IN THE NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION, NEW DELHI

Reserved on: 16/10/2025
Pronounced on : 28/11/2025

CONSUMER COMPLAINT NO. 2227 OF 2016

Smt. Sarla Devi, W/o Shri Vijender Pal Singh, R/o House No. 18 D, Gali No. 25 B, Molarband Extension, Badarpur, New Delhi – 1100044.

.... Complainant

Versus

(1) Northern Railway Central Hospital, Through Chief Medical Officer, Basant Lane, New Delhi – 110055.
(2) Chief Medical Officer, Northern Railway Central Hospital, Basant Lane, New Delhi – 110055.
(3) Batra Hospital & Medical Research Centre, Through the Medical Director, C/o Choudhary Aishi Ram Batra Public Charitable Trust, 1, Tughlakabad Institutional Area, Mehrauli Badarpur Road, New Delhi – 110062.
(4) Dr. Manish, Chief Medical Officer, Batra Hospital & Medical Research Centre, C/o Choudhary Aishi Ram Batra Public Charitable Trust, 1, Tughlakabad Institutional Area, Mehrauli Badarpur Road, New Delhi – 110062.
(5) Dr. Vijay Hangloo, Batra Hospital & Medical Research Centre, C/o Choudhary Aishi Ram Batra Public Charitable Trust, 1, Tughlakabad Institutional Area, Mehrauli Badarpur Road, New Delhi – 110062.
(6) United India Insurance Co. Ltd., 118, Second Floor, Barashvulla Chowk, Chawri Bazar, Delhi – 110006. **... Opposite Parties**

BEFORE:
HON'BLE MR. JUSTICE A.P. SAHI, PRESIDENT
HON'BLE MR. BHARATKUMAR PANDYA, MEMBER

For the Complainant	:	Mr. Rajinder Singh, Mr. Arjun Sharma, Mr. Gagan Yadav, Mr. Krishan Gopal, Advocates
For Opposite Parties-1&2	:	Mr. Vikrant N. Goyal, Mr. Harsh Kumar Singh, Advocates
For Opposite Parties-3&5	:	Mr.(Dr.) Bipin K. Dwivedi, Mr. Balwant Choubay, Mr. Abrar, Mr. Ankit A. Dwivedi, Advocates with Dr. Vijay Hangloo OP-5 in person
For Opposite Party-4	:	Ex-parte vide order dated 03.10.2017
For Opposite Party-6	:	Deleted vide order dated 08.07.2019

ORDER

PER BHARATKUMAR PANDYA, MEMBER

1. The present complaint has been filed by the complainant Sarla Devi against the opposite parties – hospitals and their doctors alleging medical negligence,

whereby daughter of the complainant lost her life on account of negligence and deficiency in the treatment.

2. The brief facts of the case, as stated in the complaint, are as under:

2.1 Ms. Monika Singh, D/o the complainant was taken to OP-1 Railway hospital in the intervening night of 21.07.2015 (12 AM) with complaint of severe abdominal pain and vomiting since 5 PM. She was immediately examined by the casualty medical officer on duty and presumably on the basis of earlier Ultra Sound (USD) report dated 14.05.2015 shown by her relatives, patient was given few injections and after recommending few tests, complainant was asked to get her examined in Surgical OPD on tentative diagnosis to be that of Appendicitis. In the morning of 22.07.2015 at around 9.45 AM, the patient was again brought to Surgical OPD and was examined by the doctors. After examining, the doctor asked the brother of the patient to take her home but as she was not well and was still in pain, her relatives requested the doctors to admit the patient. Even after observing and informing the doctors of OP-1 hospital about the condition of the patient, the doctors did not show any concern for immediate and timely treatment for her. With no other option, family of the patient took her to OP-3 Batra hospital at around 4 PM on 22.07.2015 in the emergency ward. OP-3 hospital admitted the patient in the casualty ward after a delay of almost 5 hours. OP-3 hospital also did not give any emergency treatment to the patient even though she was suffering from severe abdominal pain. OP-3 hospital admitted the patient at 1.15 AM on 23.07.2015 and she remained unattended for more than 9 hours, with no treatment, no medication and no urgent and immediate medical steps taken despite her serious condition, which kept on deteriorating from the time she was brought to the emergency ward and further till the time she was finally admitted by the OP-3 hospital. In the morning of 23.07.2015 at around 10 AM, patient was referred to OP-5 Dr. Vijay Hangloo, who after examining the patient, recommended various tests and CT scan. As per complainant, OP-5 doctor did not even check the patient's blood pressure and pulse rate at the time of examining her. Later on, fake readings and documents were prepared to show that her BP and pulse were normal in the morning of 23.07.2015. At 4 PM on 23.07.2015, the patient was taken to the Operation Theatre. The operation took about four hours and even after shifting the patient to the ICU, her family was not allowed to see her. The family members of the patient could see her only on the next day of the operation, that too from a distance, at around 11 AM on

24.07.2015. The consent form was got signed from the brother of the patient and after the operation, it was informed that a major operation was done and the patient's large intestine was removed and her condition was serious. The complainant (mother of the patient) kept on asking for the complete treatment record but OPs did not provide the same to her. It was only when RTI was filed by the complainant that the complete treatment record was given by the hospital. The relatives of the patient were not allowed to meet or see her in the ICU by stating that her condition was serious. Finally, at around 12-12.15 PM on 26.07.2015, the patient was declared dead. The cause of death mentioned in the Death Summary is stated to be "*Ileocecal thickening secondary to abdominal TB, perforation peritonitis, septicaemia, multiorgan failure*".

2.2 When patient was brought to or admitted in the hospital with severe abdominal pain, the first and foremost duty of the doctors was to examine the patient and get the tests/x-rays/CT scan/ultrasound etc. immediately done to know the nature of the disease, because slightest delay in the diagnosis and treatment to the patient may cause severe problem and threat to her life. In the present case, OPs 3 to 5 not only delayed the diagnosis of ailment by quickly not conducting diagnostic tests including CECT, but also there was delay in the treatment of the patient, which led to the complications and untimely death of the patient. The patient was admitted in the intervening night of 22.07.2015 and 23.07.2015 and got operated belatedly in the evening of 23.07.2015, almost after 24 hours of getting admitted in the Emergency Ward. It appears that because of delay in getting proper and timely medication/surgery, the patient died. Being aggrieved, complainant filed the present complaint on 23.12.2016 with a prayer to direct the OPs to pay compensation of an amount of Rs.1,55,60,000/- along with interest @ 18% p.a. from the date of filing this complaint till the date of payment.

3. The complaint was resisted by OPs by way of written statements filed by them. OP-1 and OP-2 filed their written statement on 14.10.2017 denying all allegations levelled by the complainant and they raised various contentions to counter the allegations. As per OP-1&2, they had administered the best available patient care and support to the patient and any allegation of negligence is vehemently denied by them. At the time of examination of the patient, her pulse was 70 per minute, which was normal, SPO2 (Oxygen saturation) was 96% which was also within normal limits. Treatment was given accordingly, i.e. inj. Diclofenac, Inj.

Pantoprazole, Inj. Ondansetron, Intravenous fluids (IVF), etc. Patient was seen by the on call surgical department doctor in casualty. The surgical department doctor noted ultrasound report brought by the patient relatives dated 14.05.2015 which mentioned Renal Calculus 3.5 mm, her pulse & B.P. was within normal limits. There was tenderness in Right iliac fossa, however no abdominal guarding or rigidity were noted. She was advised some investigations, like CBC, KFT, LFT, SE (sodium and potassium), Serum Amylase. At 9.40 AM on 22.07.2015 when she returned for consultation, she was again examined in surgical OPD and her B.P. was 80/50 mm hg and pulse was 100 per minute (pulse was within normal limit). She was not having any fever. It was decided to call doctors in surgical OPD (instead of sending the patient to Surgical OPD), who remain on call in the morning time and consultation was obtained. Treatment prescribed earlier continued. However, patient was taken by the relative/caretakers on their own in surgical OPD which is roughly 10-12 steps away from the casualty and they consulted surgical department. She was provided and prescribed treatment on the lines of renal stone and was advised to report back, if required, at any time. She was diagnosed as a case of Renal Stone and was given treatment accordingly (Plenty of fluids, Syp. ston, tab. Oflox, tab. chymoral forte, cap omeprazole, Urgendol P SOS, Domstal). However, the patient, soon after consultation in surgical OPD of OP-1, left casualty on her own and the patient did not return as per the available records despite advice for follow up. OP Nos. 1 and 2 did their best in examining and treating the patient accordingly. OP-1 & 2 denied the averment of the complainant that the deceased was earning approx. Rs.1 to 2 Lac per month for last three years. It is submitted that the complainant has not annexed any ITRs with the complaint to ascertain that she was getting remuneration as alleged in the Para 25 of the complaint.

4. Written statement was also filed on behalf of OP-3 & 5 on 14.09.2017. As per OP-3 & 5 complaint is devoid of any cause of action and is false and vexatious in nature. Best possible treatment was provided to the patient and all established medical procedures were followed and at no point of time there had been any deficiency, shortcomings in service or negligence on their part and that the complaint is highly misconceived, devoid of substance and liable to be rejected. The patient reported in casualty of OP-3 at 11 pm, and not at 4 pm as alleged, and was admitted in OP-3 hospital on 23.07.2015 at 1.15 AM by the surgical doctor on duty. The patient had stable vitals but there was some tenderness and distension of the

abdomen with sluggish bowel sound. She was administered treatment as prescribed by Dr. Manish. OP-5 (Dr. Vijay Hangloo) examined the patient in the morning on 23.07.2015 when the patient had normal vitals. After examining the patient, CECT of whole abdomen was advised to arrive at conclusive diagnosis because the haematological reports and USG were inconclusive. CECT of the abdomen (page 96 of the complaint) revealed that patient had Pneumoperitoneum, Circumferential mural thickening of terminal ileum, Ileocecal junction and caecum measuring approximately 15 mm in thickness with surrounding fat stranding with narrowing in terminal ileum with dilatation of jejuna and ileal loops causing obstruction due to terminal ileal strictures, enlarged mesenteric nodes in right iliac fossa with peritoneal thickening with ascites all suggestive of Ileocecal TB with complications of perforation, strictures and peritonitis. Ileocecal TB causing obstructions takes approx. 6 to 9 months to present as complications. The patient had long standing TB of intestine neglected without treatment leading to complications of bowel obstruction, perforation and peritonitis. The diagnosis confirmed the need of surgical intervention and the same was conveyed to the family and pre-operative investigation orders were given and PAC (Pre-Anaesthesia) was advised. High risk of the surgery and its outcome were clearly mentioned to the family and high risk consent was also obtained. It was entirely wrong to mention that consent was taken after surgery because why would the family give consent for surgery which has already been completed and why would the OPs will temper the time when they know that surgery has to be done in an hour or so. Unfortunately, inspite of best possible treatment, the patient could not survive. The informed consent of general anaesthesia was taken at 4.30 AM and the brother of the patient signed consent at 3 PM and that deliberately someone tried to change 3 by making it 8 which is clearly visible. As such the allegation of tempering is false and is denied by OPs. The post-operative notes had been written by the operating team along with procedures and findings (page 171 with complaint). So it is incorrect to say that OT notes were missing. The HPE confirmed IC TB with peritoneal fluid positive for TB bacilli and ecoli and morgenella margagne organism causing sepsis. All standard protocols were followed and procedure was done correctly and appropriately and at no point of time there was any negligence or deficiency in service or shortcomings or imperfections on the part of OP-3 & 5.

5. Averment has been made by OP-3 & 5 in their written statement that TB of the abdomen is a life threatening condition more so when left untreated. The complications of stricture, peritonitis Ileocecal mass and perforation occur in untreated and long standing TB. Moreover it depletes patient's immunity and nutritional status leading to morbidity and mortality. The patient had long standing tuberculosis as evident from the CT scan findings of perforation, peritonitis Ileocecal mass and stricture and was not treated for it. This condition needed surgery which was done but the patient came with a neglected complicated disease which led to complications. As per OPs it is false on the part of the complainant to say that there was unprofessional approach to the medical treatment and care of the patient on the part of the OPs. Established medical procedures and protocols were followed and best possible treatment was provided to the patient. The allegations of belated or negligent treatment or surgery are absolutely false and denied. Written statement of OP-3 & 5 attempts to categorically explains the causes, reasons and treatment of abdominal tuberculosis. As per OPs, abdominal tuberculosis is predominantly a disease of young adults. The clinical features of TB are varied. The most common symptoms are pain in the the abdominal area, loss of weight, anorexia, recurrent diarrhoea and low grade fever with cough and distension of abdominal region. Patients of perforation always require a surgery. Gastrointestinal TB may result in intestinal obstruction and perforation even after anti-tuberculosis therapy. Despite surgical intervention tuberculosis perforation has a high complication and mortality rate. TB is amongst the ten leading causes of death and is one of the commonest causes of death in the young. Intestinal tuberculosis is classified into three categories, *namely (1) The ulcerative form of tuberculosis is seen in approximately 60% of patients, multiple superficial ulcers are largely confined to epithelial surfaces, this is considered a highly active form of disease (2) the hypertrophic form is seen in 10% of patients and consists of thickening of the bowel wall with scarring, fibrosis and rigid mass like appearance that mimics like carcinoma. (3) The ulcero hypertrophic form is the subtype seen in 30% of the patients. These patients have the features of ulcerative and hypertrophic form* and that patient was having all the three forms of abdominal tuberculosis and she was untreated for the same prior to hospitalization. The complainant is not entitled to any relief as complaint is false, frivolous, motivated and vexatious. Furthermore, while vehemently denying any deficiency in service, it is reiterated by OP-3 & 5 that the best possible treatment was

provided to the patient and all established medical procedures were followed and at no point of time there had been any short comings in service or negligence on their part.

6. The complainant filed common rejoinder to the written statement filed by all the OPs on 31.01.2018 whereby complainant denied and disputed each and every averment made by the OPs in their written statements. It is the submission of the complainant that the life of the deceased (daughter of the complainant) could have been saved, if she would have been properly and timely diagnosed and treated. OP-1 & 2 suspected and diagnosed the patient to be suffering from "renal calculus" and gave treatment for the same, whereas they themselves had suspected that the patient might be suffering from "Appendicitis" as noted in the records. Inspite of repeated request of the family members of the deceased to admit her in their hospital, OP-1 & 2 refused to admit her and asked the parents to take her home. Complainant also denied the allegation of OP-3&5 as they are creating a story that the patient was suffering from pre-existing Abdominal TB. The deceased daughter of the complainant was working as a model and she did many modelling assignments for many projects, products and magazines and stage shows. She also took part in fashion shows and worked in a few films. If she would have been suffering from the aforesaid diseases as alleged by the OPs, she would definitely have complained it to someone, sought medical assistance. She could not have worked so hard. It is specifically denied that the deceased had gone through any of such symptoms except for the abdominal pain.

7. We have heard the counsel for the parties and perused the documents available on record. It is the contention of the complainant that on being admitted in the casualty, her daughter (patient) was examined by the doctor at OP-1 Hospital and suspected of having Appendicitis. Few injections were given to her and certain tests were also carried out. Patient was also asked to be examined in the surgical OPD. Junior doctors in the surgical OPD examined her and prescribed some medicines and, finding nothing serious or requiring hospitalisation, was advised to take the patient home. The relevant paras of allegations in the complaint, the reply of the OP may be summarised as under:

Allegations in the complaint : Para 3

The doctor after examining and prescribing some medicines asked the brother of the patient to take her home whereas complainant and her family kept on requesting the doctors to admit the patient as she was not well and she was still

in severe pain. But the doctor very rudely replied that "hum doctor hain ya tum doctor ho, hamne medicine dey diya hai, aap isko ley jao aur use next OPD mein dikhana." The doctor misbehaved with the mother of the patient very badly and they never informed the complainant about the seriousness of the disease of the patient.

Reply

Patient was seen by the on call surgical department doctor in casualty. They mentioned history of vomiting four to five episode and pain in abdomen right iliac fossa since morning. There was no history of urinary complaint, no history of loose motion or constipation, no history of bleeding per rectum. There was tenderness in right iliac fossa, however, no abdominal guarding or rigidly were noted and patient had passed flatus also. The vitals as noted are normal. She was advised some investigation, like CBC, KFT, LFT, SE (sodium and potassium), serum amylase. Investigation samples were sent from the casualty immediately. The surgical department doctor also noted ultrasound report brought by the patient relatives dated 14.05.2015 which mentioned renal calculus 3.5 mm, her pulse and B.P. was within normal limits. She was advised omnatax (Inj. Cefoperazone), Inj. Metronidazole and continued the other injections as prescribed by the casualty medical officer. She was in casualty bed continuously as per the records.

Para 6

Even after observing that the patient was suffering from Appendicitis, the doctors of OP-1 Hospital did not show any concern for the immediate and timely treatment of the patient.

Reply

The patient was taken by the relatives on their own in surgical OPD which is roughly 10-12 steps away from the casualty and consulted surgical department. She was provided treatment on the lines of renal stone. She was advised to report back SOS (if required, any time). She was diagnosed as a case of renal stone and was given treatment accordingly. The patient never returned for any follow up or any SOS emergency consultations thereafter.

Complaint Para 8 & 10

On refusal of OP-1 hospital and its doctors for admission of the patient, family was forced to take her to OP-3 hospital at around 4:00 PM on 22.07.2015 in the

Emergency ward. After delay of more than 4 hours, the patient was examined in the Emergency ward at around 8:30 PM and after further delay of almost 5 hours, the patient was admitted in the Casualty ward of OP-3 Hospital at 01:15 AM on 23.07.2015 and during this intervening period of 9 hours, no treatment and medication was given to her, no urgent and immediate medical steps were taken despite her serious condition, which kept on deteriorating.

Reply

Allegations of non treatment and unjustified delay are false and denied. The patient came to hospital only at 11 p.m. of 22.07.2015 and entry was made in admission and discharge register and that emergency room nursing assessment paper also show time as 11.00 p.m (page 157 of complaint petition) and first payment was made at 11.13 pm (OPD bill cum cash receipt Annexure-R-2). Complainant is trying to raise frivolous allegations with malafide motive.

Complaint Para 11

OP-5 Dr. Vijay Hangloo, who came at around 10 AM in the morning of 23.07.2015 (deliberately wrongly noted as 8.45 AM) examined the patient and recommended various tests and CT scan. He did not even check the patient's blood pressure and pulse rate at the time of examining. No such report was prepared on 23.7.2015 at 8.45 AM as shown in the treatment record at page 014. It is submitted that the same was prepared afterwards showing fake readings which is evident from the document itself, which mentions her BP 120/70 and Pulse 80/mt. at 8.45 AM on 23.7.2015, where as the patient had abnormal BP of 90/60 mm Hg and Pulse rate of 134/min at 11.05 pm on 22.07.2015. It is impossible to fathom as to how abnormal BP will become normal and abnormal pulse rate would become normal in 9 hours without any medication and this only shows that the progress note and doctor's note on page 014 on 23.7.2015 are fake to cover-up irresponsible act of medical negligence.

Reply

The allegations made in para 11 are absolutely false and denied. Dr. Vijay Hangloo visited the patient at 8.45 a.m. and not at 10 a.m. as being alleged. That it is mentioned in the progress notes and doctors order (Annexed at page 45 with petition) that the patient came at 11 PM and initial treatment of the patient was started and further treatment in form of I/V antibiotics stated (page

39 of petition). That there is nothing unusual in BP and pulse becoming normal after initial treatment

Complaint Para 12

On the back of page 014 the time and date are mentioned as 12 PM on 23.07.2015 suggesting further action, but no time is mentioned on page 015. On page 016, time 8 PM is mentioned stating that the consent of patient's brother was taken. The report of CT scan was available at around 3:00 PM and the patient was taken to the operation theatre at 4:00 PM on 23.07.2015, whereas page 016, shows that the consent was taken at 3 PM' on 23.7.2016 (the time mentioned on the said page is tampered). The sheets of progress notes and doctor's order have been tampered with or written afterwards which is evident from the notings on sheet No. 021 where the date and time have been tampered with (in the beginning the time is written 10.00 PM and at the end the time is mentioned as 1 AM) and on the back of the sheet No. 021, the time mentioned in the beginning is 11 PM and at the end of the page the time mentioned is 2 PM. The pages of the treatment record should be in chronological order showing the steps/action taken by the doctor, which is not so found from the record available.

Reply

As per OP-3 & 5, contents of Para 12 of PARAWISE REPLY of the written statement filed by OPs No. 3 & 5 are wrong and hence denied. It is submitted that OPs No. 3 & 5 must be aware of as to who the interested party is and who has done this manipulation, because the complainant received the said copy of the treatment record under RTI. From the document it is evident that firstly the time was written as '8' and then subsequently overwriting of number '3' was done on it. The contents of the corresponding paragraph are reaffirmed and reiterated for the sake of brevity

Para 14

OP-5 doctor informed that it was a small operation but when the patient came out of the OT at around 8 PM on 23.7.2016, it was found that it was a major operation and patient's large intestine had been removed and the patient was in a serious condition, the pulse rate was 148/min and BP was 88/62 mm Hg,

which shows that the patient was not in stable condition. But OP-5 kept on saying that the patient was recovering.

Reply

The allegations that the family was informed that the operation is a small operation is not true which is clearly indicated in the consent form. The patient was managed in SICU post operatively. All supportive and specific treatment were administered including antibiotics, blood transfusions and blood products and a team including cardiologist, physicians, interventionists and surgical team monitored the treatment. The brother of patient had signed the consent on behalf of the patient. Consent for the operation and high risk consent was taken before the surgery. It was entirely wrong to mention that consent were taken after surgery as to why would the family give consent for surgery which has already been done and why would the OPs will temper the time when they know that surgery has to be done in an hour or so. This tempering if any might have been done by somebody who had an intention to malign the hospital after understanding that the patient was having poor outcome and low chances of survival as informed decision was taken.

Para 18

Family of the patient was not allowed to be seen her in the ICU stating that she was being examined by the doctor as her condition became serious. However, at around 12-12:15 PM on 26.07.2015 she was declared dead.

Reply

That it is incorrect to say that patient's relatives have been denied access to ICU.

Para 22

When patient is admitted in the hospital with severe abdominal pain, the first and foremost thing for the doctors was to examine the patient and get the tests/x-rays/CT scan/ultrasound etc. done immediately to know the nature of the disease, because slightest delay in the diagnosis and treatment of the patient may cause severe problem and threat to the life of the patient. OPs not only delayed in the diagnosis of the cause of ailment but also there was delay in the treatment of the patient, which led to the untimely death of the patient.

Reply

The Abdominal tuberculosis is predominantly young adult disease and the USG is almost inconclusive in most cases. Reference to medical literature is made to point out the complexity of the patient's intestinal TB. Notably, no specific explanation is provided as to what diagnostic tests were performed before CECT and why the same could not be performed till 12 noon of the next day.

8. Patient was referred to OP-5 doctor Dr. Vijay Hangloo, who after examination and some tests diagnosed her of TB of intestine and was suggested operation for the same. The operation was conducted for about 5½ hrs. and after operation family members were not allowed to see her and she was kept on ventilator. It is the averment of the complainant that they were allowed to see her only at around 11 AM on 24.07.2015, whereas she was taken to the Operation Theatre at 4 PM on 23.07.2015. Around eight bottles of blood was taken from the family members in the name of the patient. OP-5 told the family of the patient that there was a small operation and nothing to worry. However, after operation and that too major operation, they came to know that large intestine of the patient was removed and she was in a serious condition, but OPs kept on assuring us that she was recovering. As per complainant, family members were not allowed to meet her for one reason or the other. It is further stated by the complainant that on 26.07.2015 at around 10:00 AM, one of the their family friend went inside the emergency to see another patient and there they saw that her daughter had no movement when they touched her feet. So as per complainant, her daughter had already expired and not responding and OPs were hiding the same from them. Finally, on 26.07.2016 at 11.56 AM hospital authorities declared the patient dead due to cardiac arrest. It is the allegation of the complainant that OPs not only delayed in the diagnosis of the cause of ailment but also there was delay in the treatment of the patient, which led to her untimely death. Deceased daughter of the complainant was working as a model and she did many modeling assignments for many projects, products and magazines and stage shows. She also took part in fashion shows and worked in a few films. She even did number of films such as 'Rave to Grave' etc. The deceased was earning approximately Rs.1 to 2 Lakh per month for last about a year or two. She used to get her remuneration mostly in cash which she would use for herself and she also used to give to the complainant for meeting expenses for better standard of living. As per complainant, OP-1&2 as well as OP-3&5 are guilty of committing medical negligence. It is further alleged by the complainant that patient was suffering from severe abdominal pain and vomiting when she was brought to OP-1 hospital and OP

doctors failed to give patient necessary and immediate medical treatment and they acted callously and failed to take reasonable degree of care expected from them. OP-1 hospital was deficient in as much as it failed to give immediate treatment to the patient and were due negligent in not admitting her to the hospital. OP-3 hospital was deficient in as much as the patient was not attended timely and no proper diagnosis/treatment was given to her. It is further averred that OP-2, 4 & 5 Doctors did not initiate the standard requisite practice (of clinical observation diagnosis - including diagnostic tests and treatment) in the case which is expected from a responsible body of professional practitioners in the medical field. So as per complainant, OP doctors and the hospitals were negligent in the treatment of the patient.

9. Hence, a compensation to the tune of Rs.1,55,60,000/-, as detailed below, has been requested to be paid by the OPs:

(a) Loss of consortium	Rs. 25,00,000/-
(b)Loss of estate & income	Rs. 1,21,00,000/-
(c)Mental agony and pain	Rs. 5,00,000/-
(e)Medical Expenses	Rs. 3,50,000/-
(f)Legal expenses	Rs. 1,10,000/-
Total	Rs. 1,55,60,000/-

10. On the other hand, it is the contention of the OP-1 & 2 that at the time when patient was brought to their hospital, all her parameters were normal and within the range. In causality, doctor of surgical department after examining her and after seeing the ultrasound report dated 14.05.2015 brought by the relatives found that there was Renal calculus measuring 3.5 mm. All the necessary investigations were done and necessary treatment was provided. Soon after consultation in surgical OPD of OP-1 hospital, patient along with her relatives left the casualty on their own. The family of the patient then took her to OP-3 hospital at their own will and they did not turn back after that. So no negligence can be attributed either towards OP-1 hospital or OP-2 doctor. Due care and caution was taken while the patient was in OP-1 hospital. Hence present complaint is not maintainable and is liable to be rejected.

11. We have heard the counsels for the parties. As far as OP-1 and OP-2, the railway hospital, are concerned, the patient came for consultation in OPD in casualty and surgical OPD and received symptomatic treatment. It is the fundamental allegation that the patient's condition required hospitalisation and aggressive treatment but the

doctors took the condition casually, did not admit the patient, and even after suspecting the appendicitis, the doctors treated her only for renal calculi. The relevant medical record is at page 23-25 of the complaint. The casualty consultation of 21st and SOPD consultations of 22nd July has noted the chief complaints of vomiting and abdominal pain and no other. The casualty OPD admission happened at 12 midnight. The USG Abdomen of 14.05.2015 is noted, results of small calculi is noted and medicines, lot of fluid and "review in SOPD SOS" have been prescribed. Some pathological tests were also prescribed. Time of "OPD Admission in casualty" is noted as 12 am, and not earlier as alleged by the complainant. The SOPD consultation was obtained next day at 930 am as recorded in the medical records. There is no evidence that only the "junior doctors" and not the surgeon examined the patient. There is no allegation with regard to the medication that was prescribed. After perusal of the evidence, we are unable to find any alarmingly or even reasonably deficient conduct in the treatment on the basis of mere allegations in the complaint and the pleadings and evidence on record as above. We find no merit in the allegations that despite request by the patient's relatives and despite alleged continuing distress and pain suffered by the patient, the incharge doctors did not admit the patient in the hospital. The fact that the patient went home and returned only next day morning for SOPD consultation, and the fact that the SOPD consultations also brought in no new line of treatment would indicate that the doctors, in their best wisdom, judgment and skill, in the circumstances, took an expert medical opinion of treatment as suggested and necessitated by medical history and clinical condition, which in our opinion, cannot be faulted in the absence of contrary expert opinion or palpable negligence or misconduct, neither of which is brought out by any credible evidence on record. The generalised and unsubstantiated allegations that the patient was not admitted in hospital despite the patient being in sever pain and despite the insistence for admission by the relatives cannot and do not persuade or lead us to any adverse findings of any negligence. The condition of the patient at this moment, in retrospect, and after noticing subsequent events as unfolded, can be surmised or felt to have perhaps required a more comprehensive investigation and even hospitalisation, but the medical decision of the treating doctors has to be evaluated on the yardstick of evidenced medical condition when the decision was taken uninfluenced by the subsequent events. Further, there is no plausible explanation or averment in the complaint as to why the patient was not brought to the OP-1 Hospital for review in the evening of 22.07.2015 when the despite such advise by OP-1. Even the initial condition

of the patient at Batra Hospital at 11 pm (pg 41-42) was recorded as "GC fair, vitals normal, afebrile". In this light, we find nothing questionable in not admitting the patient and rather advising the SOPD consultation next day. Such SOPD consultation ended with advise for further review in SOPD on SOS basis. We find no lapse, infirmity, violation of any medical protocol or negligence in this course of conduct of OP-1 and OP-2.

12. Turning to allegations against OP-3 to OP-5, as per their defense, patient had abdominal pain and vomiting when she was admitted in OP-3 hospital on 23.07.2015 at 1.15 AM. She was immediately examined by the surgical doctor on duty and treatment was started in the form antibiotics through I/V. OP-5 doctor examined her in the morning of 23.07.2015. Contrast Enhanced Competed Tomography (CECT) was advised and CECT of the abdomen revealed that she had pneumoperitoneum suggestive of perforation of bowel, circumferential mural thickening of terminal ileum and enlarged mesenteric nodes in right iliac fossa with peritoneal thickening with ascites which concluded ileocaecal TB with complications of perforation, strictures and peritonitis. Patient had long standing TB of intestine which was neglected without treatment leading to complications of bowel obstruction, perforation and peritonitis. Deteriorating condition of the patient needed surgical intervention. Family of the patient was made aware of her condition and it was made clear to them that TB of abdomen is a life threatening condition and more so when left untreated. Daughter of the complainant had long standing tuberculosis as was evident from the CT scan findings and was not treated for it. Surgery was needed to treat the same. Hence, surgery was done with proper diagnosis and with proper informed consent. As patient had come with a neglected complicated disease, her family was well informed of the high risk for outcome and high risk consent form was got signed from the brother of the patient before the operation. OPs totally disagree with the statement of the family of patient that consent for surgery was taken after operation. Time of 3 was changed to 8 was tampered by some interested person from the family of the patient. Allegation of family that operation was small but turned out to be a major one, is denied by the OPs. Consent for high risk was taken from the family of the patient. Even post operative notes were written by the operating team along with procedures and findings and allegation of OT notes being missing, are totally denied by the OPs. OP-3 & 5 also deny the allegation of the family of the patient that they were denied access to the ICU. Patient on ventilator are kept sedated and to avoid any infection, number of visitors are also kept restricted. Best

possible treatment was given to the patient and inspite of all team work from all the departments of OP-3 hospital, patient could not be saved due to her medical complications. As per OP- 3 to 5, all standard protocols were followed by them and procedures were done correctly and there was no negligence, deficiency in service or shortcomings on their part.

13. The first allegation against Batra Hospital OP-3 and Dr. Hangloo OP-5 is that the patient remained unattended and untreated in the casualty ward for 9 hours between 4 pm of 22.07.2015 and 1 am of next day, thus resulting into substantial delay in investigations and treatment which ultimately resulted into deterioration of patient's condition. While there is no evidence to substantiate the allegation, the same is denied by the OPs. It is the reply of the OPs that the patient was brought to the hospital at 11 pm, and not at 4 pm as alleged. The medical record, being the "pre-admission record" and "initial assessment" at pages 29 and 39 reveal that the patient reported at 11 pm, and after payment at 11.03 pm (Annexure R-2), the pre-admission form was filled in at 11.15 pm after which clinical examination and emergency treatment was provided in the casualty section. The admission register corroborates such timings. The hospital admission, as per the medical record at page 26 of the file, records the "admission" time of 1.15 am when the patient was admitted and shifted from casualty to ward. After noting that there is no evidence whatsoever to support the averment of the complainant that the patient reached Batra Hospital at 330-4 pm and after considering the weight of evidence on record, we conclude that the patient reached Batra Hospital casualty at 11 pm only. Therefore there is no merit in the allegations of lack of urgency and treatment as mentioned in para 9 of the complaint. The factual unsubstantiated averment of the complainant that the patient was brought at 330-4 pm is false and misleading and appears to us to have been made solely with a view to provide gravity to the allegation of delay in providing the treatment.

14. Second allegation is that practically there was no effective treatment in the emergency or in the ward form the time the patient was brought to the hospital till Dr. Hangloo examined the patient on 23/07/2015 at 10am, wrongly noted as 8.45 am on page 45. The medical records are conveniently created and interpolated as can be seen from the inconsistency in BP recording which was low 90/60 as recorded upon admission (page 157) which was recorded as normal 120/70 by Dr Hangloo at 8.45 am of the next day, which is impossible, as there was no intervening treatment, clearly implying manipulation of records. The allegation is denied and relying upon the medical

records, it is contended by OPs that the treatment was started at 11 pm of 22/07/2015. As seen on page 158, Dr. Manish examined the patient and medication was started. There is no inconsistency or abnormality as the BP was normalised during treatment when Dr. Hingaloo examined the patient. The allegations are frivolous. Having perused and weighed the medical evidence, we are unable to see any signs of interpolation or creation of medical records as alleged. Dr. Hangaloo has seen the patient at 8.45 am when the patient was "GC-stable, Afrible" and again at 12 (pg 45-46) when the findings of the CECT Abdomen is recorded in the progress-sheet. It is also unfathomable to the complainant that the low BP of 90/60 of preceding night could have become norma 120/70 without any treatment while alleging that the entry by Dr Hangloo on page 45 is interpolation and that Dr. Hangloo is guilty of delay, carelessness and lapse because no examination at all was carried out by him. Also, the counsel for the complainant drew our attention to pg 96, being CECT report which shows that the image was received at 12.46pm and report was prepared at 3 pm, contending that the result recorded at 12pm noon much earlier to the time of report by Dr Hangaloo establishes the manipulation of the records. Having perused the relevant records, we are not convinced about these allegations. There is no palpable or striking irregularity or unusualness in the recording by Dr. Hingaloo on page 45-46 of the file. We are rather persuaded by the explanation on behalf of the OPs that the CECT results were informally obtained from the hospital-attached radiology section by the consulting doctor, as can be reasonably be expected in the given scenario, because formal preparation of report can take more time. That is how thereafter the exploratory laparotomy and surgery was planned and undertaken by Dr. Hangaloo. Thus, we find no merit in the allegation that no treatment was administered till Dr. Hingaloo examined the patient at 845 am, or even by Dr Hingaloo or that the records are manipulated by the Hospital.

15. Before we examine the next allegation, the course of patient's condition and treatment may be briefly encapsulated. The CEPT report (pg. 96) dated 23.07.2015 revealed that the patient had pneumoperitoneum, suggestive of bowel perforation, which in normal parlance is intestinal perforation and discharge/leakage of material in the abdominal cavity, which can potentially speedily deteriorate patient's condition. There was moderate ascites meaning accumulation of gas or fluids. Sub Acute Intestinal Obstruction was suspected. The advice of exploratory laparotomy and surgery was given. The surgery, under vasopressure support, lasted for around 4 hours as can be seen from pg 52 that the patient was received in the surgical ward at 8 pm.

Thereafter, the condition of the patient progressively deteriorated despite multiple investigations, consultations and continued treatment. As per the death summary at page 32, the patient was declared dead at 11.56 am on 26.07.2015. The patient had Abdominal Koch's, i.e intestinal TB. The surgical findings are fecal contamination, cecal mass with perforation and change in colour of the colon. Right hemicolectomy followed by ileostomy and revisionary ileostomy were performed. Patient was moved to Surgical Intensive Care Unit. The cardiology and physician consultations were obtained in view of onset of septicemia and multiorgan failure. The patient had cardiac arrest, CPR was performed, but to no avail.

16. The next major allegation is the tampering in the timings and/or creation of records by pointing out the inconsistency or discrepancy in times or dates as recorded on the progress sheets, particularly medical record pages 14, 16 and 21. It is also alleged that the informed consent as recorded on page 16 (pg 49 of file) was obtained after, and not before, the surgery. We have perused the relevant pages. There appears to be some overwriting which may perhaps indicate the subsequent changes made in the records. Equally, it could be in the ordinary course. After scanning through the complete medical records, we are unable to infer any foul play by the Hospital or the doctor. Apart from the "High Risk Consent" as recorded in the progress sheet on page 49, there are documents at page 160-162 for consent for surgery and anesthesia. Various blood transfusion consents are also on record. As such, in our opinion, as rightly explained by the OPs during hearing, the intestinal perforation as was diagnosed was an emergency necessitating the surgery which lasted nearly 4 hours. Nothing adverse therefore can be inferred in the discrepancies as alleged by the complainant.

17. It is also alleged that before surgery, the relatives were informed that the surgery is "small or minor", while in fact it was major which took 4 hours, and that the relatives were not allowed to meet or see the patient in ICU. The allegation of non-supply of medical records is also made. It is particularly alleged that the surgical notes for patient condition during surgery has neither been prepared nor been supplied in the medical records. It is stated that despite the young patient having been kept in ICU post surgery, the lack of treatment and care resulted into her untimely death. The perforation of the gastro-intestinal track is primarily to be diagnosed through clinical examination. As a matter of fact, there is substantial delay in carrying out the CEPT and the surgery both of which should have happened immediately upon admission at 1 am of 23.07.2015. These allegations are denied in the reply. It is explained that the patient, after

admission, was optimized by the incharge doctor with antibiotics and IV fluids. The abdominal pain and distensions can be for various medical reasons, and particularly for women, the surgical and non-surgical cases need to be identified. The patient attained stability due to treatment by morning. Thereafter, on the basis of the CEPT report, the need for surgery was identified and was performed. The patient was suffering from Koch's i.e. intestinal TB which takes some time before presenting with symptoms and complications and is likely to cause perforations. Adverting to the medical literature filed along with the reply (pg 32, 34,46, 53 of reply), it has been stated that the surgery was absolutely essential, was carried out with utmost care and caution, and post-surgery complications, which can never be wholly ruled out, were managed aggressively and timely, but the onset of septicemia, multiple organ failure and cardiac arrest could not be averted despite best efforts and multiple consultations by experts, resulting into unfortunate death of the patient. Referring to literature on page 46 and 57 of the reply, it is submitted that around 62% cases of abdominal TB require surgery, and that mortality rate in abdominal TB is as high as 6%, which if perforation happens, can be as high as 17%. The records, including the surgery notes (pg 166-171) were duly provided and there is absolutely no evidenced laxity or negligence on the part of the hospital and doctors.

18. The fundamental grievance or allegation of the complainant is the delay between 4 pm of arrival of patient and 4 pm of the next day when surgery was performed after CECT. After minutely perusing the medical records and considering the contentions raised on behalf of the parties, firstly we note that the patient was admitted at 1 am of 23rd after arrival at 11 pm. The speedy deterioration of the patient's condition post surgery may lead to the thought that had the CECT been done earlier and surgery could have been done earlier, the patient could have been perhaps saved. It is also true that no diagnostic tests were conducted till CECT on the next day at 12 noon after Dr. Hangaloo's examination, and the whole treatment record for nearly 12 hours is scanty and less detailed on pages 158 and 159 of the file. However, at the same time, there is nothing on record to indicate that the "speedy" course of investigation and treatment/surgery as suggested by the complainant in the complaint was indicated as a compulsive medical necessity, non-observance of which is deviation from medical protocol so as to be labelled as negligence or culpable delay. The patient condition on admission is recorded to be only indicative of low BP, and no other alarming symptoms, which was stabilised by morning when Dr. Hangloo recorded "GC stable". It is also true,

as explained by the OPs, that the intestinal perforation itself which can manifest suddenly, once suffered, can lead to rapid and accelerated deterioration and complications within a matter of hours. There is no medical expert opinion or any authentic medical literature placed on record by the complainant to persuade us to hold that the delay of nearly 12 hours in carrying out CECT and absence of other investigations, which led to the belated diagnosis of perforation and need for urgent surgery, was compulsively indicated by the clinical condition of the patient upon admission at 1 pm. Without such scientific and medical basis placed on record by the complainant to arrive at such conclusion, we are unable to arrive at any conclusion of medical negligence on the part of the OPs in this behalf. There is merit in the explanation of the OP for the "delay" in as much as firstly the patient was getting stabilised upon admission and secondly various possible causes for the condition of patient needed to be weighed and evaluated which is medical and clinical expert judgment of the experts which we are afraid we can not put to the test of propriety in the absence of another expert medical opinion. There is no serious allegation *qua* the conduct of the surgery or post-surgery management of the patient. As such, otherwise also, the perusal of the medical record of detailed progress notes, investigation reports and nursing notes filed with the complaint is indicative of multiple consultations and monitoring, diagnostic and management efforts and treatment rendered by the hospital, which unfortunately still could not succeed in saving the patient. As the literature placed on record by the OPs would show, the post-surgery mortality rate in intestinal perforation cases is very high to the extent of 17%, and it is unfortunate that the patient fell within that 17%. The intestinal perforation occurring due to long standing untreated Koch's resulted into fecal material leaked into the abdominal cavity, which, progressively and despite medical management, resulted into infections, septicemia multiorgan failure and cardiac arrest. The high risk and other consents were duly obtained and are on record. The surgical and anesthetic notes are also very much available in the record filed by the complainant at page 166-171. Thus, we are unable to find any deficiency or medical negligence so as to make the OPs liable.

19. While concluding, we may state that it is indeed, shocking and sad that a young 22-23 year old patient lost her life within a short span of four days of hospitalisation. However, such unfortunate outcome in itself, though agreeably disturbing, shocking and unacceptable for the relatives, cannot in itself amount to negligence of the hospital or treating doctors, and, the allegations of medical negligence nevertheless have to be

evaluated dispassionately on the basis of evidence on record in light of the pleadings. The standard yard-stick on which such evaluation is to be based is whether the Hospital or the treating doctor can be held accountable for any lapse or deviation in following any standard medical protocol or practice or for lack of skill, expertise, care and caution exercised during the diagnosis, investigations, treatment or surgery or while creating respective medical records. No error or fault can be found for error in medical judgment and decision when the course adopted by the doctor is one of the recognised options. No negligence can be found also when the unfortunate outcome is the consequence of the ailment of the patient and complications arising therefrom which complications cannot be wholly avoided. The following observations of the apex court in this behalf may be quoted in this behalf:

(a) Jacob Mathew Vs. State of Punjab (2005) 6 SCC 1

18. *..... The standard to be applied for judging, whether the person charged has been negligent or not, would be that of an ordinary competent person exercising ordinary skill in that profession. It is not necessary for every professional to possess the highest level of expertise in that branch which he practises. 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."*

(b) ***Dr. Harish Kumar Khurana Vs. Joginder Singh (2021) 10 SCC 291***

11. *.....However, in unfortunate cases, though death may occur and if it is alleged to be due to medical negligence and a claim in that regard is made, it is necessary that sufficient material or medical evidence should be available before the adjudicating authority to arrive at a conclusion.*

(c) ***Bombay Hospital & Medical Research Centre Vs. Asha Jaiswal & Ors. 2021 SCC Online SC 1149***

34. *Recently, this Court in a judgment in Harish Kumar Khurana v. Joginder Singh [Harish Kumar Khurana v. Joginder Singh, (2021) 10 SCC 291 : (2022) 1 SCC (Civ) 215] held that hospital and the doctors are required to exercise sufficient care in treating the patient in all circumstances. However, in an unfortunate case, death may occur. It is necessary that sufficient material or medical evidence should be available before the adjudicating authority to arrive at the conclusion that death is due to medical negligence. Every death of a patient cannot on the face of it be considered to be medical negligence.....*

35. *.....The doctors are expected to take reasonable care but none of the professionals can assure that the patient would overcome the surgical procedures. Dr Kripalani has been attributed to have informed the complainant that the patient's legs were not working but Dr Kripalani denied all the averments by filing of an affidavit.*

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

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.

(f) Chanda Rani Akhouri Vs. M.A. Methusethupati (2022) SCC Online SC 481

27. It clearly emerges from the exposition of law that a medical practitioner is not to be held liable simply because things went wrong from mischance or misadventure or through an error of judgment in choosing one reasonable course of treatment in preference to another. In the practice of medicine, there could be varying approaches of treatment. There could be a genuine difference of opinion. However, while adopting a course of treatment, the duty cast

upon the medical practitioner is that he must ensure that the medical protocol being followed by him is to the best of his skill and with competence at his command. At the given time, medical practitioner would be liable only where his conduct fell below that of the standards of a reasonably competent practitioner in his field.

20. Seeing in this perspective, as discussed earlier, we are unable to find any deficient conduct or negligence on the part of the OP hospitals or treating doctors. In the result, the complaint is dismissed.

Sd/-

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(A.P. SAHI, J.)
PRESIDENT

Sd/-

.....

(BHARATKUMAR PANDYA)
MEMBER

aj/