating the approval of the FDA, which is the US Food and Drug Administration. The said communication dated 21.11.2001 states that the drug was then admissible in cases of severe sepsis. It is with this comment in view that the prescription for the said medicine was advised. He submits that the claim of the complainant that the said medicine was not available in India and that they had to undertake additional expenses of Rs.25,00,000/- to obtain the same is absolutely wrong and against record for which he has invited the attention of the Bench to page 95 of the complaint, which is the invoice from the same Lilly company of Switzerland. It is urged that no payment was made and the medicine was a compassionate sale. Thus, the value shown was only for custom purposes and the complainants have not paid any money for obtaining the said medicine. It is urged that it was as late as in 2011 that the US Food and Drug Administration issued a safety announcement on 25.01.2011 that the treatment with Xigris should not be started in new patients and should be stopped for patients who were being treated for the same. The submission is that this advisory came after 9 years of the incident and therefore it cannot be presumed that the said Drug was administered against medical acceptability.

18. An ancillary argument was advanced by Mr. Pattjoshi that the Hospital in its advertisement had indicated that spiral CT Scan facilities were available but in fact the CT Scan was advised and was conducted in Global Hospital as there was no such facility available in the opposite party no. 1 Hospital.

19. Learned counsel for the opposite parties relied on the following judgments to contend that medical negligence on the parameters as per the ratio of the said decisions is not at all

satisfied in the present case and consequently the claim petition should be dismissed:

1. Jacob Mathew Vs. State of Punjab & Anr., (2005) 6 SCC 1.

2. Kusum Sharma & Ors. Vs. Batra Hospital & Medical Research Centre & Ors., (2010) 3 SCC 480.

3. Dr. Harish Kumar Khurana Vs. Jaginder Singh & Ors., (2021) 10 SCC 291.

4. Bombay Hospital & Medical Research Centre Vs. Asha Jaiswal & Ors., 2021 SCC OnLine SC 1149

5. M.A. Biviji Vs. Sunita & Ors., 2023 SCC OnLine SC 1363.

20. Having given a thoughtful consideration to the issues raised, the prime contention that needs to be decided is about the allegations of Hospital Associated Infection (HAI) apart from other issues which have been raised in the pleadings and have also been orally submitted. However, before dealing with the said main contention, there are other arguments which have been advanced by Mr. Pattjoshi, learned Senior Counsel appearing for the complainant, that need to be clarified at the outset.

21. There is no dispute that the surgery was conducted successfully. The contention raised with regard to informed consent is recorded at page-249 of the case sheet and therefore to contend that it was not an informed consent cannot be accepted also for the reason that the treatment of the deceased in the present hospital was preceded by references for surgery and its complications from different hospitals which the complainant had visited in India and also the treatment advised in England at King's College Hospital in London. Looking to his entire condition, his past history and life style, he was still advised the coronary artery surgery as three vessels were critically blocked. The seriousness of the disease and its consequences were therefore well-known to the patient as well as to his attendants. Consequently, the said argument cannot be countenanced to substantiate any allegations of deficiency in service or negligence on that count.

22. One of the arguments advanced by Mr. Pattjoshi was with regard to the administration of medicine known as Xigris, contending that the medicine ought not to have been administered and even otherwise the patient and the complainant had to undertake a huge financial burden to obtain the said medicine which was neither advisable nor was easily available, yet the patient and the complainant were compelled to obtain the same and the said medicine had been incorrectly advised. In this regard, extensive arguments were raised and Mr. Pattjoshi has invited the attention of the Bench to the safety announcement made by the US Food & Drug Administration (FDA) dated 25.10.2011, stating that the medicine had failed to show any survival benefits for patients with severe septic shock. The company marketing the said medicine also announced the withdrawal of the medicine on account of recent clinical trial tests. The communication dated 25.10.2011 has been placed before the Bench in response whereto Mr. Rao, learned counsel for the opposite party hospital, urged that the said medicine was introduced in November, 2001. An approval was given by the same US Food & Drug Administration and he has placed the letter of the company M/s Lilly

indicating receipt of such approval. A perusal of the said letter indicates that the approval was based on results of clinical trial for being administered in cases of high risk of death in severe sepsis. The said drug was also approved by the Drug Controller General of India for being imported and being marketed. This approval was available to the subsidiary of M/s Lilly operating in India. The submission therefore is that as and when the medicine was prescribed to the patient, the same was an approved drug for severe sepsis and therefore its withdrawal in 2011 cannot in any way impact its prescription way back in 2002. He has invited the attention of the Bench to the billing of the said drug placed by the complainant herself to contend that no financial burden was caused on the complainant for obtaining the said drug, inasmuch as the company had sent it free of cost as compassionate sale. The said receipt is on record at page 95 of the original complaint.

23. Having considered the submissions raised and the communications, the print whereof has been handed out to the Bench and exchanged between the learned counsel, coupled with the receipt at page 95, clearly indicates that the withdrawal of the drug took place in 2011 on clinical results. Thus, to say that the drug was wrongly advised in 2002 also cannot be countenanced. The plea of the complainant that they had to bear expenses in getting the said medicine from abroad also stands controverted as the drug as prescribed was sent as a compassionate sale with no charge. The said argument therefore does not hold water and no further evidence was led on behalf of the complainants to support the same.

24. Coming to the other ancillary submissions, Mr. Pattjoshi pointed out that the death summary of the patient does not correctly record the cause of death. He has invited the attention of the Bench to the death summary which is at page 25 of the original complaint to contend that the cause of death indicates as Septicaemia with multi organ failure. He submits that the entire summary has nowhere indicated the impact of the Hospital Aided Infection and the laboratory test reports (pathological and microbiological) supporting the same, as such this is a clear deficiency and also amounts to an unfair trade practice. Mr. Pattjoshi further points out that the medical certificate of cause of death, filled in by the hospital, also incorrectly in clause (b) after giving the consequences of Septicaemia has mentioned the antecedent cause as post-operative coronary artery bypass grafting. He urges that this recital is wrong as the patient developed Hospital Infected Pneumonia and the opposite party hospital itself had carried out the laboratory tests to indicate that this was caused by the bacterial and microbiological infections that entered the body of the deceased due to unhygienic use of equipments, including a catheter.

25. Responding to the said submission, Mr. Rao, learned counsel for the opposite party, urged that there is no deficiency in the summary prepared by the hospital and full indications with complete description have been given in the summary at page 25 of the paper-book without withholding the relevant information.

26. Having heard learned counsel for the parties, the death summary prepared by the hospital does indicate the development of patchy lung lesions and also the presence of pseudomonas aeruginosa bacterial/microbiological infection (Hospital Associated Infection) for which the patient was administered medicines as he had developed respiratory distress. It is correct that this has not been shown as the cause of death in the medical certificate at page 98 of the paper-book. Nonetheless, the death summary gives the symptoms without

mentioning it as the cause of death. The issue and the relevance of the same would be discussed while deciding the primary issue of Hospital Associated Infection hereinafter.

27. Another argument which has been advanced is with regard to the negligence in not performing Tracheostomy as advised by Dr. Vigg on 05.08.2002 and which was ultimately done on 12.08.2002. For this, reliance is placed on the affidavit of Dr. Vigg, which was filed in evidence on behalf of the complainant. It is true that there is a gap in the performing of Tracheostomy but the same contributed towards the death of the patient does not seem to be corroborated as the death of the patient, according to the complainant, mainly was caused by the Hospital Associated Infection and severe Sepsis. The management part has been dealt with by Dr. Vigg in his affidavit but from the progress sheet that has been brought on record, it is evident that the patient was being attended and managed every moment, on which count it cannot be said that the Tracheostomy was delayed deliberately or negligently that had resulted in the death of the patient. There is therefore no clinching evidence of absence of care in performing Tracheostomy, which was done on medical advice on 17.08.2002. The contention of Mr. Pattjoshi is that there is no explanation as to why the hospital took more than 12 days to adopt the said procedure which might have aggravated towards the deteriorating health of the deceased. The possibility of doing the Tracheostomy before or having been delayed inspite of advice ought to have been corroborated further but from the statement of Dr. Vigg, this was neither the cause for any infection of Sepsis or the bacterial infection that might have caused Sepsis.

28. Coming to this contentious issue of Hospital Aided Infection, the laboratory reports may be referred to for an appreciation of the controversy. To start with, the condition of the patient indicated the presence of infection on 02.08.2002. The doctor sheet indicates that Dr. Sharat Talluri advised treatment to the patient for Hospital Acquired Pneumonia. The patient was also advised to be put on ventilator in case his condition deteriorates. Accordingly, medicines were prescribed and samples of fluid were taken for being tested. The test was conducted at Global Hospital and the report was received on 05.08.2002. The same has been extracted at internal page 4 of this order. The culture report clearly establishes the symptom and infection of "pseudomonas aeruginosa". Mr. Pattjoshi has advanced his submissions, contending that this infection is common to hospitals, post-surgery, and is one of the most common causes resulting in complications and are also fatal. With the help of a publication of the National Library of Medicine, National Institutes of Health, contained in Chapter 27 and explained by Barbara H. Iglewski, he submits that the epidemiology and the control advised as well as the description given would indicate that such infections are caused in hospitals as explained therein. The same is extracted hereunder:

> "Epidemiology
>
> > Pseudomonas species normally inhabit soil, water, and vegetation and can be isolated from the skin, throat, and stool of healthy persons. **They often colonize hospital food, sinks, taps, mops, and respiratory equipment. Spread is from patient to patient via contact with fomites or by ingestion of contaminated food and water."**

29. The introduction part explains the content of this bacteria as follows:

> "The genus Pseudomonas contains more than 140 species, most of which are saprophytic. …. ….. …. **It is a ubiquitous free-living bacterium and is found in most moist environments.** Although it seldom causes disease in healthy individuals, **it is a major threat to hospitalized patients,** particularly those with serious underlying diseases such as cancer and burns. **The high mortality associated with these infections is due to a combination of weakened host defence, bacterial resistance to antibiotics, and the production of extracellular bacterial enzymes and toxins."**

30. Under the heading 'Clinical Manifestations' of the said paper, it is specifically indicated that "aeruginosa" enters through catheters or urinary tracts causing pneumonia which may also be the outcome of contaminated respirators. The said article also suggests the diagnosis and the control of such infections through treatments as indicated therein.

31. He has also relied on an article by the Surgeons of the Department of Microbiology, MIMSR Medical College, Latur, India to contend that **such an infection survives in hospital environment and, therefore, it is necessary to control infections in hospitalized patients.** The said article was published in the Journal of Microbiology and Infectious Diseases in February, 2014 and the extract whereof, as highlighted by the learned counsel, is extracted hereunder:

> "Pseudomonas aeruginosa, because of its ability to grow in moist conditions with simple nutrients and because of its ability to resist the antibacterial agents and disinfectants, is **commonly found in various places of hospital environment including sinks, drains, taps, food, water, pharmacy preparations, contaminated hospital equipments, mattresses and cleaning materials** (mops, brushes). It colonizes liquid antiseptics such as quaternary ammonium compounds (cetrimide and benzalkonium in particular), eye medications, infusion fluids, soap solutions, etc. P. aeruginosa is a very significant contaminant of pharmaceuticals and cosmetics and its presence in such products causes inactivation of medicaments and direct damage to users. **Because of its ability to survive in hospital environment and medicaments, it creates threat to patient care.** Therefore, continuous and careful monitoring of these objects and sites is necessary to control infections in hospitalized patients. Regular practice of environmental survey and suitable control measures help to reduce hospital acquired infections considerably.
>
> The fact that hospital acquired infections is caused by microbes, which are prevalent in hospital environment is known since long. But unfortunately this fact is mostly overlooked and relatively very little importance has been given to the environmental studies in hospital and only a few reports are available on environmental surveillance program in hospitals."

32. The second laboratory report which has been pointed out was carried out on a culture & sensitivity sample of the Catheter, indicating "antimicrobial susceptibility profile of gram positive cocci". The culture of the "catheter lumen" indicated the same which has also been extracted at page 4 – 5 hereinabove.

33. The third infection came to be located on a microbiological culture report for **CVP TIP of the catheter**. This report indicates another infection which is extracted hereunder:

"PATIENT NAME : MR. SADERUDDIN JAVERI IP NO. 1607

AGE/SEX : 64 Y / MALE DATE OF RECEIVING : 13.8.2002

DATE OF REPORTING : 17.8.2002

DOCTOR : DR. GOPICHAN M WARD : CTICU

MICROBIOLOGY CULTURE REPORT

SPECIMEN : C V P TIP

REPORT : **COAGULASE NEGATIVE STAPHYLOCOCCUS** (STAPHYLOCOCCUS SCIURI) (ON ID STAPH) **WAS ISOLATED AFTER 18 HOURS OF INCUBATION.**

SENSTIVE TO : VANCOMYCIN

RESISTANT TO : METHICILLIN

CLARITHROMYCIN

ERYTHROMYCIN

CEFTRIAXONE

CEFUROXIME

OXACILLIN

PIPERACILLIN / TAZOBACTAM

CEFATAZIDIME

MEROPENEM

AZITHROMYCIN

AMBICILLIN/SULBACTAM"

34. This test was carried out by the hospital itself on the sample received on 13.08.2002.

35. The same day another biological report was taken for ET Secreation that is extracted hereuhnder:

"PATIENT NAME : MR. SADERUDDIN JAVERI IP NO:1607

AGE / SEX : 64 / MALE DATE : 17.8.2002

DOCTOR : DR. GOPICHAN M WARD CTICU

MICROBIOLOGY REPORT

ET SECREATION FOR GRAM STAIN : POLYMORPHS AND GRAM POSITIVE COCCI IN SHORT CHAINS ARE SEEN"

36. The fifth report that was received upon a test by the hospital itself on receiving a sample on 16.08.2002 and was given on 20.08.2002 regarding the **ICD TUBE TIP.** The same is extracted hereunder:

"PATIENT NAME : MR. SADERUDDIN JAVERI IP NO. 1607

AGE/SEX : 64 Y / MALE DATE OF RECEIVING : 16.8.2002

DATE OF REPORTING : 20.8.2002

DOCTOR : DR. GOPICHANd MANNAM WARD : CTICU

MICROBIOLOGY CULTURE REPORT

SPECIMEN : **ICD TUBE TIP**

REPORT : COAGULASE NEGATIVE STAPHYLOCOCCUS WAS ISLATED AFTER 18 HOURS OF INCUBATION.

RESISTANT TO : PIPERACILLIN / TAZOBACTAM

CEFUROXIME

CEFACLOR

CEFTRIAXONE

AMPICILLIN

AZITHROMYCIN

ERYTHROMYCIN

SLARITHOROMYCIN

SENSITIVE TO : MEROPENEM

VANCOMYCIN”

37. Thus, all these tests, according to the learned counsel, leave no room for doubt that these were Hospital Associated Infections through the catheter and the equipments utilized by the hospital during the treatment of the deceased patient. No cogent evidence by opposite party hospital was led to contradict these lab reports which are of the hospital. He therefore submits that coupled with these infections and the absence of process of Tracheostomy, as advised by Dr. Vigg, compounded the deteriorating condition of the deceased patient.

38. At this juncture, it is appropriate to deal with the evidence led particularly to the interrogatories which were filed, the answers given and pointedly with regard to the affidavit of Dr. Ajit Vigg, on which reliance has been placed by the learned counsel for the complainant. The said affidavit is extracted hereunder:

"AFFIDAVIT OF Dr. AJIT VIGG,

IN LIEU OF CHIEF EXAMINATION

ON BEHALF OF COMPLAINANT

I, Dr. Ajit Vigg S/o BVansilal Vigg aged about 54 years, residing at Hyderabad do hereby solemnly and sincerely affirm and state on oath as follows:

1. I am a Doctor and a Specialist in Chest Diseases. My qualifications are M.B.B.S., D.T.C.P., D.N.B., M.R.C.P. (U.K.), F.I.C.A. (U.S.A.) and F.C.C.P. (U.S.A.). I have been working as a Pulmonologist and I am the Head of the Department of the Chest Diseases in the Critical Care Medicine, Apollo Hospital, Hyderabad. I am also a Consultant Physician, Chest Specialist in Apollo Hospital, Hyderabad. I have been working since almost one and half decades.

2. I know late Sri. S.H. Jhaveri. I was his Consultant Doctor for almost a decade and odd. I am aware that he underwent surgery C.A.B.G. in the respondent hospital. He died due to Sepsis and multi-organ failure in the post-operative period.

3. I had visited the deceased after he was admitted and operated in the respondent hospital. I was also consulted by the respondent Hospital.

4. The deceased Jhaveri was operated by Dr.Gopichand. In fact, he opted for the respondent Hospital, being influenced by the advertisements and promises made by and on behalf of the respondent Hospital about its infrastructure, expertise and the Doctors attached to it, which it claimed to be a Corporate Hospital.

5. The respondent Hospital Surgeon who operated the deceased was fully aware that the deceased was a chain smoker. It is but appropriate that the respondent Hospital and all the concerned with it should have taken appropriate proper and extra care when they are aware that the deceased was a chronic smoker and a diabetic. The respondent should have done Tracheostomy which could have helped in weaning the patient and they should have used C.P.A.P./BIPAP to facilitate weaning. When the deceased patient was known to be a chronic-smoker, the allegation of the respondent that 'Septicaemia" had occasioned as the deceased was found smoking, one or two days before surgery, cannot be accepted. Even assuming the said allegation to be true, was true, it could not have changed the position, as the patient was a chronic smoker once the abstinence for one or two days of smoking could not have made any difference on the patient.

7. The respondent failed to take appropriate precautions while the deceased was on Ventilator. They did not proactively look for Ventilator associated Pneumonia and the respondent Hospital should have known that chances of Pneumonia was certainly high in case of those who are chronic smokers. Post-operative Septicaemia will occur due to infection and due to failure to take proper post-operative care. The respondent should have taken steps early to perform Tracheostomy, to facilitate early weaning and prevent complications.

8. The respondent should have taken extra care in the immediate post operative time, keeping in view the nature of the patient his smoking habits and keeping in view that he is diabetic. Delay in intimation of Xigris therapy proved it to be of no use after development of Septicaemia as it was too late to intervene.

9. It is submitted that chain smokers are prone to infections after surgery and adequate preventive steps should have been taken by the respondents to prevent infection. If proper care and attention was taken, the post operative complications like Septicaemia could have been avoided. In the post operative period, initially complication was started with the poor lung functioning. At that time proper care should have been taken immediately. It was not done. It is submitted that the respondent Hospital could not shift the patient to a proper Diagnostic Centre either within the Hospital or outside the Hospital as it did not have necessary ambulance with supportive equipment. The deceased S.H. Jhaveri died due to sepsis and multi-organ failure and on account of failure of the respondents to prevent infection in the post operative period."

39. A reply to the same was given by Dr. Gopichand, the Surgeon, who had performed the surgery, and the same is extracted hereunder:

"REPLY TO THE AFFIDAVIT OF DR. AJIT VIGG

I Dr. Gopichand S/o M. Narasimham, Chief of Cardiothoracic Surgeon, aged about 51 years, R/o Care Hospital, Road No.1, Banjara Hills, Hyderabad-500034 do hereby solemnly affirm and state as under:

1. It is humbly submitted that this opposite party denies every allegation made by Dr. A.Vigg except those are specifically admitted herein.

2. PARAWISE REPLY

2.1 It is humbly submitted that this opposite party knows Dr. A.Vigg and admit that Dr. A.Vigg has been a consultant chest physician at Appollo Hospital, Hyderabad. This opposite party was a consultant cardiothoracic surgeon in Appollo Hospital Hyderabad during the period 1994-1997.

2.2 It is humbly submitted that the Late S.H. Javeri did not disclose to his opposite party that he underwent any treatment by Dr.A.Vigg. Even if so any, it is out of the knowledge of this opposite party.

2.3 it is submitted that the Dr. A.Vigg visited the deceased Javari at Care Hospital at 10.00 p.m. on 05.06.2002 and after examination, he opined that it is a case of COAD (severe) and bilateral pneumonia (pseudomonas infection) and sepsis and suggested to start zosyn plus meropenum, early tracheostomy and evaluation for DIC. Dr. Ajit Vigg reviewed the deceased several times following the initial consultation and opined on 06.08.2002 that his ABGs were better and advised to continue PCV with PCV 18 cm of H_2O with PEEP of 10 cm H_2O with FIO_2 of 45% and added IV. Tavamic 500 mg IV once daily.

It is humbly submitted that Dr.A.Vigg further reviewed the deceased on 10.08.2002 after extubation and advised to continue CPAP 10 mm of H_2O. Dr. Vigg again reviewed the deceased on 12.08.2002 and advised to continue CPAP.

2.4 It is humbly submitted that Mr. Javeri himself has turned on to Care Hospital and opted to operated by this opposite party. As such this opposite party operated the deceased on 31.07.2002.

2.5 It is humbly submitted that it is not true to state that the hospital and concerned did not take proper care while subjecting the deceased to surgery as he was a chain smoker and chronic diabetic. Taking into the history of the patient that he is chronic diabetic and a chain smoker, all necessary precautions were taken including coverage with 3 antibiotics (powercef, zanocin and

Ivimicin) He was electively ventilated and extubated at 9.05 p.m. on the day of the surgery i.e, on 31.07.2002.

2.6 It is humbly submitted that it is not true to state that the opposite parties did not take proper care while the deceased was on Ventilator and after re-intubation. Inspite of all possible precautions, the deceased succumbed to post surgical complications. It is well known fact that in the medical literature that chronic obstructive pulmonary disease is associated with an increased incidence of pulmonary complications, longer ICU stays and increased operative mortality. Pulmonary complications are more common in patients with advanced age, obesity, current smoking history known as four fold increase in complications.

2.7 It is humbly submitted that the use of medicine Xigris was advised by Dr. Sarat Talluri. This drug was not available in India and Dr. Sarath made several phone calls to Delhi and Germany to convince manufactures to supply the medicine at free of cost. On compassionate grounds as a life saving measure XIGRIS was provided to Mr. Javeri by the manufacturers without any charges. Xigris was infused to Mr. Javeri from 18.08.2002 to 21.08.2002 (details available in Case sheet).

2.8 It is humbly submitted that all necessary precautions were taken to prevent respiratory infections and he was treated with appropriate antibiotics based on the culture sensitivity reports and chest physiotherapy. Despite of all thetherapeutic measures, unfortunately Mr. Javeri developed multiorgan failure and succumbed to it."

40. It is evident that in paragraph-5 Dr. Vigg asserts that Tracheostomy should have been done that could have helped in comforting the patient. He also states that the patient was a known chronic smoker. To this, the reply of Dr. Gopichand is that necessary precautions were taken and he was "electively ventilated and extubated" at the appropriate time. It is also further stated that he was treated with appropriate antibiotics. A perusal of these affidavits indicates that the allegation is not about administering any incorrect medicines but is rather of not performing Tracheostomy earlier. It has not been explained as to how the same would have prevented the complication of the infections which was the real cause of the deterioration of the health of the deceased patient. Consequently, the affidavit of Dr. Vigg does not in any way aid the allegation of negligence in the treatment that was adopted after diagnosing the infection. Dr. Vigg's affidavit makes general suggestions, indicating his opinion about the proper care and attention of the patient. The same has been replied to on oath by Dr. Gopichand, explaining that all satisfactory measures were undertaken.

41. On an assessment of the affidavits of evidence of the complainant as well as of the opposite parties, the real issue relates to the infections that led to the complications leading to the death of the patient. In this regard, the fact of a Hospital Associated Infection is corroborated by the pathological and microbiological tests indicated above. They pointedly direct towards the infections having entered through the catheter. The measures adopted by

the treating doctor by changing catheters also demonstrate that in all probability the infections had entered through such contaminated equipments which were the source of infections. The scientific tests therefore carried out do indicate that the infections were caused in the hospital on account of contaminated equipments that were used during the treatment of the deceased. The diagnosis and the prescription of medicines also indicates that the medicines had to be prescribed in order to counter the said infections, the source whereof related to the catheters and other respiratory equipments used by the hospital. It is therefore clear that the Hospital Associated Infections were caused in every probability on account of the lapses and unhygienic conditions of the hospital. There is no explanation worth the name by the hospital nor any evidence adduced and in all probability it is for this reason that the same was not reflected in the cause of death in the death summary or the medical certificate. The said infections can tend to be fatal and this is what appears to have happened in this case. There is no convincing explanation, argument or evidence to contradict this conclusion. The literature cited and relied on by Mr. Pattjoshi as reproduced hereinabove has not been contradicted by any conflicting opinion or expert evidence by the opposite party. The said literature therefore also corroborates and confirms the eminently probable cause of hospital infection.

42. The defence taken by Mr. Rao, learned counsel for the hospital, is that the patient had a very weak immunity and, therefore, he succumbed on account of his own weaknesses. It is probably correct that the patient was having a long symptomatic history of getting treated for various medical complications and his own lifestyle and habits also contributed towards his weak constitution. However, these facts were all known to the opposite parties even before they proceeded to perform the surgery. The patient was suffering from a chronic disease and was also susceptible to complications on account of his weak constitution but at the same time what aggravated the same is the hospital associated infections that seems to have compounded the worsening situation of the patient. It is quite possible and probable that had he not suffered these infections, he would have possibly survived as the coronary bypass surgery was reportedly successful.

43. Mr. Rao contended that the patient’s smoking habit which was noticed in the hospital after admission and is also recorded in his case history was another cause contributing towards his unsupportive health condition. There is no material to establish that smoking by itself would invite hospital associated infections. The same may be a reason for the lack of immunity of a particular patient but insofar as the present case is concerned, it is evident that the hospital associated infections had set in and this onset continued successively from 02.08.2002 till 17.08.2002 and even thereafter, virtually adding to the worsening health condition of the deceased patient.

44. Consequently, in the light of the evidence on record and the clinical and pathological investigations, the patient’s condition after the operation from 02.08.2002 onwards deteriorated due to the hospital associated infections, which is a clear deficiency on the part of the hospital contributing to the patient’s death.

45. The question of a direct medical negligence on the doctors, therefore, does not seem to be established but the deficiency in the services of the hospital, as noted above, causing complications arising out of the bacterial and microbiological infections have in all probability led to the failure of the organs of the patient arising out of severe Septicaemia and

his ultimate death. The hospital, therefore, is liable for damages on account of the aforesaid deficiency in service.

46. The deceased patient was a jeweller. His personal lifestyle and his habits as noted during his treatment in all probability contributed towards his weak immunity and fragile health resulting in his ailments and complications. He was aged about 64 years at the time of his death. He would, therefore, may not have survived long thereafter with a larger life span as expected of a normal human being. His income and his status are therefore indicative of his comfortable earnings but at the same time in the background above a disproportionate liability cannot be foisted on the hospital for the death of Late Mr. Zaveri. The hospital however has been found to be deficient in maintenance of its hygiene and standard protocols in order to prevent infections and, consequently, in the light of the findings above and the observations, it would be appropriate to award a sum of Rs.10,00,000/- together with interest @ 6% from the date of death of the patient i.e. 22.08.2002 till the date of actual payment, which shall be done within a period of three months from today. In the event of any non-payment, the same shall carry enhanced rate of interest of 9%.

47. The complaint stands disposed of and allowed on the above terms. Pending applications, if any, also stand disposed of.

.....J
A. P. SAHI
PRESIDENT