

**Dr. Vijay S. Pradhan and Another Vs. Dr. Niteen C. Dedhia and Others**

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**Court :** Maharashtra State Consumer Disputes Redressal Commission SCDRC  
Mumbai

**Decided On :** Sep-19-2009

**Judge :** Mr. P.N. Kashalkar, Honâ€™ble Presiding Judicial Member, Mrs. S.P. Lale, Honâ€™ble Member.

**Appeal No. :** Consumer Complaint No.33 of 2002, 426 of 2001

**Appellant :** Dr. Vijay S. Pradhan and Another

**Respondent :** Dr. Niteen C. Dedhia and Others

**Advocate for Pet/Ap. :** Mr. Shreeram Shirsat, Adv. for Complainant Mr. Vaibhav A. Singh, Adv. I/b M/s. Joy Legal Consultants for Complainant, Mr. G.N. Shenoy, Authorised Representative for O.P.No.1 in both the Complaints. Mr. A.V. Patwardhan, Advocates.

**Judgement :**

Per Mr. P.N. Kashalkar, Honble Presiding Judicial Member

1) By this common judgment, we are disposing of two complaints, one filed by Dr.Vijay S. Pradhan and another filed by Shri Manharlal J. Parekh. Both of whom had filed consumer complaint against Dr.Niteen Dedhia/O.P.No.1 and Lilavati Hospital and Research Centre/O.P.No.2, since question of facts and laws involved in both these complaints are similar.

2) In Consumer Complaint No.33/2002, Dr.Vijaykumar Pradhan is the complainant. He has averred in his complaint that he is practising Paediatrician having practice of 40 years. He was President of Bombay West Suburban branch and Vice President of the Indian Medical Association, Maharashtra State Branch. He was also member of Central Council. He is therefore well known within the medical circle of Mumbai.

3) He further pleaded that he was having a cataract in the right eye which was required to be removed surgically. He therefore approached O.P.No.1 Dr.Nitin Dedhia for carrying out surgery since Dr.Dedhia was well known Ophthalmic Surgeon having a very lucrative practice and was also having his own clinic at Bandra. He was also attached to the O.P.No.3 Lilavati Hospital. According to the complainant, O.P.No.3 hospital is a very huge and specious hospital and it is one of the best equipped hospital having latest and most modern equipments. The O.P.No.2 is the Medical Director, of O.P.No.3 Lilavati Hospital who was in-charge of day to day affairs of the administration of the hospital. The complainant pleaded that he consulted O.P.No.1 on 8/3/2000 who advised him to undergo for surgery of the cataract. As per his advice, he underwent all requisite tests for pre-operative assessment. He had no hypertension or diabetes. These tests were conducted at Lilavati Hospital itself and on 10/3/2000 cataract operation was fixed in Lilavati Hospital. It is pleaded by the complainant that on 10/3/2000 at 11.00 A.M. O.P.No.1 Dr.Niteen Dedhia operated his right eye for cataract. The Intra Ocular Lens (IOL) implantation was done by phacoemulsification method by O.P.No.1 Doctor. After surgery, he was assured by O.P.No.1 that operation was successful and there was no cause for him to worry.

4) The complainant further pleaded that on the same day, three other patients, namely Shri Jayaram Hegde, Shri Manohar Parekh and Mrs.A.Bhatia were also operated for cataract by O.P. No.1 in the same operation theatre. Those operations were carried out one after another by O.P.No.1. On 11/3/2000, when bandage was removed, complainant did not have any vision in his right eye. The O.P.No.1 Doctor expressed surprise. He washed his eye and prescribed antibiotics. On 12/3/2000, Vitrectomy was done and pus from the anti-chambers was removed, IOL was also removed. On 13/3/2000, a B-scan was done and his

eye recorded post chambers pus in vitreous cavity and also supra temporal retinal detachment was done. The pus was collected and sent for culture and sensitivity test and the culture of the pus exhibited E-Coli of faecal origin. It is further pleaded by the complainant that E-Coli is a gram negative bacteria of faecal origin from the urinary tract. The bacteria was always a contaminant of water and hence can reach the hospital operation theatre principally because of

a) Improper sterilisation of instruments,

b) Improper sterilisation of O.T. linen

c) Hand gloves inside the O.T.

d) From the Surgeons hand.

5) The complainant further pleaded that on 15/3/2000, he was again admitted to O.P.No.3 hospital and there was purulent discharge from his right eye which found to be painful. The fundus glow was absent and there was no vision. Intra ocular injections were given alongwith oral steroids and he was discharged on 22/3/2000 without any improvement. As the result of the operation, he was immobile due to hospitalisation and other disabilities. His practice also suffered so also his earnings. He therefore contacted Dr.Natarajan a reputed Retinal Surgeon and on 2/4/2000 he operated upon him for Vitrectomy of post-chamber. Infected material from his right eye was removed. The improvement was very minimal. The retina got attached on 6/4/2000 but still there was no vision. He consulted Dr.Lingam Gopal an Ophthalmologist from Chennai who opined that there was no hope of vision. Again in the month of June-2000, he was operated Retinal Detachment Haemorrhage and Vitrectomy Dome and Silicon Oil Injection for Retinal Detachment was done. On 20/10/2000, Dr.Victor Lee, an Ophthalmologist attached to Cleveland Clinic, Ohio, U.S.A. was consulted and he gave the same opinion that there was no chance of recovery of vision of his right eye. He also learnt that other three patients who was operated on the same day along with him had lost their vision. The complainant therefore pleaded that there was gross negligence and want of care and skill on the part of O.Ps which resulted into Catastrophe for the patients who were operated on the same day by O.P.No.1 in

Lilavati Hospital. The complainant pleaded that O.P.No.1 was guilty of negligence and deficiency in service because he had not ensured the taking of requisite steps and to check whether all the steps had been really implemented before surgery. He was duty bound to ensure that site which he operated would not suffer from infection of any kind which he miserably failed to do in his case. The O.P.No.1 being surgeon was duty bound to ensure that equipments he was using for surgery were duly and properly sterilised and staff assisting him was duly dressed and having properly sterilised gowns and gloves and those were properly disinfected.

6) The complainant pleads that O.P.No.2 and 3 were also guilty of negligence because O.T. and equipments kept therein or Linen provided in the O.T. were not properly sterilised. They were not properly fumigated or were not entirely disinfected. The O.P.No.3 was duty bound morally and legally to ensure that their operation theatre was infection free and they should have taken due and proper precaution to avoid infection of any kind to any patient operated in the O.T. He further pleaded that O.P.No.1 or O.P.No.2 and 3 did not take second opinion after noticing the fact that he was not getting his vision back. They did not go to the root of the problem and all the while they only tried to save their skin which itself was an act of gross negligence on their part. The O.P.No.3 did not furnish complainant case papers and indoor papers with regard to the hospitalisation in O.P.No.3 hospital. He pleaded that as a result of loss of vision in his right eye, he suffered in his practice and has become permanently handicapped. As such, he is required to employ a driver to drive his car which entails him the additional expenses of Rs.4,000/- per month. He has pleaded that loss of eye can not be compensated in terms of monies but he is claiming damages of Rs.19,93,500/- under various heads as mentioned in para 15 of the complaint. He has therefore prayed that he should be granted an award of Rs.19,93,500/- against O.Ps jointly and severally with interest at the rate of 18% per annum from the date of filing of the complaint till its payment.

7) In Complaint No.426/2001, the complainant is Shri Manharlal J.Parekh, aged about 68 years, R/o Borivali (West), Mumbai. According to him, he has been working as Accountant and Financial Executive in a private export organisation for

46 years. Seven members are dependent on him. He had consulted O.P.No.1 Dr.Niteen Dedhia in his Bandra clinic on 19/6/1999. After examination, O.P.No.1 diagnosed that he was suffering from Cataract and Glaucoma in his both eyes. He was given ointment for two months to avoid operation. Sometime in February-2000, the O.P.No.1/ Doctor advised him to go in for an operation for Cataract and Glaucoma. O.P.No.1 chose to operate left of the complainant first and suggested to undergo surgery for right eye in near future after his left eye sight becomes normal. The O.P.No.1 assured that operation would substantially improve his eyesight. The O.P.No.1 suggested and recommended that operation should be carried out at Lilavati Hospital since it was well equipped hospital having most advanced and latest facilities for medical care. Relying on his recommendation, he agreed to have the operation performed by him at O.P.No.2 Hospital even though treatment at O.P.No.2 hospital would be more expensive. Accordingly, he got himself admitted in Lilavati Hospital on 10/3/2000. O.P.No.1 Dr.Dedhia performed operation on his left eye for Cataract and Glaucoma. The cataract extraction was done with intra ocular implantation by phacoemulsification method under local anaesthesia. He was discharged at about 3.30 P.M. on the same day. However, on reaching home at 5.00 P.M., his operated eye developed some complications. He felt continuous irritation in the eye and thin watery fluid was running from the said eye. When this fact was brought to the notice of Dr.Dedhia, he was told that it was normal phenomenon and he would be okay after a while. However, complainant pleaded that he did not get any relief from the continuous irritation and discharge from the left operated eye. This fact was brought to the notice of O.P.No.1 Doctor at 7.30 P.M. On the very next day he had to approach O.P.No.1 at his Bandra clinic for remedial action. O.P.No.1 injected out some fluid from the operated eye and sent the same to Hinduja Hospital for testing. He assured complainant that there would be no problem and advised him to apply eye drops at the interval of every 20 minutes. The complainant pleaded that despite putting eye drops there was no improvement and he was not getting any relief. On 12/3/2000, he again approached O.P.No.1 who advised him to get himself readmitted in O.P.No.2/Hospital. Accordingly, he got himself readmitted in Lilavati Hospital on the advice of Dr.Dedhia. Despite inquiries, neither O.P.No.1 nor O.P.No.2 informed him what the problem was. He was also not knowing why he was asked

to get readmitted in the hospital. The O.P.No.1 carried out emergency surgery on 12/3/2000 in the operation theatre of O.P.No.2 Lilavati Hospital. In the course of operation, O.P.No.1 removed intra ocular lens implanted earlier on 10/3/2000 and cleaned the chamber and performed Vitrectomy.

8) The complainant further pleaded that he learnt that three patients out of eight who were operated on 10/3/2000 in the same operation theatre were also suffering from the same problem as he suffered. The said patients were Dr.Vijay Pradhan, Mr.Jayaram Hegde and Mrs.A.Bhatia (who lost both eyes in the operation and preferred not to proceed against these O.Ps) According to the complainant, it was thus clear that he was never told what was the problem he was suffering after the operation performed on 10/3/2000. He was kept in the dark by both the O.Ps. As such, complainants employer asked another eye surgeon Dr.B.T.Shah to examine complainant at O.P.No.2 Hospital who on examination told complainant that his eye was heavily infected and complainant should undergo Sono-B-Scan test. But, O.P.No.1 did not consider the said suggestion and suggested him that he should wait for some days under observation and treatment. There was however, no improvement in the condition of his left eye. Therefore, ultimately complainant underwent a Sono-B-Scan test on 18/3/2000 at N.M.Medical Centre, Bandra. The Complainant continuously pressurised O.P.No.1 to suggest another eye specialist for further treatment and finally O.P.No.1 agreed to give him discharge to consult another doctor. O.P.No.1 suggested name of Dr.R.P.Jahangir, retinal specialist of Charak Clinic Nursing Home at Churney Road and issued a note of introduction to him on 20/3/2000. On 20/3/2000, ultimately, he approached Dr.R.P.Jahangir who conducted emergency surgery accompanied by Dr.B.T.Shah because there was likelihood of infection causing damage to his brain and nervous system. During the said operation, 3 port pars plana vitrectomy done with removal of exudates and pus from anterior chamber and vitreous cavity and intravitreal fluid was sent for smear culture sensitivity to Hinduja Hospital.

9) According to the complainant Shri Parekh, damage had already been done during the first surgery by O.P.No.1 on 10/3/2000 at Lilavati Hospital. In the said operation, his left eye was badly infected. Dr.Jahangir had opined that there was very less chance to save the eyesight of the complainant. Once again on

30/3/2000, he underwent Sono-B-Scan test on advice of Dr.B.T.Shah. To save his left eye from total blindness he approached Dr.S.Natarajan in Aditya Jyot Eye Hospital. He was hospitalized on 4/4/2000 and was operated by Dr.S.Natarajan for AC tap and intravitreal injection. During operation, fluid was removed from the eye and again sent to Hinduja Hospital for test. Thereafter, for two months, he took treatment from Dr.Natarajan to get his left eye completely disinfected. The other two patients namely Dr.Pradhan and Dr.Hegde were also under the treatment of Dr.Natarajan.

10) The complainant further pleaded that because of lack of proper treatment after left eye surgery done on 10/3/2000, it became clear that his left eye is totally blind. Several tests were conducted, several doctors were consulted but it is now clear that he is totally blind in his left eye. Complainant has developed cataract on his right eye and he is unable to carry on day to day activity. But he is frightened to approach O.P.No.1 and 2 to undergo surgery on his right eye. He has become physically handicapped because of total blindness of his left eye and he suffered mental agony and torture due to the fact that O.Ps No.1 and 2 kept him in dark about the reasons for failure of operation and line of treatment. According to the complainant, O.Ps owed a duty to the complainant to take due care and precaution during his operation. But on 10/3/2000 they failed in their duty and O.P.No.2 did not provide an infection free operation theatre because four out of 8 patients operated on the same day in the said operation theatre lost their eyesight in their one eye due to infection during their operations.

11) Complainant learnt that he suffered infection because of E-Coli bacteria in the operation theatre of O.P.No.2. The complainant understands that E-Coli is a gram negative bacteria faecal origin and from urinary tract. Main reasons for this sort of infection is

- a) Improper sterilisation of instruments,
- b) Improper sterilisation of O.T. linen
- c) Handlers inside the O.T.

d) From the Surgeons hand.

12) It is further pleaded by the complainant that because of gross negligence of O.P.No.2 he became totally blind in one eye like three other patients who were operated on 10/3/2000 alongwith him. The O.P.No.2 is a private hospital and charges substantially higher fees and still O.P.No.2 failed to take reasonable care expected from a hospital of its standard. He is specifically mentioned the fact that O.P.No.2 did not charge complainant for second round of hospitalization from 12/3/2000 to 20/3/2000 which shows that O.P.No.2 was fully aware that it had committed gross negligence and it was vicariously liable for the negligence of O.P.No.1 and hence O.P.No.2 admitted its guilty and deficient services and waved its charges of approximately Rs.50,000/- likewise O.P.No.1 was in charge of operation. He owed duty to the complainant to perform with due care and in such a manner that complainant does not contract any infection. However, O.P.No.1 failed to take care as was reasonably expected of a surgeon performing eye surgery. He also failed to take due care in treating him post operatively. He suppressed real facts from complainants and his family members. He also avoided to consult senior Ophthalmologist on the panel of O.P.No.2/Hospital despite repeated requests by him and his family members. The O.P.No.1 also failed to conduct Sono-B-Scan test despite suggestion by the complainant. He failed to control infection by taking effective steps at the earliest opportunity. He lost valuable time and days in persisting with ineffective eye drops and in adopting wait and watch policy by his act of omission and commissions. The O.P.No.1/Doctor is guilty of gross negligence in performing surgery and also in taking post operative care and in not controlling infection and resultantly complainant lost his left eye.

13) The complainant pleaded that he had sent registered notice through his advocate to both the O.Ps. In reply, the O.Ps denied their liability to pay any compensation. He has therefore claimed actual expenses of Rs.1,30,000/- incurred for undergoing operation and other treatment. He has also alleged that his income has been substantially reduced to Rs.6 Lakhs annually because he is unable to manage his portfolio of shares and stocks because of his blindness in one eye. He has also asked for further compensation of Rs.3,50,000/- because of mental torture and agony he and his family members suffered due to failure of his

operation. He has therefore, claimed total compensation of Rs.19.80 Lakhs as per annexure 9 attached to the complaint for the gross negligence and deficiency in service of both the O.Ps.

14) In respect of C.C.No.33/2002 filed by Dr.ijaykumar Pradhan, the O.P.No.1 filed written statement and pleaded that the complainant had filed the consumer complaint to tarnish his good image and to bring disrepute to his good name. He pleaded that no element of negligence was involved and complaint should be dismissed with cost. He pleaded that the expert opinion given by Lt.Gen.Dr.Suresh Samartha(Retd.) was useless since he was trained in the branch of Psychiatry and he has passed M.D. exam in Psychiatry and he was not competent to give expert opinion in connection with Bacteriology. Here issues of environmental infection are involved. He denied that there was any negligence in treating the complainant. He pleaded that in a summary trial issues involved in the complaint should not be tried and complaint should be returned to the complainant for filing it in the civil court. He pleaded that he was highly experienced Ophthalmologist and he had taken training in Phacoemulsification technique of cataract surgery in 1992 under world renowned cataract and intra ocular lens (IOL) surgeon Dr.Hans Reinard Koch from Bonn, Germany. He also took further advanced training under Dr.Charles Casebeer at Scottsdale Arizona, U.S.A. He also pleaded that he further took special surgical training from various doctors of Italy, America and Germany.

15) He pleaded that he was appointed by Lilavati Hospital as Honorary Consultant Ophthalmologist on its faculty with effect from 1/7/1999 with a clear understanding that O.P.No.1 would pay to O.P.No.3 affiliation charges and other charges mutually agreed upon and renewal of appointment of O.P.No.1 would only be considered if O.P.No.1s performance was found satisfactorily by O.P.No.3. He pleaded that O.P.No.2 and 3 controlled activities of O.P.No.1. He pleaded that as the part of agreement, the O.P.No.3 collected 15% of the surgical fees charged by O.P.No.1 to his patients as affiliation fees apart from bed charges, operation theatre charges separately levied by Lilavati Hospital. O.P.No.1 pleaded that since his work was found to be satisfactory, O.P.No.3 reappointed him for a period one year on 1/1/2000 and again extended the appointment for one more year from 1/1/2001. O.P.No.1 further pleaded that O.P.No.3 dismissed him by way of

punishment since O.P.No.3 wanted O.P.No.1 to take blame for the infections that took place in the operation theatre provided and maintained by O.P.No.3/Hospital. He pleaded that undoubtedly O.P.No.3 was Principal and he was Agent and therefore O.P.No.3 is vicariously liable for the acts and omissions of their employees and agents including O.P.No.1. The O.P.No.1 further pleaded that bacterial infection can be picked up by the patient during hospital stay. E-Coli is one of the common organisms responsible for this infection. E-coli is usually found in a human feces and urine. Patients usually pick up this infection because of unclean hospital and environment or unsterile operation theatre environment. E-Coli contaminates water and can be seen in the water used in the operation theatre. It can also be transmitted to the patient via the aerial route if the air of the operation theatre is not properly sterilized. If, the operation theatre is used for Urology and Gastro-Enterology cases there is a chance of high colony of count of E-Coli which is disastrous to an ophthalmology case. For this reason no urology/gastro-intestinal cases are permitted in ophthalmic theatres. In the instant case, both urology and gastro-intestinal cases were operated in O.T.No.5 as permitted by O.P.No.3 where eye cases were also operated.

16) He further pleaded that O.P.No.1 evaluated the infrastructural facility available at O.P.No.3s operation theatre and found him to be not equipped to manage complicated delicate eye surgeries. The Nurses were not trained to manage eye surgeries. So, the O.P.No.1 decided to shift his personal expensive state-of-art equipment with consent of O.P.No.3. His own ophthalmic microscope, the phacoemulsifier and surgical instruments were brought to O.P.No.3/ Hospital and entrusted to the care and custody of Lilavati hospital and he himself brought his own staff with the consent of O.P.No.3 to manage the cases and to train the staff of O.P.No.3. This arrangement was discontinued only from 30/3/2002. The personal staff of O.P.No.1 was brought in the operation theatre by O.P.No.1 with the permission of O.P.No.3 and all of them were issued identity cards by O.P.No.3. He further pleaded that the equipments of O.P.No.1 given in custody of O.P.No.3 were expected to be sterilised in the operation theatre of O.P.No.3 itself. He specifically pleaded that phaco probe used by O.P.No.1 in all the patients was adequately sterilised and it was not responsible for the eye infections. The bacteriological studies conducted by O.P.No.3 on Phaco probe was found to be

having no bacteria. O.P.No.1 further pleaded that operation theatre No.5 where complainant was operated for cataract was provided by O.P.No.3. It was sterilized by O.P.No.3 and it was under exclusive control and custody of O.P.No.3. O.P.No.3 never kept O.T.No.5 as an exclusive ophthalmic theatre which they were duty bound to do so. In O.T.No.5, all sorts of cases were operated upon. Those included surgeries on uro-genital system and gastro-intestinal system where infection was rampant. The O.P.No.3 was well aware of this fact that eye surgeries should be permitted only in an exclusive ophthalmic theatre. The O.P.No.1 pleaded that it was only after the inquiry and directions of the appropriate authority that a separate operation theatre was provided for ophthalmic use as is clear from Exh.16. He pleaded that had O.T.No.5 had been exclusively reserved for eye surgeries right from beginning these infections would not have arisen. So, it was the hospital who had to decide which operation theatre should be used for what sort of surgeries.

17) The sterilisation of O.T.No.5 was also undertaken by O.P.No.3 Lilavati Hospital by protocols of short fumigations using aerosol generator. This does not sterilize and disinfect environment adequately. Thus, short sterilisation led to eye infections. Maintaining a sterile theatre environment is the prerogative of O.P.No.3. If proper Formalin/Potassium Permanganate Fumigation was undertaken by O.P.No.3, eye infections could have been a rear phenomenon.

18) He further pleaded that O.P.No.3 was supposed to maintain its own autoclaving register. But no such register or record has been maintained by O.P.No.3 in respect of O.T.No.5 regarding autoclaving protocols. So, hospital does not have any proof that its equipments and the linen provided in O.T.No.5 were indeed sterilized. Dr.Dedhia further pleaded that while performing operation he was assisted by Dr.Ajay Dudhani. Surgery lasted for 35 minutes and complainant was then transferred to recovery room. Complainant was given intra vitreal injection of antibiotics during surgery. He was also given I.V. of antibiotics and steroids. He was discharged on request at night and advised to come for follow up on next day. Ultimately, the complainant had gone to Dr.Natarajan in June-2000 where he was operated for retinal detachment and vitrectomy and silicon oil injection. O.P.No.1 pleaded that on 20/10/2002 Dr.Victer Lee saw the patient and

was of the opinion that vision of the right eye was lost.

19) He further pleaded that the hospital was inspected by three member committee appointed by Government of Maharashtra, Directorate of Medical Education and Research as three patients had suffered eye infections on the same day in the same operation theatre. The members were Dr.S.M.Sapatnekar, Dr.T.P.Lahane and Dr.D.V.Kaundinya. During the inspection by the committee, the O.P.No.1 was deliberately kept away from the inspecting team. He therefore submitted all the true facts of the case to the Committee by letter dated 12/4/2001 which he addressed to Dr.T.P.Lahane, Professor and Head of Department of Ophthalmology, Grant Medical College, Sir J.J.Hospital Mumbai. The Committee gave report listing the conclusions and making recommendations.

20) The O.P.No.1 further pleaded that when there was Catastrophe of such a magnitude O.P.No.3/Hospital ought to have conducted an internal enquiry and should have come to the conclusion suo motu as to what really went wrong. No such inquiry was conducted possibly to hush up whole the issue. O.P.No.1 further pleaded that the operation was indeed successful and at that point of time there was no reason to believe that there would be post operative eye infection by E-Coli. The infection occurred because in O.T. No.5 all sorts of surgeries involving gastro-intestinal and urological operations were allowed to be performed by O.P.No.3. He admitted that Jayaram Hegde, Dr.Vijaykumar Pradhan, Mrs.Padmini Bhatia, Mr.Manhar Parekh were all operated on the same day in O.T.No.5 and three patients including Dr.Vijaykumar Pradhan and Mr.Manhar Parekh contacted eye infection. He pleaded that he had taken all the requisite precautions and care while operating complainant but eye of the complainant developed post operative infection because of unsterile theatre environment which was due to inadequate theatre fumigation and allowing Uro Surgeons G.I. Surgeons to use operation theatre No.5. The O.P.No1 asserted that he was highly qualified person. He undertook necessary pre operative investigations before operating on the case. Glaucoma was controlled before operating for cataract and he followed same techniques in operating eye of the complainant as followed by Ophthalmologist all over the world. He further pleaded that the source of infection was the environment of the theatre and not the suture material employed by him. He

alleged that in the first case which was operated, the probe used was sterilized at the CSSD of O.P.No.3/Hospital. This case showed post operative infection inspite of an absolutely sterile probe. This goes to show that infections were from theatre environment which was contaminated by E-Coli. It was E-Coli infection that was responsible for the loss of eyesight in the instant case. The problem became more serious because O.T.s of the O.P.No.3 was not fumigated by formalin and potassium permanganate. That was done by short periodic aerosols which does not adequately destroy bacteria present in the atmosphere of the theatre. The O.P.No.1 therefore pleaded that O.P.No.3 is responsible for all the lapses and he can not be blamed for the post operative infections Dr.Pradhan and Shri Parekh sustained after he had conducted operations on them. He therefore prayed that he should be discharged from the case.

21) The O.P.No.3/Lilavati Hospital filed affidavit in reply of Dr.H.L.Chulani, Director Medico Legal Cell of Lilavati Hospital. It denied that there was any gross negligence or want of care and skill on the part of hospital as alleged by the complainant and other patients. It pleaded that on 10/3/2000, operation were conducted on seven patients including complainant and Government of Maharashtra, Directorate of Medical Education and Research had appointed Committee of Dr.S.M.Sapatnekar, Dr.T.P.Lahane, and Dr.D.V.Kaundinya as per letter received by hospital on 6/4/2001 from the Directorate of Medical Education and Research. The Committee so appointed, visited the hospital and saw the medical records kept by the hospital. All available record of fumigation of theatre of operations, record of central sterile supply department and system followed by the department, reports of culture done on 10/3/2000 was presented before the Committee. It was made clear in the letters submitted to the committee that operation theatre was without any bacteria and infective germs and same was absolutely fit for conducting operations. Exh.D-3 is the internal record of the hospital submitted to the hospital authorities which clearly revealed that O.P.No.1 Dr.Dedhia did not follow procedure laid down by the hospital. He did not autoclave instrument after each operation or surgery. Instruments were autoclaved by him after two to three cases only. All these cases were in sequence. So there was possibility of first patient harbouring E-Coli and then infection getting transmitted to next two patients. It was also found that all the sets of instruments used for the

operation of the complainant were personal instruments of O.P.No.1 and cleaning and packing of the same was done by a person who was directly under control of Dr.Dedhia. The medicines i.e. Cellulose injection, eye drops, sutures and the implants were from Dr.Dedhia's personal stock. O.P.No.1 Dr.Dedhia always comes to the hospital with his three assistants who are allowed to go in operation theatre with him. Some visitors are also permitted inside the operation theatre by O.P.No.1. The hospital pleaded that it has not been guilty of any deficiency in service. The operation theatre and all other implements and tools like linen, gloves etc. were totally disinfected. It is only O.P.No.1 who refused to use hospital instruments for operations and also refused to autoclave instruments after each operation and created all these problems. In fact, hospital authorities were also not aware as to what went wrong with the right eye of the complainant after operation. But in any case hospital is not liable for the negligence of O.P.No.1.

22) O.P.No.3 hospital further pleaded that O.P.No.1 adopted substandard methods of surgery in spite of being cautioned by the staff of operation theatre. The persons directly under his control would only handle pre operative and post operative care of the patients. Personal staff brought by O.P.No.1 was responsible for substandard methods of surgery as such meeting was held with O.P.No.1 on 13/10/1999 and O.P.No.1 was sufficiently warned in the said meeting about his substandard methods of surgery. Exh.6 is the copy of minutes of the meeting held on that day with O.P.No.1. The hospital further pleaded that O.P.No.1 disregarded and discarded short gowns specially made and provided in the hospital theatre. O.P.No.1 did not take second set of phaco tubing so that each set can be autoclaved before an operation. The O.P.No.1 did not keep operation door bolted to control excessive movement of personnel. The suturing material stored in formalin by O.P.No.1 were discarded and destroyed by the hospital. The hospital pleaded that it has installed high speed steam sterilizers in the operation theatre of model HS-1321. This can be used for rapid sterilization after each operation. O.P.No.1 failed to use the said sterilization after each operation. He used it after two or three cases. Hospital had taken abundant precautions to see that operation theatre, the linen and the equipments are totally germ free and no problem is caused to any patients. But O.P.No.1 did not listen to the advice of hospital and from 3/8/2002 hospital had suspended O.P.No.1 and now is not connected with

the hospital.

23) Hospital further pleaded that only eye of the complainant was damaged and since he is a Paediatrician how can he continue his practice with one eye. The hospital pleaded that claim made by the complainant is exorbitant. They also disputed claim of the complainant for sum of Rs.3,00,000/- for treatment to be taken in U.S.A. when Dr.Victor Lee of Cleveland Clinic, Ohio, U.S.A. had opined that there was no chance of recovery of vision in the right eye of the complainant. The hospital therefore pleaded that complaint should be dismissed with cost.

24) In respect of C.C.No.426/2001 filed by Manharlal Parekh, O.P.No.1 Dr.Dedhia filed detailed written statement but most of the points raised in the written statement are already mentioned above while giving pleading of Dr.Dedhia in answer to complaint filed Dr.Niteen Pradhan. We need not repeat the said pleadings suffice it to say that Dr.Dedhia in this written statement is also throwing blame for the infections on O.P.No.2/Lilavati Hospital and is claiming that infection occurred to Manhar Parekh because of lack of care taken by Lilavati Hospital in maintaining O.T.No.5 it was not properly fumigated or sterilized. The equipments were not autoclaved. Lilavati Hospital has not maintained autoclave register for O.T.No.5. All sorts of surgeries were permitted in O.T.No.5 by Lilavati Hospital and that is why three out of those patients who were operated by him in that O.T. on 10/3/2000 suffered E-Coli infection post operatively and amongst them were Dr.Vijaykumar Pradhan, Jayaram Hegde and Manharlal Parekh.

25) According to O.P.No.1 complainant was advised to undergo surgery both for Cataract and Glaucoma with intra ocular lens implantation after he was thoroughly examined by him. He was admitted for surgery in Lilavati Hospital on 10/3/2000. He was operated in O.T.No.5 at Lilavati Hospital. Surgery lasted for 50 minutes. Left eye cataract extraction surgery was undertaken with implantation of intra ocular lens by phacoemulsification technique with trabeculectomy under local anaesthesia. Operation was uneventful and he was kept under observation till 3.00 p.m. and was discharged thereafter from Lilavati Hospital. Post operative condition of the patient was normal. Drops were instilled and he was advised to follow up for a routine check up. On 11/3/2000, patient complained of watering, discharge and

some irritation to his left eye. On examination there was sign of infection in the left eye. Second expert opinion from Dr.Ajay Dudhani, Vitro-retinal surgeon was taken. Immediate treatment for control of infection was started. Injection of antibiotic was given. On 12/3/2000, he was again examined by Dr.Ajay Dudhani but there was no improvement in the condition of the eye. So, he was advised to get himself admitted in Lilavati Hospital for removal of intra ocular lens and vitrectomy. At 12.00 noon he was taken for surgery for left eye anterior chamber wash + IOL explantation + vitrectomy. This operation was done by O.P.No.1 assisted by Dr.Ajay Dudhani and was lasted for 40 minutes. Usual post operative treatment was given. This was continued upto 19/3/2000. On 20/3/2000, patient asked for discharge as he wanted to take further treatment from Dr.Jahangir. Accordingly discharge was given with a referral note to Dr.Jahangir. On 25/3/2000, on the request of complainant, O.P.No.1 visited him at Charak Clinic where he was under treatment of Dr.Jahangir and Dr.B.T.Shah who had operated upon him. On 30/3/2000, the patient was once again examined by O.P.No.1 with latest sonography report from N.M.Medical Centre showing complete retinal detachment in the left eye. As there was complete retinal detachment, patient was informed that regaining vision in the eye was not possible. Thereafter, he received legal notice from complainant. O.P.No.1 claimed that notice was also sent by complainant to O.P.No.2 Hospital and in reply O.P.No.2 stated that Dr.Niteen Dedhia/O.P.No.1 was not at all at fault. That reply is at Annexure-13 to the written statement. O.P.No.1 further pleaded that he had taken all the requisite care and caution while treating the complainant but the eye of the complainant developed post operative infection because of the unsterile theatre environment which was due to inadequate theatre fumigation and allowing uro-surgeons and GI surgeons from also using the Ophthalmic operation theatre. O.P.No.1 further reiterates:

- a) O.P.No.1 is a highly qualified person who undertook a surgery which he was an expert at.
- b) All necessary preoperative investigations were undertaken before operating on the case.
- c) The glaucoma was controlled before operating for cataract.

d) The case was operated by one of the established techniques followed by ophthalmologists all over the world. O.P.No.1 relies on the Book reference annexed as Annex.15. The surgical treatment and the post operative management were correctly undertaken and this fact is also vouched for by none other than the ophthalmologist of the complainant Dr.Natarajan (Annex.19) and Dr.Ajay Dudhani (Annex.20)

26) The O.P.No.1 clearly pleaded that E.-Coli infection was rampant in the theatre environment or the water used in the theatre if proper care is not taken. When ophthalmic theatres are used by other specialties especially Uro-genital and gastro-intestinal surgery, the theatre environment is always contaminated. The contaminating organism under the situation is E-Coli. It is this E-Coli that was responsible for the loss of eye sight in the instant case. This problem gets even more serious if O.T. is not fumigated by formalin and potassium permanganate. The O.T.s of O.P.No.2 are not fumigated by conventional technique but short periodic aerosols are being used. This does not adequately destroy bacteria present in the atmosphere of the theatre. O.P.No.1 Dr.Dedhia further pleaded that there was no imperfections or shortcoming in the services rendered by O.P.No.1 to the complainant because in reply the O.P.No.2 too gave clean chit to him and O.P.No.2 had even renewed his contract as of 1/1/2002. The O.P.No.2 is blaming him now because it wants to make a small doctor scape-goat for the deficiency in service rendered by Lilavati Hospital. Hence, O.P.No.1 pleaded that complaint should be dismissed with cost. He filed affidavit in support of his written statement and he has also given affidavit of Dr.Natarajan, affidavit of Dr.Dudhani and affidavit of Mrs.Bhatia and has relied upon some other letters and correspondence.

27) O.P.No.2 filed affidavit in reply of Dr.H.S.Chulani and the pleadings is the same as has been found in the written statement Hospital has filed while answering the complaint of Dr.Vijay Pradhan. It denied that Hospital was in anyway negligent in providing services to the patient and in providing all the facilities to Dr.Dedhia and his team. Dr.Dedhia did not follow procedure laid down by the Hospital. He did not autoclave the instruments after each operation. The instruments were autoclaved by him after two to three surgeries. The instruments

used by Dr.Dedhia were his personal instruments of which cleaning and packing was done by a person directly under his control. Medicines, sutures, eye drops and implants were also from personal staff of Dr. Dedhia. Dr.Dedhia was always accompanied by his three assistants in the theatre and visitors were permitted inside the operation theatre by O.P.No.1. The Hospital blamed O.P.No.1 Dr.Nitin Dedhias negligence in not following hospital procedure and in not autoclaving operation instruments. The Hospital has disputed the claim of complainant being very exorbitant, he being 67 years old at the time of operation. It therefore prayed that complaint should be dismissed with cost. Hospital has filed certain documents and internal reports submitted to the hospital by the various staff members working in the hospital. They have also filed affidavit of certain staff members i.e. of Mr.Rosario Francis Pacheco, Mrs.Gauri Bhatia, Ms.Ancy Jacob E., and Sister Daisy Raj.

28) We heard Submissions of Mr.Shreeram Shirsat, Adv. for complainant/Dr.Vijay Pradhan in C.C.No.33/2002 and Mr.Vaibhav A.Singh, Adv. I/b M/s.Joy Legal Consultants, for complainant/Shri Manharlal Parekh in C.C.No.426/2001 and Mr.G.N.Shenoy, Authorized Representative of O.P.No.1/Dr.Niteen Dedhia in both the complaints and Mr.A.V.Patwardhan, Adv.for O.P.No.2 and 3 in C.C.No.33/2002 and O.P.No.2 in C.C.No.426/2001.

29) Now the following issues arise for our determination.

The issues and our findings thereon as under:

Sr.

No.

## **ISSUES**

### Findings

1) Whether consumer complaints filed by both the complainants is not tenable since criminal court is seized of a criminal complaint filed by complainant Dr.Vijay Pradhan ?

No

2) Whether these complaints involved complicated question of facts and laws and as such these matters should be referred to the civil court for adjudication ?

No

3) Whether the complainants proved that they contacted infection on 10/3/2000 after they were operated by Dr.Niteen Dedhia in O.T.No.5 of Lilavati Hospital

Yes

4) Whether loss of eyesight by both the complainants after operation is attributable to the negligence of Dr.Niteen Dedhia/O.P.No.1 and/or to the negligence and deficiency in service attributable to Lilavati Hospital

Negligence of Dr.Dedhia as well as of Lilavati Hospital

5) What amount of compensation should be payable by O.P.No.1 Dr.Nitin Dedhia and by Lilavati Hospital?

As per final order passed below.

6) Whether the complainants are entitled to get cost of the proceedings and from whom ?

Yes. From O.P.No.1 and 2

## REASONS

30) Issue No.1:- It is an admitted position that Dr.Vijay Pradhan has already filed criminal complaint and same is pending before Metropolitan Magistrate Court at Bandra. In that complaint, Dr.Bhimani, Medical Director of Lilavati Hospital and Research Centre is shown as Accused No.1 and Dr.Nitin Dedhia is shown as Accused No.2. Said complaint is filed U/s 338 r/w Sec.34 and 109 of I.P.C. However, filing of criminal complaint can not debar the complainant from invoking Consumer Forums jurisdiction to entertain and try consumer complaint if complainant is alleging deficiency in service against Dr.Dedhia/O.P.No.1 and

Lilavati Hospital/O.P.No.2 and 3. In criminal complaint, offenses are required to be established beyond the reasonable doubt against the accused persons but in consumer complaint compensation is sought for the deficiency in service, unfair trade practice etc. if complainant is injured in any manner by the acts and omissions of O.Ps. This is a civil remedy where as filing of criminal complaint is a criminal prosecution. Two proceedings are distinct in nature and operate in different spheres. Therefore, in our considered view pendency of criminal complaint is no bar for entertainment of consumer complaint at the instance of Dr.Niteen Pradhan. Hence, there is no merit in the objection raised in this behalf by both the O.Ps. We therefore, record our finding on issue no.1 in the negative.

31) Issue No.2 :- It was the contention of Dr.Shenoy, A.R. of Dr.Dedhia/O.P.No.1 that these two complaints involved complicated question of facts and laws and therefore the complaint should be returned to the complainants for filing civil suit in the civil courts for redressal of their grievances. We are not in agreement of the submission made by O.P.No.1. The case does not involve any complicated question of law and facts as alleged by O.P.No.1/Dr.Dedhia. These are the two complaints purely involving allegations of medical negligence and deficiency in service on the part of Dr.Dedhia and O.P.No.2 Lilavati Hospital. So, complaints of this nature, as they are, can be decided without any legal hitch. There are number of such complaints Consumer Foras are deciding day in and day out. So, even this objection taken by O.P.No.1/ Dr.Dedhia is appearing to be without any substance and we hold that Consumer Commission is quite competent to decide consumer complaints involving medical negligence on the part of doctors as well as the hospital. We, therefore, record our finding on issue No.2 in the negative.

32) Issue No.3:- We have affidavits of both the complainants on record. They have categorically stated that after their operation by Dr.Dedhia in Lilavati Hospital on 10/3/2000, immediately they contacted infection. It came to light on following day. Remedial treatment was given by Dr.Dedhia and some other experts but ultimately because of infection both of them lost the eye operated by Dr.Dedhia permanently. Both of them were subjected to second operation to arrest infection but it was of no avail and ultimately Dr.Lingam Gopal told them on examination of operated eye that there were no chances of regaining eye sight to both the complainants. These

facts fortunately are not disputed by both the O.Ps in their written statements and in the affidavits they have filed. In fact, O.P.No.1 Dr.Dedhia not disputing the loss of eyesight by both the complainants asserted that infection occurred because of E-Coli bacterial presence in the operation theatre and E-Coli infection occurred because of the fact that the O.T.No.5 of Lilavati Hospital was freely allowed to be used for surgeries of uro-genital system and gastro-intestinal cases and in that O.T. itself on 10/3/2000 Dr.Niteen Dedhia was permitted to perform eye surgeries on seven patients and in the process three out of seven patients who had undergone eye operation had suffered infection which resulted into total blindness of the said eye of both of them. Our complainants are the two victims who have lost their eyes permanently in the operations conducted by Dr.Dedhia/O.P.No.1 in O.T.No.5 of Lilavati Hospital. These facts are not denied or controverted by both the O.Ps. So, relying on affidavits of complainants themselves, we can hold that complainants lost their eye in the operation performed by Dr.Dedhia in O.T.No.5 belonging to Lilavati Hospital. Complainant Dr.Vijay Pradhan has produced affidavit of Lt.Gen.Dr.Suresh Samartha(Retd.) who was Commandant of Armed Forces Medical College from 1993-94 till his retirement on superannuation. After retirement, he worked as Medical Director of Bombay Hospital from September-1994 to June-1997, then Medical Director of Duncan Gleneagles Hospital Calcutta from June-1997 to June-1999 and Chief of Medical Services, Moolchand Hospital, Delhi from December-1999 to April-2001. This expert witness was having expertise as to how to control infections in the hospital. After reading papers presented by Dr.Vijay Pradhan, he has opined that the pathological report of infection was E-Coli infection. In his opinion, E-Coli infection in the immediate post operative period (within 48 to 72 hours after surgery) can only result in due to various causes as listed below :

- a) OT Linen of the abdominal/perineal/gynaecological being washed together with linen used for eye surgery
- b) Followed by improper sterilisation of the linen
- c) Eye instruments being sterilised together with the instruments used in the abovementioned surgeries and sterilized inadequately

d) Improper washing of hands by Members of the O.T. Team-Doctors, Nurses, O.T. Technician, etc. or handling without gloves.

He further testified that the complainant Dr.Pradhan and other patients who were operated on the same day for ophthalmic surgeries have suffered infection and have lost their vision and source of infection in such cases was from operation theatre and most probably due to improper sterilisation and it was probably E-Coli infection.

33) This affidavit has been chided by Dr.Dedhia wherein he asserts that this expert was M.D. in (Psy.Med.) and he could not be relied upon to tell about ophthalmic surgeries. He was not specialist in this stream. So, his affidavit should be discarded in toto. We do not agree with the submission of O.P.No.1 in this behalf. Lt.Gen.Dr.Suresh Samartha was Commandant of Armed Forces Medical College, Pune and was also working as Medical Director of three hospitals from 1994-2001. Such a person must be held to be expert in the administration of hospitals and hospitals include O.Ts and other related matters. He has already mentioned that he used to look after infections of hospital O.T.s. Such a person is testifying before us that in O.T. there can be E-Coli infection if the place is not properly sterilised as per established protocols and these infections were responsible for the loss of eyesight of these two patients. Thus, relying on affidavit of Dr.Vijay Pradhan supported by affidavit of Lt.Gen.Dr.Suresh Samartha and also relying on affidavit of Shri Manharlal Parekh, we hold that both the complainants lost their eyesight because post operational infection they contracted immediately after they were operated by Dr.Niteen Dedhia in the O.T.No.5 belonging to the Lilavati Hospital and we reiterate that this is not at all disputed by both the O.Ps though O.P.No.1 is blaming Lilavati Hospital for not properly sterilising the operation theatre and O.P.No.2 Lilavati Hospital is throwing blame on Dr.Niteen Dedhia. Thus, we have no hesitation in holding that it is clearly established by the complainants that both the complainants lost their eye sight in the operation performed by O.P.No.1 on 10/3/2000 in the O.T.No.5 of O.P.No.2 Lilavati Hospital. We, therefore, record our finding on issue No.3 in the affirmative.

34) Issue No.4:- What is not disputed by both the O.Ps is the fact that on 10/3/2000 seven ophthalmic operations were performed in the O.T.No.5 at Lilavati Hospital and out of seven patients operated, three patients contracted infection and in the said infection, the three patients lost their eyesight of the operated eyes. Of the three patients, Dr.Vijay Pradhan and Mr.Manharlal Parekh are the two complainants herein. Since, it was found that three out of seven patients operated on the same day in the same O.T. of Lilavati Hospital had lost their eyesight, there was very much hue and cry in the public at large and ultimately Government of Maharashtra had to step in and Director of Medical Education and Research Mumbai was pleased to appoint a Committee of experts to look into the alleged loss of vision in some patients at Lilavati Hospital Mumbai in 2000. This committee was formed after about of one year but it was the Committee of experts and they were independent persons working in government hospitals. One was Dr.S.M.Sapatnekar, Head of the Committee who was the then Director of Haffkin Institute, Parel. Another was Dr.T.P.Lahane, Professor and Head of the Department Ophthalmology Grant Medical College, Byculla and third was Dr.V.Kaundinya, Professor and Head of the Department, Microbiology, Grant Medical College, Byculla. This Committee of experts visited Lilavati Hospital on 9/4/2001 because three persons had lost their eyes after cataract operation. Committee has mentioned their names as Mr.Jayaram Hegade, Dr.Vijaykumar Pradhan and Mr.Manhar Parekh. Number two and three are the complainants in these two complaints. Committee went through hospital record and it found that there was vitreous aspirate showing growth of E-Coli. E-Coli are commonsal in the intestine and normally not found in the environment. The Committee found that the source of infection may be substances used during operation intra-ocularly. They were Ringer Lactate (irrigating fluid), Visco-elastics, Intra-ocular lens, Phaco-probe. According to the Committee it was found that ophthalmic operations were carried out on first floor as well as on the third floor. On the third floor operation theatre in which this episode occurred ophthalmic surgeries were combined with Plastic Upper Thoracic Surgeries and Urology and entrance for ophthalmic O.T. and for general O.T. was opposite to each other and scrub was common for both of them. In ophthalmic O.T. there was no record of autoclaved material (in the form of registers in proper format) with pin-up of thermal indicator tapes. Operation

theatre had laminar flow and positive ventilation facility however protocols of short fumigation using aerosol generator are carried out instead of the proper formalin fumigation using heat or potassium permanganate for 24 or 48 hrs. The Committee also noted that the episode occurred on 11/3/2000. However, the administration neither informed government or the F.D.A. Even preliminary enquiry was not carried out by the administration. It did not attempt to locate the source of infection, a usual administrative action which is mandatory after such a serious episode. The Committee further noted that inspite of such dreadful incidence, the operations continued which suggests the casual attitude of administration towards the patients. The Committee therefore made following conclusions:

- 1) The source of infection can not be located as inquiry is carried out after one year after episode.
- 2) Operation theatre is combined with other specialties.
- 3) Not even a preliminary inquiry was carried out after the episode.
- 4) Administration has failed to inform Govt. and F.D.A.
- 5) The administration is so callous that inspite of serious tragedy of eye loss to three patients, they have recovered full charge of the hospital from the patients which is ridiculous.
- 6) In ophthalmic O.T.No.5 Autoclave register is not maintained.
- 7) Only short term (half hour) fumigation is done in all O.T.s using aerosol generators.

The Committee therefore recommended that ophthalmic operations should be conducted only in dedicated ophthalmic theatre till then all such surgeries should be stopped. The Committee also recommended action to be taken to be initiated against guilty. The Committee further recommended that proper hospital infection control committee with proper records of minutes as per state guidelines of 2000-2001 should be established and government should be informed accordingly.

35) We are attaching greater importance to the recommendation made by this Committee of experts. They have arrived at certain conclusions after seeing that dismal condition of hospital and its O.T. and poor quality of administration of the hospital. Some of the records were not maintained properly. Fumigation of O.T. was not done. Only short term fumigation using aerosol generators was done in all O.Ts at Lilavati Hospital. Operation theatre was combined with other specialties and source of infection was not tried to be located by the administration despite the horrible incident that had occurred in the hospital on 10/11/3/2000 wherein three out of seven patients who had undergone eye surgeries at the hands of Dr.Niteen Dedhia had lost their eyesight and all these operations were conducted in O.T.No.5 on the third floor controlled and managed by Lilavati Hospital. This report of expert per se proves negligence on the part of Lilavati Hospital and to some extent on the part of Dr.Niteen Dedhia/O.P.No.1. In fact, this report of Committee itself is sufficient to hold O.P.No.1/Dr.Niteen Dedhia and O.P.No.2 Lilavati Hospital guilty of medical negligence because of three patients out of seven had lost their eyesight in the operation conducted on 10/3/2000. It appears from the Committee report that O.T. was not sterilised properly, the equipments were not autoclaved properly, what is more in ophthalmic O.T.No.5 autoclave register was not maintained at all. This would go to establish that no autoclaving of the equipments and instruments was done after each surgery either by the hospital or by the staff of Dr.Niteen Dedhia because no autoclave register was maintained at all in O.T.No.5. So, without autoclaving material instruments and equipments, Dr.Dedhia continued to operate one after another patient on 10/3/2000 and hospital also permitted him to do so brazenly disregarding the established protocols and this has resulted in the ultimate loss of eyesight by three patients out of whom two are the complainants before us. So the blame if any, the lapses if any, the lacuna if any must be shared equally by O.P.No.1/Dr.Nitin Dedhia and O.P.No.2 and 3 Lilavati Hospital. This is the irresistible conclusion we can draw from the facts and circumstances of the case.

36) We may mention here that one of the Committee members Dr.T.P.Lahane is even today Head of the Department and Professor of Ophthalmology of Grant Medical College and J.J.Group of Hospitals, Mumbai and today he is the leading eye surgeon of India. He has conducted more than 1 lakh surgeries and has been

awarded by Padmashree by the Government of India. Such a devoted person, a really expert person in the field was Honble Member of this Committee which has suggested above recommendations and which has drawn the above conclusions. So, based on the conclusions drawn, the recommendation made by the Committee, we can certainly hold O.P.No.1/Dr.Niteen Dedhia and O.P.No.2/Lilavati Hospital guilty of medical negligence of highest order. Nothing more is required to hold them guilty of the charge of medical negligence leveled by the victims of O.P. No.1 and 2.

37) It is also interesting to note that in the affidavits, in the written statements, the O.P.No.1 Dr.Niteen Dedhia is throwing blame on Lilavati Hospital and O.P.No.2 Lilavati Hospital in turn is trying to pass on blame on Dr.Niteen Dedhia thereby it wants to save its own skin and its reputation in the public at large. It is therefore necessary to see what each of the O.P. is alleging against the other. This will throw voluminous light on how doctors conducting operations in Lilavati Hospital are least bothered about the adverse atmosphere available in the O.T.s while conducting operation and conversely it will also expose hospital administration about hospitals callous and indifferent attitude towards the safety of the patients taking treatment, undergoing operations though patients are paying huge amount of fees to the hospital to ensure they get best of treatment in a premier hospital like Lilavati Hospital of Mumbai.

38) It is the case of O.P.No.1 that he is not but Lilavati Hospital was negligent in running and managing the hospital. According to him, infrastructure in O.P.No.3 Lilavati Hospital is hopelessly bad and consultants are required to bring their own costly equipments not only in the department of Ophthalmology but in other departments also. He also asserted that consultant like him was required to bring dedicated ophthalmologic nurse and the staff of his own. He also asserted that Lilavati Hospital did not have dedicated ophthalmology O.T. Fumigation of the ophthalmic O.T. was substandard. Records were not maintained. In the O.T. there was pressure on the doctors to perform operations and to give business to the hospital. If business is not brought to the hospital, the consultant is shown the door, which is leading to a huge unethical form of work. The hospital had not informed government of this incident but tried to hash up the same. Dr. Dedhia

also mentioned that there was no infection control committee in Lilavati Hospital. He also argued that he was agent of O.P.No.3 and O.P.No.3 was vicariously liable for all the staff whether full timer or part timer.

39) Thus, from the assertions made by Dr.Dedhia, it is crystal clear that all was not well in the Lilavati Hospital. There was no proper fumigation of the operation theaters. There was no sterilisation of equipments. There was no dedicated exclusive ophthalmic theatre in Lilavati Hospital. All types of surgeries were permitted in O.T. No.5 where eye surgeries were performed by Dr.Dedhia at the instance of Lilavati Hospital. No autoclaving was done by the staff of Lilavati Hospital after each surgery was over. For fumigation short cut method was employed and there was every possibility of operation theatre environment being infested with some bacteria. Lilavati Hospital did not provide adequate staff in the operation theatre and they were insisting that consultants should bring business. These sorts of lacunae have been highlighted by Dr.Dedhia in his defense and this has been well confirmed by the Dr.Sapatnekar Committee appointed by Government of Maharashtra to which we have made reference in hereinabove para.

40) Lilavati Hospital has taken defense that for the loss of eyesight of three patients, the O.P.No.1 was squarely responsible. He had not autoclaved the instruments and equipments after each surgery was performed. He had not taken staff of Lilavati Hospital and brought his own. Dr.Dedhia was permitting anybody to enter in the operation theatre and he himself was negligent in not taking good amount of care post operatively of all the three patients who lost their eyesight. Thus, we are finding that hospital is blaming Dr.Dedhia and Dr.Dedhia is blaming hospital for the ultimate loss of eyesight suffered by three patients out of seven who had were operated by Dr.Dedhia in Lilavati Hospital on 10/3/2000. One thing is clear that both of them are expert. Dr.Dedhia is expert in ophthalmic surgery and Hospital is expert in hospital management and maintenance of O.T.s. When both of them are throwing blame on each other, one thing is certain that everything in the hospital was in a mess. Nobody bothered about the welfare of patients for whose benefits these hospitals are run. Dr.Dedhia and Lilavati hospital were only concerned with earning monies at the cost of patients health. Hospital too was

greedy in seeing that its O.T. are used to a maximum possible extent and income should be generated. In doing so, both of them contributed to neglect of the vital aspects of hospital administration more particularly administration and maintenance of O.Ts. Dr.Sapatnekar Committee has thrown a lot of light on these aspects of matter though they had an occasion to visit Lilavati Hospital after about one year since the happening of the said episode. Had the Committee a chance to visit Lilavati Hospital immediately after this incident, some more skeletons would have tumbled down from the cupboards of Lilavati Hospital. Even then the report of Dr.Sapatnekar in which leading ophthalmologic expert Dr.Lahane was the Honble member has drawn valuable conclusions which clearly go to show that Lilavati Hospital was negligent in maintaining operation theatre free of infection on that day. They had not maintained autoclave register in the operation theatre and they had permitted personal staff of Dr.Dedhia to come in at operation theatre. They had also permitted Dr.Dedhia to use his own equipments though Lilavati Hospital vouches that they are having state of art equipments in their hospital since it is a premier hospital of Mumbai. They permitted all sorts of operations in O.T.No.5. No dedicated ophthalmic O.T. was earmarked in Lilavati Hospital.

41) Some affidavits have been filed on behalf of Lilavati Hospital to show that their staff was taking usual precautions to arrest infections of O.T.s. But those affidavits are of no use to defend Lilavati Hospital for the simple reason that deponents are the staff members of Lilavati Hospital who have sworn affidavits in favour of O.P.No.2 and 3. As such, we are discarding them in toto. Suffice it to say that environment in operation theatre where seven ophthalmic surgeries were performed by Dr.Dedhia was having infection. There was E-Coli infection found in the eyes of these two complainants and this was because of the fact that hospital had permitted Dr.Dedhia to perform eye surgeries in O.T.No.5 where all other types of surgeries were freely allowed. Hospital ought to have known that ophthalmic surgeries are special type of surgeries which require exclusive and dedicated ophthalmic theatre. In absence of any such dedicated O.T. earmarked for ophthalmic surgeries, such type of infections are bound to be there which could affect post operative care of all the patients who are operated in such a theatre. Gastro intestinal and uro-genital surgeries were performed in O.T.No.5 which should not have been permitted in such a theatre in Lilavati Hospital. For

sterilisation of O.T. short cut method was used and not prescribed procedure was followed. Aerosol generator was used for sterilisation and fumigation. In fact they should have used formalin and potassium permanganate. In the circumstances, we are finding that Lilavati Hospital no doubt was guilty of utter negligence and indifference of high order in maintaining and administrating operation theatres, in permitting Dr.Dedhia to bring his own staff and his own equipments for eye surgeries, in not fumigating operation theatre properly and not maintaining in house autoclave register in each operation theatre and in not undertaking any inquiry after this major episode had taken place in the hospital. On the other hand, they tried to hash up the matter and tried to throw blame only on Dr.Dedhia whom they had given extension for the next year after his earlier term had ended. Dr.Dedhia was suspended as consultant only after 2002 when report of Dr.Sapatnekar Committee was out. So, for loss of eyesight of these two complainants hospital will have to be blamed squarely.

42) But, we are also of the view that Dr.Dedhia can not escape the charge of medical negligence leveled by complainants against him in as much as being an ophthalmic expert he should have known that he should not conduct surgeries of these two complainants in the general O.T. assigned by Lilavati Hospital and not when exclusive dedicated ophthalmic O.T. was not available. Secondly, he should have not used his own personal staff and personal equipments and should not have selected Lilavati Hospital for conducting the surgeries on the complainants when he knew that there was no proper sterilisation in O.T. done by Lilavati Hospital and that Lilavati Hospital was resorting to short cut methods in sterilising and fumigating operation theatres. As an expert, he failed in this sphere and therefore he must be blamed for the loss of eyesight by both the complainants. He can not simply point out accusing finger against Lilavati Hospital to save his own skin. Lilavati Hospital is in the position of Principal and Dr.Dedhia can be said to be a Agent therefore as such Principal Lilavati Hospital has to shoulder the liability for whatever had gone wrong at the hands of Dr.Dedhia. Dr.Dedhia also has to share his blame for the loss of eyesight by two complainants when he did not act as an leading ophthalmologist because he compromised on many things turning Nelsons Eye to the short comings he has now highlighted in the O.T.s managed by Lilavati Hospital.

43) In the totality of the circumstances, we are finding that in terms of the defence taken by O.P.No.1 and 2 and in terms of expert committee report submitted by Dr.Sapatnekar Committee to the government, the hospital as well as Dr.Dedhia both are liable for showing a medical negligence vis a vis both the complainants. They lost eyesight for good, not because of individual lapses committed by O.P.No.1 and or O.P.No.2 but owing to the joint lapses committed by both of them which ultimately resulted in post operative infection of both the complainants to the operated eye which ultimately caused them the loss of eyesight. It is for this reason, we are inclined to record finding that in this case Dr.Dedhia as well as Lilavati Hospital both must be held guilty of medical negligence of highest order which resulted in the loss of eyesight of the two complainants. We therefore, record our finding on issue No.4 accordingly.

44) Some rulings have been cited by both the O.Ps but we have to decide question of fact with reference to available evidence on record and the rulings are hardly useful to take different view of the matter. They can not turn the scale of justice. In the light of voluminous circumstances brought on record it is clearly established that there was deficiency in service and negligence on the part of Dr.Dedhia and Lilavati Hospital and as such we are ignoring those rulings.

45) IssueNo.5:- Dr.Pradhan has claimed amount of Rs.19,93,500/- as compensation inter alia for the loss of practice for the expenses payable by him to the driver, for the treatment expenses, for further treatment to be taken in U.S.A. and for loss of future practice for the next five years. He has enclosed his income tax returns and other documents in support of his claim for more than Rs.19 Lakhs. However, we are of the view that Dr.Pradhan who was 71 years old in 2002 when he filed complaint was inherently unable to continue the practice due to old age as Paediatrician and therefore one can not expect that he would have continued his practice without any hindrance despite advanced age with same enthusiasm which he was having at the age of 71. So, his demand for more than Rs.19 Lakhs is appearing to be on higher side and in our judicial assessment we are inclined to grant a compensation of Rs.5 Lakhs to him payable by O.P.No.2 Lilavati Hospital for the loss of eyesight and Rs.1 Lakh also payable to him by Dr.Dedhia/O.P.No.1 because both of them in our view are liable for the sufferance

of Dr.Vijay Pradhan since he has permanently lost eye sight of his one eye because of negligence and deficiency in service on the part of O.P.No.1 and O.P.No.2 and 3.

46) In respect of Shri Manharlal Parekh, he has claimed Rs.19.80 Lakhs as compensation. In 2001, he was 68 years old and he claimed that he was working as financial executive in a private organization and has a family of seven dependent members. A person who is 68 years old can not be said to be having any dependent except his own wife and he can not be expected to be continued as financial expert in the private export organization at this age. Therefore, lumpsum amount is required to be paid to him for the loss of his eyesight as in the case of Dr.Vijay Pradhan. We feel it just and proper to direct Lilavati Hospital to pay a sum of Rs.5 Lakhs to this complainant also for the negligence and deficiency in service of O.P.No.2 and equally we would like to direct O.P.No.1 Dr.Niteen Dedhia to pay Rs.1 Lakh as compensation to the complainant Shri Manharlal Parekh for the loss of eyesight because of his negligence and deficiency in service. We therefore record our finding on this issue accordingly.

47) Issue No.6:- Coming now to the cost to be awarded we feel that both the O.Ps should be directed to pay the cost to both the complainants because they have been fighting these cases for the last 7-8 years. Looking to the nature of this litigation, since this was a fight between a patient and giant hospital and a expert ophthalmologist, in the interest of justice, we are inclined to direct Lilavati Hospital to pay cost of Rs.50,000/- to both the complainants individually and further direct Dr.Dedhia to pay cost of Rs.10,000/- each to both the complainants. This is the least we can do to alleviate their sufferings, pain and trauma of prosecuting a trial of this nature.

48) Before parting with this judgment, we like to observe that now a days there is unholy alliance patently seen between medical experts and premier hospitals of every city in our country. Doctors and hospitals join hands just rob the poor and helpless patients who approach them with some high hope of getting quick medical relief. But, their hopes are now days shattered because experts as well as hospitals both have their eyes only on patients money and not patients health

care. We have come across many instances wherein unnecessary surgeries are performed just to grab the monies from the patients. We also come across so many cases wherein doctors and hospitals are showing least interest in the welfare of patients they are treating. Everybody in this field has only one aim i.e. to earn lakhs of monies and for earning monies they go to any extent. O.Ts are freely given to any surgery by the hospital flouting the well established protocols and norms and so called medical experts are at the fall of hat suggesting patients to undergo surgery though many of the surgeries could be avoided. When surgeries are conducted they invariably tell patients and their relatives that the surgery went off uneventful which is in fact otherwise. Even in these two cases, doctor had told patients and their relatives that surgery was successful but ultimately it was found that the surgery was responsible for the loss of eyesight of two complainants. This is a very sorry state of affair obtainable in health care industry. In the process it is poor hapless patients who suffer mentally, physically and in terms of his pocket. This tendency is required to be curbed to be taking strong measures and by passing stringent orders by Consumer Forums and other courts so that there should be some sort of deterrence on the part of medical experts and hospitals in recklessly running health care industry with total disregard to the patients wellbeing. In the result, we pass following order.

## **ORDER**

- 1) Consumer Complaint No.33/2002 is allowed.
- 2) O.P.No.1/Dr.Niteen Dedhia is directed to pay a sum of Rs.1 Lakh as compensation to the complainant/Dr.Vijay Pradhan.
- 3) O.P.No.2 and 3/Lilavati Hospital and Research Centre is directed to pay a sum of Rs.5 Lakhs as compensation to the complainant/Dr.Vijay Pradhan.
- 4) It is hereby directed that Dr.Dedhia should pay cost of Rs.10,000/- to the complainant/Dr.Vijay Pradhan and bear his own costs.
- 5) It is further directed that Lilavati Hospital and Research Centre should pay cost of Rs.50,000/- to complainant/Dr.Vijay Pradhan and bear its own costs.

II) 1) Consumer Complaint No.426/2001 is allowed.

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