NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION
NEW DELHI

REVISION PETITION NO. 1989 OF 2016

(Against the Order dated 01/03/2016 in Appeal No. 573/2014 of the State Commission Delhi)

1. SWETA KHANDELWAL
W/O. AMIT KHANDELWAL, 1903, GALI NO. 3,
KAILASH NAGAR, GANDHI NAGAR,
DELHI

.....Petitioner(s)

Versus

1. DR. A.K. JAIN & 2 ORS.
IXI 2392, STREET NO.12, KAILASH NAGAR,
NEW DELHI-110031
2. DR. USHA JAIN,
IXI 2392, STREET NO. 12, KAILASH NAGAR,
NEW DELHI-110031
3. RISHABH MEDICAL CENTRE,
IXI 2392, STREET NO. 12, KAILASH NAGAR,
NEW DELHI-110031

.....Respondent(s)

BEFORE:
HON'BLE MR. JUSTICE R.K. AGRAWAL,PRESIDENT
HON'BLE DR. S.M. KANTIKAR,MEMBER

For the Petitioner : Appeared at the time of arguments through Video Conferencing
For Petitioner : Mr. Anish Verma, Advocate

For the Respondent : Appeared at the time of arguments through Video Conferencing
For Respondents : Mr. Pankaj Singhal, Advocate with
Dr. A. K. Jain – in person

Dated : 03 Jun 2022

ORDER

Pronounced on: 3 rd June 2022

ORDER

DR. S. M. KANTIKAR, MEMBER

Gossypiboma, a retained surgical sponge, is a rare complication following any surgical procedure and is primarily a result of human error. Such patients often have vague clinical presentations and the diagnosis often comes as a surprise. Thus, all general physicians, surgeons and radiologists must be aware of this rare iatrogenic disorder but clinically significant entity having medico-legal implications.

1. The present Revision Petition has been filed by the Complainant – Sweta Khandelwal (hereinafter referred to as the 'patient') under Section 21(b) of the Consumer Protection Act, 1986 against the Order dated 01.03.2016, wherein the State Consumer Disputes Redressal Commission, Delhi (hereinafter referred to as the "State Commission") accepted the Appeal and set aside the Order passed by the District Consumer Disputes Redressal Forum, East (hereinafter referred to as the "District Forum") in Consumer Complaint No. 106/2013 and dismissed the Complaint.

2. Brief facts that on 13.09.2012, Dr. A. K. Jain (hereinafter referred to as the 'Opposite Party No. 1') and Dr. Usha Jain (hereinafter referred to as the 'Opposite Party No. 2) performed Caesarian delivery (LSCS) of Sweta Khandelwal (hereinafter referred to as the 'Patient') at Rishabh Medical Centre, Delhi (hereinafter referred to as the 'Opposite Party No. 3'). The patient was discharged on 18.09.2012, though her condition was not good. She approached the doctor again, but she was sent back stating that everything was fine. Her stitches were removed, but she was not feeling well. She again visited the doctor who told that it was a problem of indigestion. On 23.09.2012, she developed unbearable abdominal pain and her abdomen was swollen like balloon. On the next date, she was admitted to St. Stephen Hospital at Delhi and was operated. During operation, the doctors found infected sponge and 1.5 liters of pus in the pouch of Douglas (POD). She was discharged on 11.10.2012. Thus, being aggrieved by the alleged carelessness of the Opposite Party No.1, the Complainant filed a Complaint before the District Forum, East Delhi.

3. The Opposite Parties Nos. 1 to 3 filed their Written Version and raised the question of maintainability of the Complaint as there was no cause of action against the Opposite Parties and the Complaint was bad for misjoinder of Parties. The Opposite Party No. 1 never participated in the surgery. The Opposite Parties strongly denied that any sponge was left in the abdomen during surgery. It was further submitted that the Complainant had not disclosed about her previous Caesarian operation at Rajasthan. Therefore, there was a possibility of the sponge being left in the body at previous Caesarian operation and the same remained in existence. It was further submitted that during the present Caesarian operation, the operating doctor did not touch the back of uterus, i.e. portion from where alleged sponge was removed.

4. The District Forum, on hearing the Parties, partly allowed the Complaint and awarded compensation of Rs. 10 lakh against the Opposite Parties.

5. Being aggrieved, the Opposite Parties filed the First Appeal before the State Commission. The State Commission allowed the Appeal and dismissed the Complaint.

6. Being aggrieved, the Complainant filed the instant Revision Petition.

7. We have heard the learned Counsel for the Parties. The Opposite Party No. 1 – Dr. Jain was also present during arguments.

8. The learned Counsel for the Complainant submitted that it was a case of gross negligence on the part of the Opposite Party No. 2, who left the sponge in the abdomen during the LSCS operation.

9. The learned Counsel brought our attention to the Order of the Delhi Medical Council, which is reproduced as below:

> *"2. It is observed on examination of x-ray no. XR39162 dated 24 th September, 2012 of the St. Stephens Hospital of the patient Swetha that the same was indicative of presence of a foreign body. As per the medical records of St. Stephens Hospital, the patient underwent em. Laparotomy with peritoneal lavage on 24 th September, 2012, wherein 1.5 litres of pus was drained and sponge was found in POD.*
>
> *3. It is also noted that the abdominal ultra-sonography report of the patient dated 21 st January, 2010 of Geeta Diagnostic Centre, Bharapur, Rajasthan did not reveal any abnormal findings.*
>
> *4. It is, thus, apparent that the sponge recovered at St. Stephens Hospital, was left negligently in the abdomen of the patient during LSCS procedure performed at Rishabh Medical Centre.*
>
> *5. Dr. Usha Jain made an error in judgement by not investigating diligently the cause of the post-operative abdominal pain reported by the patient and by simply attributing the same to gas."*

10. The rival arguments from the learned Counsel for the Opposite Parties are that the Complainant concealed the previous LSCS done five years back and it was the possibility that the sponge remained there since then. He further argued that the USG could not give conclusive findings in the back of the belly. At the time of LSCS the doctor opens abdomen from front midline and has no access to the back side. Therefore, there was no chance to miss the alleged sponge in POD which was found by the St. Stephen Hospital. The Counsel further brought our attention to the final order passed by the Disciplinary Committee of Delhi Medical Council on 17.10.2016 which reversed the Order of DMC. It is reproduced as below:

> *" The Council by majority observed that it cannot be conclusively proved that any professional misconduct of gross nature should be attributed to the doctors of Rishabh Medical Centre and a benefit of doubt may be granted to the doctors with an advice to further improve the surgical protocols at the place of their practice particularly implementing WHO surgical safety guidelines and quality standards protocols related surgical safety in its letter and spirit. In view of the same, the punishment of removal of name of Dr. Usha Jain, is not warranted .*

11. We gave our thoughtful consideration to the arguments from both the sides. We also have gone through the Surgical Text books [1] [2] and the research articles/case reports viz "Gossypiboma diagnosed fifteen years after a cesarean section: A case report [3] , Gossypiboma in a post caesarean patient: surgeon's dilemma [4] . Gossypiboma – A nightmare for surgeon: A rare case with review of literature [5] . From the said medical articles inference could be drawn

that prevention is always better than cure. WHO surgical safety checklist should be strictly adhered to. In case of discrepancy in count, appropriate action should be taken immediately to decrease morbidity of the patient. In case, patient presents with post-operative complications like fever with abdominal pain or discharge from wound, a high index of suspicion for retained sponge should be considered.

12. The Opposite Party was putting blame on the Complainant. The contention of the Opposite Party is that the gauze was left by the doctors at Bharatpur, where she was operated five years before. Even the treating doctor submits that the Complainant had not disclosed her previous LSCS. We are surprised how the Opposite Party No. 2, an experienced Gynaecologist, while examining the patient, failed to see the operative scar of the previous LSCS of the instant patient. Secondly, it is more relevant to rely upon the Medical Record of St. Stephen's Hospital. We note at the time of admission, the abdomen was distended, firm mass felt. The Ultrasound done on 24.09.2012 revealed uterus (12.5x9.1x5.1 cm) and a HETEROGENEOUS COLLECTION (MASS) (10X10X10 cm), it was suspected as pus collection. The patient was properly investigated and operated. After the operation, the pus culture sensitivity was done and treated the patient with appropriate antibiotics. Thirdly, the operative findings recorded by the surgeon at St. Stephen's Hospital confirm the above findings and the same are reproduced as below:

> *Surgery consultation was taken.*
>
> *Pt was planned for EM. Laprotomy with peritoneal lavage on 24/9/12*
>
> *Operative Findings- Abdomen opened by Midline incision, purulent 1.5 litres pus drained, cavity inspected, sponge found in POD. Cavity washed. Bowel inspected by Surgeon. No bowel injury. No fecal contamination. Drain kept. Abdomen closed in layers. Pus & sponge shown to relatives.*
>
> *Pt had fever, on POD -3 & 4 managed conservatively, minimal d/s from s/l on POD10 daily dressing done, alternative sutures removed on POD 13-complete stitch removal on POD-15 s/l healthy.*

Therefore, in our considered view, the sufferings of the patient were due to the pelvic abscess because of retained sponge after LSCS.

13. We agree that the mistakes can and do happen, at the same time, an operation is a stressful experience, enduring pain and discomfort afterwards can worsen this emotional distress, not only for a patient but also for her husband and loved ones. The principle of what constitutes medical negligence is now well established from the several judgments of the Hon'ble Supreme Court. In **Jacob Mathew Vs. State of Punjab & Anr** . [6] and **Achutrao H. Khodwa Vs. State of Maharashtra** [7] , wherein it has been, *inter alia,* observed that a medical practitioner must bring to his task a reasonable degree of skill and knowledge and must exercise reasonable degree of care. In Achutrao H. Khodwa's case (supra) concluded that since a foreign body was left in the system during the surgery, it clearly indicated that failure of reasonable degree of care thus medical negligence. Therefore, following the above principle, in the instant case we have no hesitation to hold the Opposite Parties liable for medical negligence.

14. We do not accept the Order of Disciplinary Committee of DMC, which held that *the punishment of removal of name of Dr. Usha Jain, is not warranted*. The Disciplinary Committee failed to consider the operative findings of St. Stephen's Hospital.

15. Regarding the compensation in such injuries and distressing experience, of course, no amount of money can turn back the time and reverse the harm already done, but receiving compensation for unnecessary surgery or surgical errors can at least help the patient to overcome some of the challenges that lie ahead. The Hon'ble Supreme Court held that the basis of computing compensation under common law lies in the principle of *"restitutio in integrum,"* which, when translated, refers to ensuring that the person seeking damages due to a wrong committed to him/her is in the position that he/she would have been had the wrong not been committed [8] . In Nizam's case (supra), it was held that the Judge in medical negligence litigation has complete and absolute discretion in awarding compensation, therefore unless evidentiary proof of the expenses incurred, or proposed expenses, is provided, the judge may in his/her own capacity determine the claim to be excessive or not reflective of prevalent costs. [9]

16. In the instant case, on noticing a foreign body, the sponge was removed at St. Stephen's Hospital. Thus, the operative details (supra) and findings of DMC prove that medical negligence is attributed on the treating doctor (surgeon). Adverting to the quantum of compensation, it is highly subjective in nature in the medical negligence cases. In the instant case, the Complainant has not filed the details of expenses, however, the District Forum awarded Rs. 10 lakh, which, in our view, is on higher side. The Hon'ble Supreme Court categorically cautioned the tribunals, in the case of **National Insurance Co. Ltd. vs. Kusuma** [10] **,** observing that the amount of compensation awarded was not expected to be a windfall or bonanza, nor should it be niggardly or a pittance. "Whether there exists a reasonable expectation of pecuniary benefit" was always a mixed question of fact and law, but a mere speculative possibility of benefit was not sufficient. Therefore, in the ends of justice, the compensation is reduced to Rs. 5 (five) lakh, as just and adequate in the instant case.

17. Based on the discussion above, the Order of State Commission is hereby set aside. The award made by the District Forum is modified. Accordingly, the Opposite Parties are directed to pay Rs. 5 lakh to the Complainant within 6 weeks from the receipt of Copy of this Order, failing which the Opposite Party shall be liable to pay 7% interest till its realization.

The Revision Petition is partly allowed.

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[1] Love & Belly

[2] Faruqson's

[3] Qatar Med J.2014; 2014(2): 65–69

[4] Singh SB et al. Int J Reprod Contracept Obstet Gynecol. 2020 Dec;9(12):5137-5139

[5] Gothwal M et al. J Mid-life Health 2019;10:160-2

[6] (2005) 6 SCC 1

[7] AIR 1996 SC 2377

[8] Malay Kumar Ganguly vs. Sukumar Mukherjee and Ors. (2009) 9 SCC 221

[9] Nizam's Institute of Medical Sciences vs. Prashant S. Dhanaka, (2009) 6 SCC 1

[10] (2011) 13 SCC 306

.....J
R.K. AGRAWAL
PRESIDENT
.....
DR. S.M. KANTIKAR
MEMBER