NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION
NEW DELHI

CONSUMER CASE NO. 129 OF 2010

1. BARNALI CHOWDHURY & ANR.
W/o. Late Sh. Kuntal Chowdhury, R/o. A-8, Nabadarsha Coop Group Housing Society Ltd.,
Birati, P.S. Dum Dum Airport,
Kolkata - 700 134
2. Master Samanway Chowdhury
S/o. Late Sh. Kuntal Chowdhury., Through Guardian & Next Friend, Smt. Barnali Chowdhury
R/o. A-8, Nabadarsha Coop Group Housing Society
Ltd, Birati, P.S. Dum Dum Airport, Kolkata- 700134 .....Complainant(s)

Versus

1. WOODLANDS MEDICAL CENTRE LTD. & ANR.
8/5 Alipore Road
Kolkata - 700 027
West Bengal
2. DR. RAJESH JINDAL
Medical Oncologist, R/o 49/101, P.G.M. Shah Road
Kolkata - 700 033
West Bengal
3. Dr. Sanjay Patawari
7D, Chowringhee Terrace
Kolkata- 700 020.
4. West Bengal Medical Council
8, Lyons Range, 3rd Floor
Kolkata - 700 001.
5. Directorate Of Health Services,
Government of West Begal,
Swasthya Bhawan, GN-29, Sector V, Salt Lake,
Kolkata .....Opp.Party(s)

BEFORE:
HON'BLE DR. S.M. KANTIKAR,PRESIDING MEMBER

For the Complainant : Appeared at the time of arguments
Mr. Sanjiv Kakra, Sr. Advocate
with Mr. Bheem Sain Jain, Advocate
Mr. Shikhar Gupta, Advocate
Mr. Akash Madan, Advocate

For the Opp.Party : Appeared at the time of arguments
Mr. Rajeev Virmani, Sr. Advocate
with Ms. Rashmi Virmani, Advocate
Mr. Krishan Tewary, Advocate

Mr. Mohit Dang, Advocate for OP-1
Ms. Suruchi Suri, Advocate
with Mr. Simranjot Singh, Advocate for OP-2
Mr. Pushpinder Singh, Advocate for OP-3

Dated : 03 Apr 2023

ORDER

***Res ipsa loquitur* is not a cause of action but a rule of evidence. It eliminates the need for expert testimony on the standard of care and if the standard of care was breached, but it does not eliminate the complainant's need to establish the causation.**

1. The present Complaint has been filed under section 21 of the Consumer Protection Act, 1986 by Smt. Barnali Chowdhury (Complainant No. 1) and her son – Master Samanway Chowdhury (Complainant No. 2) against the Woodlands Medical Centre, Kolkata (for short 'Woodland Hospital – OP-1), Dr. Rajesh Jindel, Oncologist In charge (OP-2) and Dr. Sanjay Patwari, Anesthetist (OP-3) for alleged medical negligence causing death of Kuntal Chowdhury due to administration of Vincristine intrathecally.

2. The Complaint:

2.1 In Feb-March 2008, Mr. Kuntal Chowdhury (since deceased, hereinafter referred to as the 'patient') was diagnosed as Stage IIB Non-Hodgkin's Diffuse large B-cell lymphoma **(NHL- DLBCL**) at Tata Memorial Hospital (**TMH**), Mumbai. He was under treatment of Dr. Purvish M. Parikh Professor and Head of Department of Medical Oncology. The Chemotherapy by **MCP 842** protocol was advised. At the end of March, the patient was airlifted to Kolkata and for chemotherapy (chemo) under consultation of Dr. Rajesh Jindel, the Medical Oncologist (OP-2). He advised the patient to get admitted in Woodlands Medical Centre, Kolkata (OP-1). The Chemo port insertion was done on 01.04.2008 and thereafter, till 11.06.2008 the patient completed three Chemo cycles uneventfully. All 3 cycles were tolerated, no adverse reaction and the patient was comfortable. He gained around 10 to 12kg of weight.

2.2 On 17.02.2008, for B2 cycle the patient consulted OP-2 in his private clinic and as he advised, the patient got admitted to OP-1 in morning on 18.06.2008. It was alleged that at about 10.30 am Dr. Sanjay Patwari (OP-3) administered Chemo. He Intrathecally (**IT)** injected Vincristine instead of it was to be given Intravenously (**IV**). Thus, due to wrong administration of Vincristine intrathecally, the patient's condition alarmingly deteriorated. On 20.06.2008, realizing the precarious condition of the patient and in order to wash off their hands form willful negligence the patient was discharged by OP-1 and 2 and referred him to TMH, Mumbai for emergency management. The patient was airlifted to Mumbai and admitted in TMH. He was admitted under Dr. Reena Nair, Additional Professor, Department of Medical Oncology with symptoms of fever, weakness of lower limb and urinary retention. Neurology reference was also taken. Dr. Reena Nair counseled the family members of the patient about very slim chances of survival because of progressive deteriorating condition. Therefore on 24.06.2008 the patient was shifted at Belle Vue Clinic, Kolkata.In the meantime, on 07.07.2008 a complaint was filed before West Bengal Medical Council (WBMC) by the family of patient against the OPs for willful negligence. The patient unfortunately passed away on 09.07.2008.

2.3 Being aggrieved, by the untimely death of the patient at the age of 37 years, who was working as a Software Engineer and sole earning member of the family, the patient's wife and minor son have filed the instant Consumer Complaint before this Commission and prayed Rs. 3.10 Crore as compensation.

3. Defense:

All the OPs have filed their respective Written Versions.

3.1 Reply of Woodland Medical Centre (OP-1)

The Director – Mr. Probir K. Bose filed reply on behalf of OP-1. He submitted that the Complaint is not maintainable against the OP-1. It involves complicated question of facts, which cannot be adjudicated in summary proceedings under the Consumer Protection Act, 1986 and the Civil Court is appropriate to decide such matter. The death of the patient was admittedly an act of negligence alleged to have been committed by

the OP-2 and OP-3. Both the doctors were not associated directly with Woodland Hospital - OP-1, therefore, the management of the hospital cannot be held liable especially, there are no allegations of any administrative negligence or failure to provide basic infrastructure to the patient. Moreover, the patient had a natural death at his home after several weeks after his discharge from the hospital. He submitted that the OP-1 is a day care centre, provides facility for the doctors for their short treatment. Therefore, OP-1 has no major role in the treatment of the instant patient. He further narrated the events happened on the fateful day. The patient was admitted by OP-2 around 9.00 am on 18.06.2008. At around 10 am, the OP-3 Anesthetist came to Room No. 231. The Matron on duty sent one sister Kakoli Biswas to assist OP-2. The OP-2 took the vials from the patient's bedside locker and placed it on the trolley and made preparation of **lumber puncture (LP)** to give intrathecal Chemo injection. The sister Kakoli followed his instructions only and Dr. Patwari – OP-3 drew up the contents of vials, which he had placed on trolley and kept the injection ready. The LP was done with some difficulty at 3rd attempt and then he injected the medicine intrathecally. After the procedure, the OP-3 left the hospital. After 15 about minutes, immediately after knowing Vincristine was wrongly injected intrathecally, the OP 2 and 3 returned to the patient at 10.45am and took corrective steps by withdrawing CSF and gave injection hydrocortisone intrathecally. However, both the doctors have not reported the implication of said error to the hospital or the authority. The OP-2 just mentioned in the record as 'IT-VCR' instead of intrathecal Vincristine. The OP-1 submitted that, the hospital has no opportunity to deal with the patient further as the patient was already discharged and sent to TMH.

3.1.1 Therefater, OP-1 examined the medical record and noted that the doctors had not disclosed the mistakenly administrated inj. Vincristine and about no neurology reference made though neurological complication occurred. The OP-1 initiated internal inquiry of the said incident and prepared **Sentinel Event Report** on 02.07.2008. The OP-1 conducted a departmental inquiry, which was attended by OP-2 and Ms. Sulekha Mandal (Nurse), but the OP-3 was absent. The inquiry was done by the WBMC at the OP-1, wherein the sisters Kakli Biswas and Sulekha Mandal were questioned. There was no negligence on the part of the OP-1. The Hospital further states that:

3.2. Reply of Dr. Rajesh Jindel (OP-2)

Dr.Rajesh Jundel submitted that he is practicing Medical Oncology since 2001 and attached to various hospitals in Kolkata. He has been associated with OP-1 Hospital for the last eight years. He denied the negligence as alleged. He had full sympathy with the Complainants. The MCP - 842 protocol includes two drugs that are given one Intravenous (**IV**) as well as other Intrathecal (**IT**). In this case as per protocol the drug **Vincristine** was to be given intravenous (IV) and **Arabinocide – Cytarabine** Intrathecally. As the patient was unable to do it afford the injection (₹50,000 per dose),the OP-2 made the arrangement with the drug company whereby one free injection was made available.

3.2.1 He was not involved in the wrong administration of inj. Vincristine and in fact it was given by Dr. Sanjay Patwari between 10 to 11am, without consulting him. In fact, he asked the OP-3 to be available on 18.06.2008, so that LP could be done and intrathecal therapy could be started under his supervision. He further submitted that as per his daily routine, he attended the patients during rounds. He further submitted that he was not informed that the patient had not got himself admitted in the hospital after buying the requisite medicines. As per usual medical practice, the OP-2 had engaged the medical practice, initially Subhashree Majumdar and later on Dr. Sanjay Patwari for limited purpose of lumbar puncture. On all earlier occasions, such arrangements were made, the LP was done by Anesthetist in the presence of OP-2. Immediately knowing after the mistake, remedial steps were taken and the patient was shifted to TMH, Mumbai. He made his sincere endeavor to overcome the effects of inadvertently injected injection intrathecally.

3.2.2 Initially, the complainants have not made Dr. Patwari as a necessary party. Vide Order dated 09.04.2014, he was made as OP-3. The OP-2 further submitted that Dr. Patwari not only acted negligently, but also committed grave error, not being cautious in dealing with drug Vincristine. The drug comes with a box warning '**FOR INTRAVENOUS USE ONLY**'. Therefore, the Complainants can maintain the complaint against Dr. Patwari. He further submitted that as per the settled law, the hospital is vicariously liable for the negligent act of nursing staff and allowing Dr. Patwari to administer inj. Vincristine, when there is no such instruction received from OP-2. The sister Kokila Biswas and Sulekha Mandal deposed

before the Penal Committee of WBMC that Dr. Sanjay Patwari was fully responsible for the wrong administration as he prepared the injection and pushed the injection.

3.3 Reply of Dr. Sanjay Patwari (OP-3)

The OP-3 submitted that he is a qualified Anesthetist, the OP-2 requested him over telephone to administer intrathecal Chemotherapy session to the patient. As a stopgap arrangement as it involved lumbar puncture (LP). On three occasions i.e. 26.05.2008, 30.05.2008 and 02.06.2008, he administered intrathecal chemotherapy injection to the patient at bed side in OP-1 hospital. The patient paid Rs. 1,500/- each time directly to him. The OP-2 was not present on every occasion for the reasons best known to him. On 17.06.2008 the patient was examined by OP-2 and advised for B2 Cycle of chemotherapy. The OP-2 requested him to administer chemotherapy on 18.06.2008 at OP-1 hospital. Accordingly, on 18.06.2008, he reached the OP-1 hospital, visited the nursing station at around 10.30am and the nursing In-charge informed that the prescribed injection was not available with the patient at that time. He thereafter, visited the patient wherein the patient informed the OP-3 and the nursing staff that he procured those injections and these are with his possessions.

3.3.1 The OP-3 further submitted that on all previous occasions (cycles), the injections were transported from Pharmacy by the designated personnel of OP-1. The intrathecal drugs were not packed separately to the Ward in the designated container. The hospital has not followed the international recommendation and there were procedural lapses on the part of OPs-1 and 2, who were expected to be aware of such errors. The OPs-1 and 2 have not implemented specific guidelines in Chemotherapy instruction sheet as provided by TMH and they kept OP-3 in dark about such instructions. The OP-1 is responsible to provide necessary infrastructure and trained support staff to treat cancer patient.

4. All the parties completed the pleadings, filed the report of WBMC and Heath Dept. They have filed various medical literatures on NHL.The Complainant filed the web printouts of OP-1, claiming committed compassionate care along with personalized treatment for various types of chemotherapy, targeted, hormonal and immunotherapy services Medical Oncology.

5.0 Arguments:

5.1. On behalf of Complainant:

The learned Sr. Counsel for complainant reiterated the facts. He submitted that it is the clear case of **Res Ipsa Loquitor**. He submitted that the OPs are shifting burden on one and other. The all the OPs are liable for negligence causing death of Patient. The OP-1 is corporate entity, and can't take a shelter as it was a day care center. Learned Sr. counsel brought my attention to the details of hospital establishment, the brochure and the agreement executed between the working doctors and management. He relied upon the medical literatures. He further argued that the deceased patient was 37 years of age, an engineer therefore the compensation prayed was appropriate, just reasonable and it was not inflated or imaginary.

5.2. **Arguments on behalf of OPs.**

The learned Sr. Counsel for OPs during arguments reiterated their respective evidence. The learned Sr. Counsel for OP-1 submitted that the contemporaneous documents to be relied in this case. The treating doctors were responsible for the entire medical negligence and the hospital has no role in the treatment, except it provided the infrastructure and nursing assistance as a day care. Therefore, OP-1 has limited role and it was not liable vicariously. The OP-3 collected his charges directly. The learned Counsel for OP-2 and 3 reiterated their evidence.

6. Observations:

6.1 The undisputed sequence of events leading to the death of Kuntal Chowdhury would show that at TMH Mumbai he was diagnosed as **NHL- DLBCL** and chemotherapy by **MCP 842** protocol was started under supervision of the medical oncologist Dr.Rajesh Jindel (OP-2) at Woodlands Medical Centre Ltd. (OP-1) in Kolkota. First 3 chemo cycles were uneventful and assistance of anesthetists for intrathecal injection of **Cytarabine**. Overall the patient was admitted 14 times including the day of incident, The LP was performed for 7 occasions previously by Dr.Subhashree Majumdar and remaining were done by Dr.

Patwari (OP-3). During 4rd chemo cycle, on 18.06.2008 admittedly Dr.Sanjay Patwari (OP-3) instead of Cytarabine, wrongly administrated Vincristine intrathecally. After knowing the mistake OP-2 and 3 tried to minimize the side effects of Vincristine drawn 7-8 ml of CSF and gave steroid intrathecally but finally the patient shifted to TMH on 20.6.2008 for further management. However, due to bad prognosis, brought back to Kolkota but expired on 09.07.2008 in Belle Vue hospital.

6.1. It is evident from the letter dated 26.06.2008 of Dr. Rajesh Jindel (annex.C/pg119) admitted about the incident and involvement of OP-3. The part of letter is reproduced as below:

> Mr. Kuntal Choudhary is my patient who was referred to me from Tata for chemotherapy. He is suffering from diffuse large B cell lymphoma and was advised MCP 842 protocol for treatment He had already received three cycles on this protocol and was admitted for the fourth cycle to Woodlands on 18/6/08. On day one of this cycle intrathecal Ara-C 70 mg is also given. In the previous cycle also I had asked Dr. Sanjay Patawari to give him the intrathecal injections. This time also I requested him to give intrathecal Ara-C. The patient got admitted on 18/06/08 about 9 am I was informed. Dr. Sanjay Patawari came and gave him an intrathecal injection which he soon realized that he had given inj. Vincristine instead of Ara-C. He rang me up telling me of the incident. I rushed to the spot. Before I reached the bed of the patient, the patient also rang me that a wrong injection had been given to him. On my way to the patient I contacted ray friends in Tata over the remedial measures that may be taken now. We decided to drain out the amount of CSF which had been injected from the same spot and pushed 100 mg of inj. Hydrocortisone in an equal volume. Subsequently I discussed this at length with my teachers and colleagues in Tata and made arrangements for the patient to be shifted there for treatment. The patient was admitted to Tata on 20/06/08 late in the evening. This incident was reported verbally to the authorities in Woodlands on 18/06/08 and they were regularly informed of all the developments.

6.2. The hospital investigated the matter and prepared the **Sentinel Event Recod and Report**, (Anx. D/pg 120) which narrated the sequence of events on the date of incident (4th Chemo) .It was noted that the OP-3 had given wrong injection and he did not cross-check the medication details before administration. Dr. Patwari informed Dr. Jindel about the error and arrived to visit the patient, discussed those events with their seniors in TMH over the phone. Both have repeated lumbar puncture and drained 8ml of CSF and gave 100 mg (diluted) in 5ml of distilled water, intrathecally. The matter was discussed with the patient and his father and the patient was discharged on 20.06.2008.

6.3 The WBMC vide Order dated 07.05.2017 found OP-2 guilty of infamous conduct in professional respect and removed his name from Register of WBMC for period of one year. The OP-2 preferred an Appeal before the Principal Secretary, Department of H & FW, West Bengal who absolved OP-2 from all charges and reversed the decision of WBMC. It was held that WBMC has held OP-2 guilty on the basis of presumptions alone without any material of wrongful administration. The Appellate authority held the OP-3 guilty of wrongful administration of drug. However, I don't see any bearing on the instant case filed under the Consumer Protection Act, 1986.

6.4 It is evident that, for the instant patient taking MCP 842 Chemo, the TMH has issued the specific Chemotherapy instruction sheet. At SL No.1 of instruction is that,

"1. All chemotherapy should be administered only by qualified/trained Medical Oncologist"

7.0 Discussion:

I have carefully perused the evidence affidavits filed by the OP-1 to 3. Perused the entire medical record. Also gone through several medical literatures on NHL treatment, the Chemo protocol and errors etc.

7.1 The contention of OP-1 that the patient was referred to OP-2 by TMH and he selected OP-3 anesthetist for LP. On 17.06.2008, patient visited OP2 in his private clinic; he prescribed the drugs and asked to get admitted to OP1 on 18.06.2008 for 4th chemo cycle. The OP-2 also called at same time to OP3 and asked him to come to hospital on 18.06.2008 for LP and administration of intrathecal injection. However, in the absence of OP2, Vincristine was administered intrathecally by OP3 on 18.06.2008. The OP3, in his contemporaneous noted, the Case History, and in the Sentinel Report has not mentioned about

the role of administration of a wrong drug by the nurse. It was clear admission of OP-3 committed a mistake. The hospital wants to establish OP2 and OP3 were acting independently for chemotherapy.

7.2 Admittedly, the medical negligence in administration of Vincristine wrongly was proved. Now the question to be answered is who is liable for the medical negligence.

7.3 In my view, now there is no need to dissect more to prove the negligence of the OPs. The "things speak on its own" the principle of **"Res Ipsa Loquitor"** squarely applicable to the case on hand. There is no need go to great lengths to prove the negligence. In the instant case, upon hearing the arguments form OPs, it seems the OPs are shirking way from each of their responsibility, but they are trying to shift the blame on one and another.

7.4 **Was it an inadvertent mistake or an accident ?**

On careful perusal of entire sequence of events and the contemporaneous medical record, in my view, it was neither an inadvertent error nor an accident in the instant case. The cotemporaneous medical record and evidence of nurse clearly prove that OP-3 did not check the medication details before administration. OP-3 prepared the Vincristine, performed LP and injected the drug intrathecally, under the impression that it was injection Arabinocide - Cytarabine. After injecting, he left the Hospital, but he was telephonically informed after 15 minutes having given the wrong injection. OP-2 was called to the hospital and after discussion with OP-2 repeat LP was done and drained 8 ml of CSF and also given injection Hydrocortisone through LP. On 20.6.2008 the patient was airlifted to TMH, Mumbai for further management.

7.5 In my view the OP-1 (Woodlands) was trying to establish its case that there was no negligence from the hospital. The OP-1 hospital held an enquiry on 02.07.2008 and the Sentinel event report was prepared narrating the events of 18.06.2008. Same were confirmed by OP 2 & 3 and also by the concerned nurse. Even in that report OP 3 does not suggest that the nurse has handed over a wrong vial to him. The Contemporaneous medical record OP-3 in his note he does not mention about that the nurse handed over wrong inj vial to him. The record does not show that OP-3 immediately informed either the nurse or hospital administration about the wrong administration of Vincristine injection. The contention of OP-1 was that, OP-2 has selected OP-1 as a day care centre for Chemotherapy and chose OP-3 to carry out LP and intrathecal injection. Thus it was not a case that the Complainant came to OP-1 Hospital and was put under the treatment of OP-2 for chemotherapy. On 18.06.2008 the OP-3 administered Vincristine injection intrathecally in the absence of OP-2. Nothing was mentioned in contemporaneous notes about the nurse of OP-1 had any role to play in administration of a wrong drug.

7.6 On perusal of medical record, it is important to note that in the contemporaneous reply the OP-2 nowhere said that OP-3 was engaged by him for the limited purpose of lumbar puncture and that too in the presence of OP-2 only. Thus it proves that OP-2 had engaged OP-3 to administer injections intrathecally which OP-3 acted upon on all occasions. It appears that after thought OP- 2 was trying to set up his case before this commission.

7.7 In the **Sentinel report** was duly signed by OP-3 proves that he did not cross check the drug before administration. OP -3 nowhere stated that inadvertent administration of inj. Vincristine instead of inj. Cytarabine intrathecally, which was omission on the part of the nurse.

8.0 **Literature on Vincristine:**

I have gone through the standard text books on Oncology namely Manual of Clinical Oncology by Casciato (Author) and Principal and Practice of Oncology by Vincent T. DeVita, few literatures on Vincristine and errors.

8.1 **Intrathecal chemotherapy: Potential for Medication Error:**

Cancer Nursing[1]

> "The outcome has proven fatal even when the error has been recognized during the actual administration process and only a fraction of the drug was given intrathecally. Vincristine inhibits tumor growth principally via interference with mitotic spindle function by binding to

tubulin to block its polymerization into microtubules, thereby inhibiting mitosis in metaphase. Neurotoxicity results from a subsequent blockage of axonal transport and, thus, in axonal degeneration. Binding to tubulin has been shown to occur in less than 5 minutes, so any intervention, however rapid, has a limited chance of success."

8.2 **Eliminating vincristine administration events[2]**

"If given intrathecally vincristine is nearly always fatal with an irreversible painful ascending paralysis When vinca alkaloids are injected intrathecally destruction of the central nervous system occurs radiating from the injection site."

8.3 **Death and Neurological Devastation From Intrathecal Vinca Alkaloids[3]**

"The first reported case of fatal ascending myeloencephalopathy caused by the intrathecal administration of IV VINCRISTINE occurred in the U.S. in 1968. 8 between 1968 and 2007, 17 cases in the U.S. plus 49 cases worldwide were reported in the literature. 9 nearly all of these events resulted in death . The few patients who survived experienced devastating neurological effects, including persistent vegetative state and quadriplegia.

After all patients rarely survive after IV VINCRISTINE or another vinca alkaloid has been administered intrathecally, and the subsequent decline until death is slow and painful, both emotionally and physically for the patient and their loved ones."

9.0 **Law laid down by Hon'ble Apex Court onmedical negligence:**

9.1 Negligence as defined by the court in **Jacob Mathew v. State of Punjab[4]** that the breach of duty which one party owes to another. The duty can be in the form of an act or omission and it is referred to as the duty of care and due to the negligence of which it causes an injury to the person. In the case of medical negligence, it is the failure of medical practitioners to exercise certain acts or omission while discharging their duties with respect to their patients could not be saved.

9.2 In the case of **Spring Meadows Hospital & anr. Vs. Harjol Ahluwalia & anr.[5],** Hon'ble Supreme Court in wherein it has been observed:-

"9. ….. Very often in a claim for compensation arising out of medical negligence a plea is taken that it is a case of bona fide mistake which under certain circumstances may be excusable, but a mistake which would tantamount to negligence cannot be pardoned. ……..

10. Gross medical mistake will always result in a finding of negligence. Use of wrong drug or wrong gas during the course of anaesthetic will frequently lead to the imposition of liability and in some situations even the principle of res ipsa loquitur can be applied. Even delegation of responsibility to another may amount to negligence in certain circumstances. A consultant could be negligent where he delegates the responsibility to his junior with the knowledge that the junior was incapable of performing of his duties properly."

As discussed (*supra*), this is a case of **Res Ipsa Loquitor**.

9.3 **Vicarious Liability**:

In the instant case, the OP-1 hospital is vicariously liable for the act of OP-2 and 3, who treated the patient negligently. This view, dovetails from the case of **Maharaja Agrasen Hospital and Ors. Vs. Master Rishabh Sharma and Ors[6]** wherein Hon'ble Supreme Court observed:

"11.4.17. It is well established that a hospital is vicariously liable for the acts of negligence committed by the doctors engaged or empanelled to provide medical care. It is common experience that when a patient goes to a hospital, he/she goes there on account of the reputation of the hospital, and with the hope that due and proper care will be taken by the hospital authorities. If the hospital

> fails to discharge their duties through their doctors, being employed on job basis or employed on contract basis, it is the hospital which has to justify the acts of commission or omission on behalf of their doctors."

9.3.1 Thus, as per the law laid down (*supra*) in my view the OP-2 and 3 are responsible for not adhering to MCP- 842 Protocol, thus they can't escape from the liability. The role of nurse was limited. As per chemotherapy protocol the chemo dose was to be prepared and drawn by the Oncologist. There was no allegation of any infrastructure or other lapse on the part of OP1 hospital where the patient has been successfully administered treatment on previous occasions. It is also an admitted fact that OP2 was in-charge of the treatment which was to be done as per Protocol MCP-842 and if not followed, both doctors are liable for the consequences. However, even though the OP1 had no role to play in the entire treatment aspect, is vicariously liable here.

9.3.2 The management of a hospital not only involves providing services of doctor or other staff, but also to ensure that proper treatment is provided to the patient. In the present case, nothing is on record that the nurse was not a trained or not for Chemotherapy. It is not evident the hospital has system checks or Standard Operating Procedures (SOP) for Chemotherapy and to prevent such incidents. The Hon'ble Supreme Court in **Smt. Savita Garg Vs. The Director, National heart Institute, IV (2004) CPJ 40 (SC)** has held the following:-

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

9.3.3 The hospital (OP-1) cannot escape its vicarious liability for the medical negligence that has been meted out in the present case. Thus, I am of the opinion that the hospital is required to compensate for the medical negligence that has happened in the hospital.

9.3.4 The contemporary wisdom is that doctors should focus on patient care and the managers with administrative background shall focus on the day-to-day business of a hospital. The hospital as an organization in most cases today is run not by the doctors but by the administrators. These administrators dominate and dictate medical practices in majority of these hospitals. The conflict between quality care and financial success has heralded more complexity in the management of the patients. Hospital administrators are largely concerned with generating revenue by imposing deadlines/targets and pressurizing doctors. Thus in such situations, if a case of medical negligence arises, the principle of vicarious liability shall apply.

9.4 **Duty of Care :**

9.4.1 The Supreme Court on the concept of **Duty of Care** clearly explained in the case of **Dr.Laxman Balakrishna Joshi v. Dr. Trimbak Babu Godbole** [7] as below:

> 21. A person who holds himself out ready to give medical advice and treatment impliedly undertakes that he is possessed of skill and knowledge for that purpose,
>
> 1. he owes a duty of care in deciding whether to undertake the case,
>
> 2. he owes a duty of care in deciding what treatment to give and,
>
> 3. he owes a duty of care in the administration of that treatment.
>
> A breach of any of these duties gives a right of action for negligence to the patient.

22. This means that when a medical professional, who possesses a certain degree of skill and knowledge, decides to treat a patient, he is duty bound to treat him with a reasonable degree of skill, care, and knowledge. Failure to act in accordance with the medical standards in vogue and failure to exercise due care and diligence are generally deemed to constitute medical negligence.

9.4.2 Similarly in P**.B. Desai vs State of Maharashtra & Anr**[8] the 'Duty of Care' towards the patient clearly explained as below:

"Once, it is found that there is 'duty to treat' there would be a corresponding 'duty to take care' upon the doctor qua/his patient. In certain context, the duty acquires ethical character and in certain other situations, a legal character. Whenever the principle of 'duty to take care' is founded on a contractual relationship, it acquires a legal character. Contextually speaking, legal 'duty to treat' may arise in a contractual relationship or governmental hospital or hospital located in a public sector undertaking. Ethical 'duty to treat' on the part of doctors is clearly covered by Code of Medical Ethics, 1972. Clause 10 of this Code deals with 'Obligation to the Sick' and Clause 13 cast obligation on the part of the doctors with the captioned "Patient must not be neglected".

9.4.3 Having regard to the observation on ' Duty of Care' I find the hospital (OP-1) and two treating doctors failed in their duty of care. The doctors OP-2 and 3 were equally responsible for failure of duty of care. The OP-2 as a Medical Oncologist did not follow the Instructions prescribed by the TMH for Chemotherapy. He was not present during chemotherapy, which was against the mandatory protocol. And secondly, the OP-3 blindly administered Vincristine intrathecally; it was utter failure, carelessness and dereliction in the duty of care.

9.4.4 There are glaring deficiencies visible from the hospital (OP-1). There are no safety guidelines for treatment of cancer patients and about Chemotherapy. No documentation, no Standard SOPs for the Care of the patient receiving Cytotoxic or Biologic Agents. The hospital has not maintained records properly. For Intrathecal Chemotherapy only staff who have been appropriately trained and accredited, and whose names appear in the appropriate register are permitted to have involvement in the prescribing, dispensing, issue, checking and/or administration of intrathecal chemotherapy appropriate to their role and training. There are several procedural lapses on the part of OP-1. The Intrathecal drugs were not packaged separately for delivery to the ward in designated containers and clearly labeled on the outer container "**For intrathecal use**" as is required as per International recommendations. The hospital and the treating doctors are expected to be aware of unexpected errors. The specific guidelines provided in the Chemotherapy Instruction Sheet provided by Tata Memorial, Hospital, Mumbai were not followed strictly, just acted casually. Thus, the hospital OP-1 is held liable for those deficiencies in services and patient care. The hospital made fruitless and absurd attempt in its defense that it was a day care procedure and the responsibility lies with the concern doctors. It should be borne in mind that the hospital had displayed its infrastructure, facilities, name of specialist, departments and other facilities etc. through the brochures, website and advertisements. Therefore, the hospital apart from vicarious liability, is also liable for deficiency, failure of duty of care and unfair trade practices.

10. Compensation:

Adverting to the award of Compensation, the basis of computing compensation under common law lies in the principle of '**restitutio in integrum'**[9] 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. This implies that the victim needs to be compensated for financial loss caused by the doctor's/hospital's negligence, future medical expenses, and any pain and suffering endured by the victim. By no stretch of imagination, the court should award a paltry sum for gross negligence, and vice versa exemplary compensation need not be awarded in case of slight or normal negligence.

10.1 As the Hon'ble Supreme Court noted in **Sarla Verma vs. Delhi Transport Corporation case**[10] that

> "The lack of uniformity and consistency in awarding compensation has been a matter of grave concern… If different tribunals calculate compensation differently on the same facts, the claimant, the litigant, the common man will be confused, perplexed, and bewildered. If there is significant divergence among tribunals in determining the quantum of compensation on similar facts, it will lead to dissatisfaction and distrust in the system."

10.2 In the catena of judgments of Hon'ble Supreme Court, laid down different methods to determine '**just and adequate compensation'**. It was held that there is no restriction that courts can award compensation only up to what is demanded by the complainant. We would like to rely upon few judgment of Hon'ble Supreme Court viz **Sarla Verma & Ors. vs Delhi Transport Corp. & Anr**[11]**, Nizam's Institute of Medical Sciences Vs Prasanth S. Dhananka & Ors.**[12]**, Dr. Balaram Prasad vs. Dr. Kunal Saha & Ors.**[13]

10.3 It is true that compensation cannot be calculated in a perfect mathematical sense, cannot be precise and accurate, but has to be within certain broad guidelines, and within certain broad parameters. It was observed by the Hon'ble Supreme Court in **Sarla Verma's** case –

> "While it may not be possible to have mathematical precision or identical awards, in assessing compensation, same or similar facts should lead to awards in the same range. When the factors/inputs are the same, and the formula/legal principles are the same, consistency and uniformity, and not divergence and freakiness, should be the result of adjudication to arrive at just compensation."

10.4 In the **Nizam Institute case ,** the Hon'ble Supreme Court did not apply the multiplier method. In 1990, twenty-year old Prasant S. Dhananka, a student of engineering, was operated upon at the Nizam Institute of Medical Sciences, Hyderabad. Due to medical negligence of the hospital, Prasant was completely paralysed. The court did not apply the multiplier method and awarded a compensation of Rs. 1 crore plus interest.

10.5 The Hon'ble Supreme Court**, in Kunal Saha case,** very clearly mentioned that there were problems with using a strait-jacket formula for determining the quantum of compensation. It noted the problem in the following words:

> "… this Court is skeptical about using a strait jacket multiplier method for determining the quantum of compensation in medical negligence claims. On the contrary, this Court mentions various instances where the Court chose to deviate from the standard multiplier method to avoid over- compensation and also relied upon the quantum of multiplicand to choose the appropriate multiplier … this Court requires to determine just, fair and reasonable compensation on the basis of the income that was being earned by the deceased at the time of her death and other related claims on account of death of the wife of the claimant…"

11. **Conclusion:**

In many cases, both doctors and the hospitals have been held responsible for paying compensation. In majority of the situations, an individual doctor(s) may not be in a position to pay the huge compensation (in crores of rupees) until the hospitals are also made party in the litigation. In a specific instance, **Balram Prasad vs. Kunal Saha**[14] the Hon'ble Supreme Court reduced the liability of individual doctors considerably, that was imposed by this commission.

11.1 Sequel to the above discussion, it was the case of ***Res Ipsa Loquitor*** and further I conclusively determine 'deficiency' as well as 'unfair trade practice' on the part of the hospital - OP-1, a multispecialty

tertiary care hospital of which the highest standard of essential infrastructure and patient's care, protocols and management was expected but which it failed to provide. The medical negligence is conclusively attributable to both the doctors (OP-2 & 3), however the negligence of Anaesthetist (OP-3) is writ large. A young engineer lost his precious life at 37 years, left behind wife and a minor child. This necessitates just and adequate compensation. There is no straight jacket formula for award of compensation, it is difficult to quantify the value of human life in monetary terms, but considering the facts of the case and respectfully following the principle which has been laid down by the Hon'ble Apex Court (*supra*), in my view, the interests of justice would be met, if the amount of compensation of Rs. 60 lakh appears to be just and adequate in the present case.

11.2 Accordingly, the total amount of Rs.60 lakh as compensation awarded to the Complainants. Out of it, the Woodlands Medical Centre Ltd (OP-1) shall pay Rs. 30 lakh, the Medical Oncologist Dr.Rajesh Jindel (OP-2) shall pay Rs.10 lakh and the Anesthetist Dr.Sanjay Patwari (OP-3) shall pay Rs.20 lakh.

The entire amount shall be paid within six weeks from today, failing which the concerned opposite parties shall be liable to pay 8% p.a. interest till its realization. In addition, the hospital shall pay Rs. 2 lac towards litigation charges.

The Complaint is partly allowed.

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[1] Cancer Nurs. 2014 Jul-Aug;37(4)

[2] Quick Safety Issue 37, October 2017

[3] P & T August 2016 Vol.41 No.8

[4] (2005)SSC(Crl)1369

[5] (1998) 4 SCC 39

[6] 2019 SCC OnLine SC 1658,

[7] (2013)15 SCC 481

[8] [2013] 11 S.C.R. 863

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

[10] (2009) 6 SCC 121

[11] 2009 (6) SCC 121

[12] 2009 (6) SCC 1

[13] (2014) 1 SCC 384

[14] (2014) 1 SCC 384

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DR. S.M. KANTIKAR
PRESIDING MEMBER