IN THE STATE COMMISSION: DELHI

(Constituted under Section 9 of the Consumer Protection Act, 1986)

Date of Decision: 31.05.2017

First Appeal No. 1093/2013

(Arising out of the order dated 25.09.2013 passed in Complaint Case No. 501/2009 by the District Consumer Disputes Redressal Forum (Central) Kashmere Gate, Delhi-110006)

In the matter of:

Shree Jeewan Hospital

Through its Chairman

Dr. Vijay Sabharwal

At 67/1, New Rotak Road

New Delhi-110005 **.....Appellant**

Versus

Smt. Rubina

W/o Sh. Mohd.Tamkeen

R/o T-424, Fourth Floor

AhataKidara, GaliPahadWali

Idgah Road, Sadar Bazaar

Delhi-110006 **.....Respondent**

CORAM

N P KAUSHIK - MEMBER (JUDICIAL)

SALMA NOOR - MEMBER

1. Whether reporters of local newspaper be allowed to see the judgment? Yes

2. To be referred to the reporter or not? Yes

N P KAUSHIK – MEMBER (JUDICIAL)

JUDGMENT

1. Shree Jeewan Hospital 67/1 New Rohtak Road New Delhi, the appellant has challenged the orders dated 14.08.2013/25.09.2013 passed by the Ld. District Forum (Central) Kashmere Gate Delhi. Vide impugned orders Ld. District Forum directed the appellant to pay to the respondent/complainant Smt. Rubina an amount of Rs. 3,00,000/- towards compensation for causing harassment, mental agony and pain. An amount of Rs. 10,000/- was awarded as costs of litigation.
2. In brief, Smt. Rubina was admitted in appellant's hospital on 15.09.2009 for delivery and on the same day at about 11:15 pm, she gave birth to a female child. However while conducting the delivery the doctorsleft a needle in her uterus. There was profuse bleeding thereafter and the respondent suffered pain and trauma. After the delivery, she was shifted to the room/ward but the bleeding did not stop. She made a request to the doctors for a checkup but they did not pay any heed to her request. On the next date i.e. on 16.09.2009 an x-ray was conducted. It was revealed that a needle had been left in her uterus. Doctor Akash conducted the surgery in the night of 16.09.2009. Needle was removed.
3. Patient Smt. Rubina underwent an ultrasound of the whole of the abdomen on 24.11.2009 at BanwariLal Charitable Imaging Centre Delhi. It was revealed that her uterus had actually retroflexed. It was opined that she would not be able to conceive a child again. Respondent/Complainant Smt. Rubinaclaimed a compensation to the tune of Rs. 10,00,000/-.
4. In its defence, the appellant/OP admitted the admission of the respondent/complainant and the birth of a female child. The appellant however denied negligence. Appellant submitted that due to the presence of blood and oedema (swelling) of the tissue, the needle slipped into the superficiallayers of the muscles. The doctor tried to feel the needle but it could not be located. Itwas decided to explore the area under general anesthesia later in the morning after the swelling would reduce and the bleeding would be under control. The appellant submitted that a bleeding after delivery is a normal phenomena. Respondent/complainant and her attendants were explained what had happened. Appellant hospital denied if the uterus of the complainant was ruptured. Appellant stated that the complainant had visited the hospital again on 13.10.2009 with a problem of Urinary Tract Infection (UTI).
5. Ld. District Forum referred to the report of **Delhi Medical Council who had opined that the breaking of needle does happen occasionallyduring stitching of wounds.** Ld. District Forum observed that the allegation that the uterus was retroflexed due to the said

episode had got no valid evidence. Ld. District Forum however held the appellant hospital guilty of medical negligence which resulted in pain, harassment and mental agony to the respondent.

6. Present appeal has been filed on the grounds inter-alia that the Ld. District Forum failed to take into consideration that as per opinion of the Delhi Medical Council it was not a case of medical negligence. Relying upon the case of ***Martin F. D'Souza*** v. ***Mohd. Ishfaq ,*** 2009 III AD (SC) 345 appellant submitted that the Ld. District Forum should have referred the matter to the competent doctor or committee of doctors to find out if prima facie there was a case of medical negligence. Only thereafter notice should have been issued to the appellant. In the absence of any medical opinion from the side of the respondent, damages could not have been awarded. Appellant further submitted that revisit of the respondent to the hospital on 29.09.2009 and 13.10.2009 shows that she had no grievance. Next submission of the appellant/OP is that the circumstances that the blood pressure and the pulse rate of the respondent/complainant were normal shows that the needle did not cause any mental agony and excessive bleeding.
7. Before proceeding further, it may be mentioned here that the respondent/complainant approached the police after the abovesaid incident. Police did not take any action. Complainantfiled a complaint under section 156(3) Criminal Procedure Code wherein Ld. CMM directed the registration of an FIR (orders dated 30.09.2010). Accordingly an FIR bearing No. 219/2010 Police Station DBGupta Road New Delhi under Sections 337/420/468/471/201/120 (B) IPC was registered.
8. Appellant/OP filed a CRL.M.C. 3369/2010 with CRL.M.A. No. 16680-81/2010 in the Hon'ble High Court of Delhi. It was submitted that a complaint before the Consumer Court was preferred on the same allegation. Hon'ble High Court vide orders dated 27.10.2010 observed that the proceedings before the Consumer Court had no effect on the criminal act of negligence. An FIR could be registered for the criminal act of negligence.
9. Another CRL.M.C.bearing no. 2140/15 was filed by the appellant seeking quashing of the FIR. Vide orders dated 29.10.2015 the Hon'ble High Court dismissed the petition with the costs of Rs. 25000/- each on the petitioners therein. Paragraphs 11,12,13,14 and 15 of the orders are relevant. The same are reproduced below:

"11. It is not in dispute that when allegations of negligence are leveled against a Doctor, an opinion is required to be taken whether there was negligence on his part or not. In this case also, opinion was taken, which is a part of chargesheet and on considering the same, Ld. Trial Court has taken the cognizance. The fact remains that during course of investigation, original treatment sheet of complainant was taken into police possession, which reveals that it has cutting on 'Page 3' on the original notes and name of Dr. Anita and nurse Chunchun has been added, which were not there in the earlier notes provided by the hospital authorities. ***Moreover, hospital authorities also failed to produce the X-ray plate of the complainant.*** *Accordingly, Sections 420/468/471/120B IPC were also added during investigation and chargesheet under sections 337/420/468/471/120B/201 IPC was filed.*

12. In the FSL report at Point-III, the Assistant Director Forensic Science Laboratory, Govt. of NCT of Delhi gave a report that the person who wrote the red enclosed signatures, stamped and marked S-70 to S-93 also wrote the red enclosed signatures similarly stamped and marked Q-6/1 to Q6/2. This fact is also evident from the reply of respondent no. 2, wherein she stated that a comparative signatures/writing marked as S-70 to S-93 are of Dr. AkashSabharwal (petitioner no.

2). Hence FSL authorities have clearly stated that Q6/1 and Q6/2 are of petitioner no. 2. ***Thus, it clearly shows that Dr. AkashSabharwal has committed forgery.***

13. It is not in dispute that the hospital is registered in the name of Dr. SumanSabharwal, petitioner no. 1. ***Dr. Anita of the aforesaid Hospital in reply to questionnaire submitted that Dr. Raheen had performed the delivery of the complainant Rubina. It is pertinent to mention here that Ms. Raheen is registered with Delhi Pharmacy Council only as a Pharmacist, whereas she has been alleged to be a Doctor by the hospital authority.Thus, the petitioner no. 1 had employed a Pharmacist to carry out the surgery*** *. This shows an utter carelessness on the part of the petitioner no. 1, in whose name the hospital is registered.* ***Thus petitioner no. 1 conspired and manipulated with the records.*** *Therefore, the benefits of the judgments relied upon by the petitioners cannot be given to the petitioners herein, keeping in view the facts and circumstances of the present case.*

14. The complainant was admitted for delivery in the petitioner's hospital on 15.09.2009 and a female child was born at 11.15 PM. The doctors of the petitioner's hospital were most negligent in attending respondent no. 2 and left a needle in her uterus and after the surgery, they stitched the vagina and shifted respondent no. 2 to a ward. However, in the ward she suffered gigantic mental trauma and further lots of blood came out of her vagina/uterus and it was the restless night in the lifetime of respondent no. 2. This fact is admitted by the doctors in the discharge slip that a needle was left in the uterus of the complainant during the surgery and after diagnosis X-ray in the evening same was removed.

15. It is pertinent to note that in reply to the complaint filed under section 12 of the Consumer Protection Act, petitioners admitted that due the presence of blood and oedema (swelling) of the tissues, the needle slipped into superficial layers of the muscles. However, stated that the doctors tried to feel the needle, but it could not be located and the doctor decided to explore the area under general anaesthesia later in the morning after the swelling would reduce and bleeding would be under control. But the fact remains that the Consumer Forum vide order dated 14.08.2013 had directed the petitioner's hospital to pay a sum of Rs. 3,00,000/- as compensation to respondent no. 2 for causing harassment, pain and mental agony and further directed to pay a sum of Rs. 10,000/- as litigation expenses. ***However, till date, the petitioners have not paid even a single penny to respondent no. 2."***

1. Present appeal has been filed on the grounds inter-alia that expert's opinion as given by the Delhi Medical Council shows that it was not a case of medical negligence. Appellant submits that the Ld. District Forum ought have not awarded damages in favour of the respondent. Relying upon the case of ***Martin F. D'souza*** (supra) appellant submits that the consumer forum should have obtained experts' opinion before issuing notice. Next submission of the appellant is that the Ld. District Forum failed to take into consideration that after her discharge from the hospital on 16.09.2009, respondent re-visited the same on 23.09.2009 as well as on 13.10.2009. This fact shows that she had no grievance against the appellant. Respondent had not gone to any other hospital for treatment after her discharge.

Appellant further submitted that the Ld. District Forum erred in holding that the needle caused mental agony or excessive bleeding. Award of compensation of Rs. 3,00,000/- was highly exhorbitant.

2. In reply to the appeal respondent/complainant Smt. Rubina submitted that a needle was left in her uterus after she delivered the baby. Despite that her vagina was stitched. She was shifted to the ward where she suffered gigantic mental pain. A lot of blood came out of her vagina and it was the most restless night in her life. Respondent/complainant submitted that it was surprising as to why the doctor stitched the opening of the vagina when the needle had been left inside. The doctors waited for another full day for locating the needle. X-ray was done only at 04:30 pm in the evening on the next date. Surgeryto take out the needle was done in the night. X-ray or ultrasound was not done immediately after it was discovered at the time of delivery that the needle had been left in the body. Neither the respondent nor her relatives were told that a needle had been left. The bed sheets and packs were changed several times due to profuse bleeding. No doctor paid any heed to the excessive bleeding and unbearable pain.
3. While referring to the investigation of the case in FIR No. 219/10 Police Station DeshBandhu Gupta Road Delhi(on the directions of the court), the respondent submitted that the Hon'ble High Court declined quashing of the FIR vide its orders dated 27.10.2010 and again vide orders dated 29.10.2012.
4. Respondent/complainant referred to the investigation done by the police who found that there was a cutting at page 3 of the original notes which did not exist in the copies of the same provided to the police earlier. Names of Dr. Anita and Nurse Chonchon were added. Respondent referred to the statement of Dr. Anita made to the police and stated that it was Dr. Raheen who had performed her (Rubina's) delivery. Dr. Raheen was registered with Delhi Pharmacy Council only and was not a qualified doctor. She was not competent to perform delivery and apply stitches on episiotomy wound. In her reply to the appeal respondent/complainant raised the following questions:

i. ***Whether the x-ray of the patient should have been done immediately or after one day;***
ii. ***Whether the hospital was right in stitching of the vagina/uterus under the circumstances when a needle had been left out;***
iii. ***Whether the hospital was right in sending the patient to the room instead to the ICU;***
iv. ***Whether Doctor Raheen who was BUMS and a registered Pharmacist was competent to perform the delivery;***
v. ***Whether the patient should have been operated immediately or after one day;***
vi. ***Whether the Senior Doctor under the circumstances should have performed the surgery immediately or should have waited for one day for the needle to cause damage to the body of the complaint;***

1. Respondent submitted that in the discharge slip the appellant admitted having left theneedle in the body during stitching. Respondent submitted that her visits to the hospital on 23.09.2009 and 13.10.2009 related to the urine infection which was the result of the needle lying into her uterus for full one day. She further submitted that she got ultrasound of her whole abdomen done on 24.11.2009. It was revealed that her uterus had actually been retroflexed. Respondent further submitted that the blood pressure and pulse rate being normal were not indicative that everything was normal.

2. I have heard at length the arguments addressed by the counsel for the appellant and the counsel for the respondent.
3. From the documents filed before this Commission, it is seen that there are photocopies of 46 pages of clinical notes (including a few pages of the charge sheet filed in the FIR in the court) and an x-ray film. X-ray film is exhibited as exhibit C1 (while dictating these orders) whereas the clinical notes and the charge sheet (running into 46 pages) are collectively exhibited as exhibit C2 (while dictating these orders). Each page of exhibit C2 is signed by this Commission while dictating these orders.
4. Lady Hardinge Medical College Delhi gave the experts opinion vide its letter dated 29.03.2011. Delhi Medical Council gave its opinion vide letter dated 10.06.2011. In its letter dated 20.06.2012 Delhi Medical Council reiterated its opinion given vide its letter dated 10.06.2011. The experts opinions given by the Lady Hardinge Medical College dated 29.03.2011 and Delhi Medical Council dated 10.06.2011 are reproduced below:

Experts opinion, Lady Hardinge Medical College & Smt. S K Hospital, New Delhi Department of Obstetrics & Gynecology

- *As per the record, the 2 zero vicryl needle broke while stitching the Episiotomy on 15.09.2009 & it is clearly written in the discharge slip of the hospital.*
- *X-ray pelvis done on 16.09.2009 shows the needle in the pelvis*
- *Needle was removed under GA on 16.09.09*
- *Pt. made uneventful; recovery & was discharged on next day i.e. on 17.9.09*
- *Needle was in the perinium& not in the uterus as mentioned by the complainant*
- *Inadvertent breakage of needle can some time occur & the needle breakage at the time of stitching of episiotomy in this case is an accident & cannot be a cause of subsequent infertility in the patient.*
- *The needle was in the perinium& it could not have damaged the uterus.*

Experts Opinion dated 10.06.2011 by Delhi Medical Council

"On perusal of the representation from police and documents submitted therewith, the Delhi Medical Council observed that breaking of needle does happen occasionally during stitching of wounds. In episiotomy wound since patient is not under anaesthesia, hence, too much manipulation is not advisable. In this patient, attempt was made to localize the needle. Next day due precautions were taken. Once patient complained of pain in the episiotomy wound, needle has been taken out completely.

Prima Facie no case of medical negligence is made out on the part of Dr. Anita and Dr. Ila at Shree Jeevan Hospital."

1. Perusal of the abovesaid opinion shows that the experts have opined on breakage of needle at the time of stitching of episiotomy. On the contrary, the case of the appellant hospital

itself is that a needle was left while stitching the episiotomy. In para 3 (b) of the appeal the appellant categorically stated that a needle slipped into the superficial layer of the muscles. Appellant contended that the thread 0.2vicryl got separated from the needle. In other words, it was not the case of breaking of the needle as presented before the experts by the defending hospital and its doctors. It is also not the case of the respondent/complainant that the needle broke into two or more parts. Opinion of the experts to the effect that the breaking of the needle happens occasionally is, therefore, not relevant in the present contest.

2. Basic question that arises in the matter is whether Dr. Raheen who was simply a pharmacist, was competent to conduct the delivery and perform stitches on the episiotomy wound. The appellant hospital named Shree Jeevan Hospital is registered in the name of Dr. SumanSabarwal. Dr. Vijay Sabarwalhowever is shown as its chairman. Dr. Anita in her statement to the police stated that Dr. Raheen who was posted as RMO in the hospital had effected the delivery. Dr.Raheen had also carried out the stitches. Dr. Anita was on shift duty from 02:00 pm to 08:00 pm on 15.09.2009. Dr. Anita had left for her home at 09:00 pm. She received a telephonic call at her house at 11:00 pm and by the time she reached the hospital, the job of effecting delivery and applying stitches had already been performed by Dr. Raheen.
3. In relation to the controversial clinical notes on page 3, Dr. Anita admitted that the notes upto the portion where she put her signatures alone were in her handwriting. She denied the remaining contents of the page and stated that the same were not in her handwriting. Police investigated the matter relating to the cutting on page 3 of the notes. Page 3 once supplied to the police did not bear the cutting and the names of Dr. Anita and nurse Chonchondid not appearthereon. Similarly papers supplied earlier did not have any cutting. The said pages appear as pages 27 and 28 in exhibit C2. The criminal court also took cognizance of the said manipulation made by the hospital and for this reason an appropriate charge was framed against the accused persons. Final outcome of the court proceedings is still awaited. Perusal of page 27 of exhibit C2 shows that vide alleged manipulation delivery had taken place at 11:45 pm on 16.09.2009 whereas actually the delivery had taken place on 15.09.2009. Be that as it may, it has come on record that delivery was got effected by Dr. Raheen alone. It has also come on record that Dr. Raheen is simply registered as a Pharmacist in Delhi Pharmacy Council. Her educational qualifications have not come on record. **Dr. Raheen is not a qualified doctor and not competent to conduct delivery and apply stitches on episiotomy wound.**
4. Divisional Bench of the Hon'ble High Court of Delhi in WP(C) No. 7865/2010 decided on 08.04.2016 noticed the observations made by the Hon'ble Apex Court in the case of ***Dr. Mukhtiar Chand*** v. ***State of Punjab,*** (1998) 7SCC 579.From the said case of ***Dr. Mukhtiar Chand*** (supra), the Hon'ble High Court culled out a few propositions one of which is as under:

'that a person who does not have knowledge of a particular system of medicine but practices in that system is a quack and a pretender'.

The Hon'ble High Court in WP(C) No. 7865/2010 observed as under:

> *"Section 2(7) of the DMC Act defines "Medical Practitioner" or "practitioner" as "a person who is engaged in the practice of modern scientific system of medicine and all its branches and has qualifications as prescribed in the First, Second or Third Schedule to the Indian Medical Council Act, 1956 (102 of 1956)" and Section 2(8) thereof defines "Medicine" as "modern scientific system of medicine and*

includes surgery and obstetrics but does not include veterinary medicine or veterinary surgery or the Homoeopathic or the Ayurveda or the Siddha or the Unani system of medicine" and further provides that "The expression "medical" shall be construed accordingly". Section 2(14) thereof defines a "registered practitioner" as "a medical practitioners having register-able qualification as prescribed in the Indian Medical Council Act, 1956 (102 of 1956) whose name is, for the time being, entered in the register, but does not include a person whose name is provisionally entered in the register".

1. Applying the stitches on episiotomy wound falls within the ambit of 'Modern Scientific System of Medicine'. Clearly Dr. Raheen who was not a qualified doctor, was not competent to apply stitchesas she did not possess the requisite qualifications and obviously lacked knowledge and skill in the field. It was for this reason that she could not keep the needle and thread together. **Lack of competence *per se* amounts to negligence**. In the case of ***M/s Spring Meadows Hospital &Anr*** v. ***HarjolAhluwalia*** through, K S Ahluwalia&Anr., AIR 1998 SC 1801. The Hon'ble Apex Court observed as under:

> *"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".*

1. In the case of ***P N Thakur (Prof.)&Anr.*** v. ***Hans Charitable Hospital &Ors.,*** III (2007) CPJ 340 (NC), hospital was held liable for allowing unqualified person treating complicated and emergency case. Para 29 of the judgment of the said case is relevant and the same is reproduced below:

> *"29……It is not clear whether Dr. Rehan is actually registered and if so whether the registration is valid or renewed for him to continue with the opposite parties hospital. If he is not registered under Ayurvedic and UnaniChikitsa Board then the hospital could not employ him to treat patients in the hospital. This information has not been supplied by the hospital authorities. Since this information has not been furnished for the reasons best known to the respondents, we feel that in case proper papers were produced, it might have gone against the respondents and as such we believe that adverse inference should be drawn against the respondent. We further find support in taking this view from other material on record, which is being referred to hereinafter."*

1. In the case of ***ShajahanYoosuf Sahib &Anr.*** v. ***Prasad Kumar T.,*** III (2016) CPJ 458 (NC), the Hon'ble National Commission held that the doctor was not qualified to do laser surgery and for that reason was held negligent.

2. **Instead of employing a qualified doctor who draws a salary around rupees two lakhs, appellant hospital is getting the job done by a pharmacist. How many such episiotomy wounds have been stitched by Dr. Raheen is anybody's guess.**
3. No material has been placed on record by the appellant hospital suggesting that Dr. Raheen recorded any clinical notes to the effect that she had left the needle while carrying out the stitches. Page 30 of exhibit C2 allegedly are the clinical notes written immediately after the delivery and at 11:45 pm on 15.09.2009. The said notes are not in the handwriting of Dr. Raheen. Dr. Anita and nurse Chonchonare shown to have written the notes. Notes at page 28 are the copy of notes at page 27 except that addition, cutting etc. do not appear at page 28. Be that as it may, it is clear that Dr. Anita had not effected the delivery. It is supported by the statement of Dr. Anita made to the police.
4. There is nothing on record to show that the hospital authorities told the patient or her attendants after the delivery that the needle had been left in the body of the patient. There is no record to the effect that in view of the oedema and blood, x-ray was planned to be done in the morning of the next day. Patient was admittedly not referred for x-ray in the morning of the next day. Patient was transferred to the ward after stitchingthe episiotomy. She was not sent to the ICU. Appellant hospital has not placed on record any medical literature to show that it was not advisable to locate the needle by way of x-ray immediately after discovering the same having been left in the body. There is no literature to show that allowing the needle to remain in the body would not cause any damage to the body.
5. Dr. Akashwas onhis routine visit when the patient Smt. Rubina complained of severe pain to him on the next day in the evening. It was at that juncture that the patient was advised to go for x-ray. X-ray machine of the appellant was stated to be out of order. She was sent to the adjoining hospital named 'Jeevan Mala' for getting the x-ray done. Complainant has placed on record a receipt for an amount of Rs. 250/- issued by Jeevan Mala Hospital towards x-ray. It shows the timing of 04:30 pm and date as 16.09.2009. It clearly supports the case of the complainant that her x-ray was done in the evening of 16.09.2009 when she was operated upon for removal of the needle in the night of 16.09.2009.
6. Perusal of the x-ray film exhibit C1 shows that a complete needle with its sharpend and the other end with an eye is seen. It is a round type of needle. Had it been a straight needle, it could have traveled to other parts of the body and caused serious problems. Act of the appellant hospital is thus highly negligent.
7. Appellant hospital has made an attempt to manipulate the records to cover up the fact that the delivery was effected by Dr. Raheen who was not competent to do the same. Appellant hospital has gone to the extent of manipulating the records to make believe that it was Dr. Anita and Nurse Chonchon who conducted the delivery.
8. Admittedly x-ray machine of the appellant hospital was not in order when it was required immediately after the delivery to locate the needle. The patient should have been sent for x-ray examination to a nearby hospital immediately after Dr. Raheen discovered the factum of having left the needle in the body. Appellant hospital was again 'deficient in service' when it did not have the necessary equipment ready. In the case of ***Monilek Hospital and Research Centre*** v. ***Padamchand Jain*** , 2013 (1)CPJ 136 (Raj), the Hon'ble State Commission held doctor and hospital guilty of negligence for undue delay of 15 hours in diagnosing blood clot in the artery to transplanted kidney. The hospital did not have the MRI facility, in the said case. In the case of ***D.K.Sharma& Others*** v. ***PG Institute of Medical Education and Research & Others,*** 2002 CTJ 833 (Chandigarh), the operation having been commenced had to be abandoned by the doctor as drill machine was not kept ready. Drill machine borrowed from other department had failed to work. Hospital was held liable for negligence. In the case of ***M Rajavadivelin*** v. ***Janamma Hospital*** , 2013(2) CPJ

622 (NC), Hon'ble National Commission held the hospital guilty of negligence when there was no ventilator facility. It was held that the doctor should not have conducted a major surgery without ensuring availability of life saving facility.

9. Now coming to the allegation of negligence in leaving the needle in the body, in the case of ***Jaswinder Singh and Ors.*** v. ***SantokhNursing Home,*** 2006(1) CPJ 85 (Chandigarh), the patient was operated for removal of fibroid from uterus and for total hysterectomy. She was discharged after a few days. She developed fever, persistent pain near the kidneys, drowsiness, nausea etc. No ultrasound or swab test was advised. On an ultrasound, two mops/gauges were foundin her abdominal cavity. Principle of ***res ipsaloquitor*** was applied. The doctors of the hospital were held jointly and severely liable.
10. In view of the foregoing reasons, the appeal preferred by the appellant hospital is dismissed. Appellant hospital is burdened with costs of Rs. 30,00,000/- (Rs. Thirty Lacs) for being 'negligent' and 'deficient in service' as discussed above. The said costs shall be deposited by the appellant hospital in Consumer Welfare Fund of the State maintained by this Commission. Let these costs be deposited within a period of sixty days from today failing which it shall carry interest @ 12% p.a.
11. Copy of the orders be made available to the parties free of costs as per rules and thereafter the file be consigned to Records.

(N P KAUSHIK)
MEMBER (JUDICAL)

(SALMA NOOR)
MEMBER