

Sanjay Mutha and Others Vs. Dr. Jayashree Desai and Others

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SooperKanoon Citation : sooperkanoon.com/1146415

Court : National Consumer Disputes Redressal Commission NCDRC

Decided On : Feb-01-2013

Judge : J.M. Malik, Presiding Member & the Honourable Mr. Vinay Kumar, Member

Appeal No. : Original Petition No. 198 of 2001

Appellant : Sanjay Mutha and Others

Respondent : Dr. Jayashree Desai and Others

Judgement :

Vinay Kumar, Member

Shri Sanjay Mutha, together with his wife Smt. Rupa Mutha and daughter Sonal, has filed this Consumer Complaint in July, 2001. The matter arose out of the developments at OP-3/Laxmi Clinic on 19.7.1999. Complainant No.2/ Rupa Mutha had undergone a Fallopin Tube Test (hereinafter referred to as FTT) performed by OP-1/ Dr. Jayashree Desai assisted by the anaesthetist, Dr. Sampath Kumar/OP-2. This was in the background of the fact that the first child of the couple was born in March 1988 and they were hoping to have a second child.

CASE OF THE COMPLAINANTS

2. As per the complaint petition, the procedure was performed in the morning of 19.7.1999 at OP-3. While she was still in the operation theatre, her

husband/Complainant No.1 was informed that Mrs Rupa had developed cardiac arrest. At about 11:30 A.M. she was shifted to Care Hospital Hyderabad, accompanied by OP-2/Dr. Sampth Kumar. Allegedly, she arrived at Care Hospital in comatose condition. She remained under treatment there till she was shifted to Chennai on 16.8.1999 for further treatment.

3. Now, Rupa Mutha, as per the Complaint Petition, lives in a vegetative state, unable to talk, move or think and is like a living corpse. It is alleged that her present condition is on account of brain damage suffered due to hypoxia (inadequate supply of oxygen to the brain), which happened at OP-3 during the course of the Fallopian Tube Test performed by OP-1 and OP-2.

4. The Complaint Petition seeks a total compensation of Rs.687.60 lakhs, which includes the incurred and projected expense of treatment as well as loss of professional earnings by the patient, who was a practising Chartered Accountant, before her medical misfortune.

5. During the course of the proceedings before this Commission, interrogatories were served by both parties and their respective replies have been brought on record. The OPs were also permitted to produce the record of treatment at Care Hospital, Hyderabad. The case of the complainants has been argued by Mr. K. Harshavardhan Reddy, Advocate. The OPs were represented by Mr. Yoginder Handu and Tulsi Raj Gokul, Advocates. Both counsels have been heard extensively in October 2012 and the records submitted by the two sides perused carefully.

6. The reason for consultation with OP-1 is explained in the **affidavit evidence of Complainant No.1/Sanjay Mutha**. The couple had a daughter born in 1988. They were also concerned about the condition of alopecia (premature baldness), which had afflicted their first child. Yet, they wanted to have a second child at the earliest. The advice to go in for Tube Patency Test was due to the gap between the birth of the first child and plan for the second pregnancy.

7. The case of the Complainant, as detailed in his affidavit evidence, is that Care Hospital had certified that the patient was brought to them after she had suffered

from **Hypoxic Encephalopathy**. Before that the discharge summary of OP-3/Clinic has recorded that she was having **myclonicjerks** of her fingers, which, as per medical literature (Harrisons Principles of Internal Medicines) indicate severe brain damage. **The discharge summary also records that Rupa had bradycardia before cardiac arrest.** It is alleged that bradycardia is secondary to Hypoxia, which could show that the patient was suffering from lack of oxygen prior to cardiac arrest. The affidavit evidence also seeks to counter the claim of the OPs that the patient was taken from OP3/Nursing Home under sedation. It is contended that the sedative injection (Diazepam 10 mg.) was given 150 minutes before shifting her to Care Hospital. Had this been the truth, the patient would have regained consciousness and would not have been received in Care Hospital in comatose condition.

8. The Complainant has questioned the correctness of the decision to conduct the procedure (Rubin Test) under general anaesthesia. The affidavit evidence also challenges the claim of the OPs that general anaesthesia was given on the request of the patient. **Complainants main contention is that the patient was not anaesthetised for the entire duration of the test as the medicine given for this purpose would have had effect for only five to eight minutes.** It is alleged that she was anaesthetised only with 330mg pentothal and 0.6 mg atropine. No analgesic was given. Also that thereafter the OPs have not maintained any clear record of the condition of the patient when she was sinking into cardiac arrest.

RESPONSE AND EVIDENCE OF THE OPPOSITE PARTIES

9. Per contra, the case of the opposite parties has been made out in a very detailed response, denying the allegation of negligence in the treatment of Smt. Rupa Mutha. Fallopin Tube Test is explained to be decided upon as the Complainant wanted to have a successful pregnancy and a healthy baby. The patient was not new to the OPs and had been under treatment of OP-1 for several years. Rupa was an intelligent educated person and had given her consent for the procedure as well as for general anaesthesia. Her husband had not accompanied her to the clinic therefore, did not directly know what had transpired between the patient and OP-1 in this matter.

10. As per the written response, OP-3/Hospital was equipped with Pulse Oxymeter and Defibrillator, which contained a cardiac monitor as well. This was also seen by Dr. Raghu, Cardiologist and Dr. Shridhar, Neurologist, who were permitted to join the OPs in the operation theatre on the request of the second Complainant. **No change was suggested by these two doctors in the treatment being provided by the OPs to the patient.**

11. The patient suffered cardiac arrest before she was shifted to Care Hospital. In para 8 the written response states that:-

It is necessary to notice that immediately after the Tube Testing was over, N2O was cut off and 100% Oxygen was given to the patient with face mask who was spontaneously breathing. All of a sudden the patient, who is the 2nd complainant herein, developed gasping with jerky irregular laboured breathing and Oxygen saturation started falling while the patient still held with mask with 100% Oxygen and Cardiac arrest occurred rapidly. Immediately on such noticing the patient's head end was lowered and endotracheal intubation was done IPPV with 100% oxygen was given and Cardio-Pulmonary Resuscitation was started.?

12. However, the very next para of the written response states that at about 11.30 a.m. the patient was shifted to Care Hospital and there is no evidence or reliable material to support the allegation of the Complainants that the patient suffered from Hypoxia, even before commencement of the transit to Care Hospital. The written response claims that there was no scope for Hypoxia while the patient was in the Operation Theatre of the opposite parties. Both the notes of the Anaesthetist, who is the 2nd opposite party herein, and the Discharge Summary of the 1st opposite party do not indicate any such occurrence while the patient was in the Operation Theatre.? The OPs have denied that any brain damage to the patient had occurred in the course of conduct of the Rubin Test and claimed that the cardiac arrest had no relationship with the procedure performed on the patient. **A question would arise here, that if there was no hypoxia what else could have caused the sudden deterioration in the condition of the patient, leading to her transfer to Care Hospital in reportedly comatose condition.** As per the written response, no expert medical opinion has been specifically relied upon by

the Complainants, which can hold the OPs responsible for the present condition of the patient. The OPs, it is claimed have taken all reasonable care and have made all efforts.

13. The written response also contends that on the question of treatment or management of the patient, there can be difference of opinion on procedure. More than one right way of managing, must however be accepted in practice by the medical profession. No opinion given by one set of experts can be said to be conclusive proof of the applicable practice. There can be more than one type of management practice, which can be followed.

14. Accordingly, the claim of the Complainant that the Rubins Test is neither reliable nor preferable, has been challenged by the OPs. It is stated that the Complainant has partially quote from the book by name 'The Principles of Gynaecology' by Senior Norman Jeffcoate. **The same book, while dealing with the assessment of female fertility, deals with Tubal Patency Test states that it should be carried out during the seven days following the ends of menstrual period as there is practically no risk of disturbing the fertilised ovum, at that time.**

15. The OPs have also challenged the contention of the Complainants that, instead of following an old practice of Rubins Test, the more contemporary procedure of Hysterosalpingography should have been conducted. According to the OPs both the procedures are available at the option of the medical practitioner. It cannot be contended that one is obsolete and abandoned. **It is contended that both Rubins Test as well as Hysterosalpingography are available at the option of the medical practitioner and it is wrong to allege that the Rubins Test has become obsolete and abandoned, is unsustainable.**

16. The OPs have also challenged the contention of the Complainants that the discharge summary is silent about the time consumed in performing the procedure on the patient, the time when she started gasping and when she went into the cardiac arrest. **It is contended that from a combined reading of the Anaesthetists Notes prepared by OP-2 and the Operation Notes, it becomes clear that the Rubins Test procedure started around 8.30 AM and around**

8.55 AM when the procedure of Tube Test was over, patient developed acute breathing difficulty, gasping and cardio pulmonary arrest.

17. Similarly, the allegation that irregular performance of Rubins Test has resulted in cardiac arrest, is strongly denied. **In this behalf, the allegation of the Complainants that the failure of the OPs to deeply anaesthetise the patient had led to vagal cervical reflex, is rejected by the OPs as baseless.** It is claimed that Rubins Test is a simple, minor and short diagnostic procedure that can be done as out-patient procedure unless the patient insists for general anaesthesia due to apprehension etc.

18. According to the OPs, general anaesthesia was given on the request of the patient herself. However, the written response of the OPs simultaneously admits that:-

œAs already submitted that in case of performing the Rubins Test it can be performed even as an out patient procedure without administering anesthesia and analgesic. In fact several authorities clearly published that in various cases the Rubins Test was performed on patients without analgesic. But yet to prevent the possible surgical stimulation in connection with the dilatation of cervix as an abundant caution the opposite parties have chosen to administer general anaesthesia to the patient for which the consent was obtained from the 2nd complainant-patient.?

Thus admittedly, the decision to do the procedure under general anaesthesia was not at the instance of the patient. It was professional decision of the OPs.

19. As per the OPs, the patient was alright till the end of the Rubin Test procedure. She developed sudden gasping and cardiac arrest, only thereafter. The OPs claimed that the patient developed difficulty in breathing only during recovery from anaesthesia and not during dilatation of the cervix. **It is claimed by the OPs that within three minutes, the cardiac rhythm of the patient was restored and she was handed over to Care Hospital with adequate supply of oxygen. This claim loses all its veracity in the face of the report of Care Hospital, filed in**

the course of these proceedings.

20. The net outcome in this case is that the life of Complainant No.2/ Rupa Mutha has nearly got destroyed at the end of a medical procedure which, in the opinion of the OPs, was a minor one and could even have been performed as an out-patient and without general anaesthesia. We have therefore considered the records submitted by both parties very carefully and heard their respective counsels at length. **ARGUMENTS OF THE COUNSELS**

21. Learned counsel for the Complainants Mr. K. Harshvardhan Reddy, sought to make out a case of medical negligence on the following grounds:-

1) Rubins Test was an outdated procedure and should not have been resorted to in the year 1999. Medical literature filed by the OPs themselves shows that false results are frequent in this test it is not commonly used practice.? (Clinical Gynecology (Fourth Edition) by K Bhaskar Rao and N N Roy Chowdhury, page 151).

2) Continuous supply of the oxygen was not given to the patient. Due to this the patient suffered from Hypoxia, leading to Hypoxic Encephalopathy.

He referred to the evidence in the Discharge Summary of OP-3, depositions and medical literature and argued that --

a. Hypoxia (falling oxygen level in the body) was followed by bradycardia (slowing down of beating of the heart). Brain damage occurred due to prolonged hypoxia and bradycardia. **Discharge Summary of OP-3 mentions that bradycardia had ensued, though it is denied by OP-1.**

b. The discharge summary also refers to myoclonic jerks of forefingers which has also been mentioned in the testimony of Dr Sridhar, Neuro Physician who had admittedly seen the patient at OP-3 hospital, after cardiac arrest. As per medical texts, this is indicative of brain injury. (Harrisons Principles of Internal Medicine, Twelfth Edition, Vol I)

22. De hors, learned counsel for the OPs argued that gasping was a sudden and unexpected development. He argued that the record of treatment would also show that endo-tracheal intubation was done when the patient suddenly started gasping. Cardiopulmonary Resuscitation (CPR) was done and the patient was revived. Before shifting to Care Hospital, availability of ventilator was ensured. OP-2 accompanied the patient to Care Hospital. Drs Raghu and Sridhar were allowed inside the operation theatre, on the request of Complainant-1. All that could be done was done.

23. OP-1/Dr Jayshree Desai has said in her affidavit that œAll my concern at that time was to carry out the test as quickly as possible to ensure that general anaesthesia would be as short as possible.? In a subsequent para, OP-1 also says that œ By the time when the patient suffered the cardiac arrest at 8.55 AM, the procedure of tube testing was complete. Therefore, it cannot be said because of the pains she suffered she had suffered the cardiac arrest.? **Thus, while the declared intention was to keep it a short spell of general anaesthesia, the procedure admittedly took about 25 minutes. According to the complainants, given the quantity of anaesthetic agents administered, the patient could have been anaesthetised for about 5 minutes only.**

EVALUATION OF EVIDENCE

24. OP-2/ Dr Sampath Kumar, has in his affidavit evidence, strongly averred that hypoxia did not occur during or after the FTT procedure at OP-3 or even during transit to Care Hospital. **This assertion is in direct conflict with the certificate of Care Hospital which showed that the patient was brought at 11.30AM in comatose condition and was diagnosed with post operative, post resuscitation state Hypoxic encephalopathy. She was kept on ventilator till 28th July 1999 and MRI of brain showed mid brain altered signal suggestive of hypoxic changes.** This certificate comes from a hospital that treated the patient from 19th July to 16th August 1999. Therefore, in our view the attempt of OP-2 brush it aside in his affidavit, as a œfraudulently obtained? certificate, cannot be accepted. **More so, as the OPs have not led any evidence to counter it and the affidavit of OP-2 also admits that in the emergency caused by the cardiac**

arrest suffered by the patient, he had failed to attend to the preparation of anaesthesia notes simultaneously.? The affidavit also says that the patient's parameters such as PR, RR, O₂, saturation etc. are routine observations. Though they are observed and monitored the same might not have been reflected in the anaesthesia notes, in the circumstances of the case.?

25. Dr. Shyam Sundar of Care Hospital has, in response to the interrogatories, stated that "The patient was examined besides me by a neurophysician and a cardiologist. Laboratory investigations were conducted to rule out other causes of encephalopathy and we as a team arrived to the conclusion that she had suffered hypoxic encephalopathy i.e. brain damage because of lack of oxygen for more than 10 minutes?". He has also stated that occurrence of bradycardia and gasping before cardiac arrest are signs of hypoxia leading to cardiac arrest. No expert opinion or medical authority has been produced by the OPs to show any error in the above opinion given by Dr Shyam Sundar.

26. In reply to the interrogatories, OP-2 denied that bradycardia was the cause for cardiac arrest which the patient had, admittedly suffered. As per Anaesthesia Notes prepared by him, the patient had suffered from gasping which was followed by cardiac arrest. **But, he accepts, in the same response, that atropine "which is a drug of choice for treating bradycardia" was given to Rupa Mutha. He also concedes that coexistence of bradycardia may be a case of manifestation of occurrence of hypoxia as per the authorities.?** However, he qualifies it by claiming that she was given atropine to prevent and not control bradycardia. It is also claimed that atropine was used while administering anaesthesia to prevent and depress vagal stimulation. But admittedly, no analgesic was used.

27. While answering the interrogatory on this point OPs-1 and 2 have asserted that general anaesthesia given to Rupa Mutha was good enough and deep enough to prevent vagal reflex. **But, while denying the allegation of inadequacy of anaesthesia, the OPs have claimed that anaesthesia was not given at 8.30 AM but at about 8.40 AM and the entire FTT procedure was completed before 8.55 AM, when the cardiac arrest occurred.** OP-1 has made a tentative claim

that at 8.55 AM the patient must have been still under anaesthesia effect?. This is contrary to their records and pleadings.

28. OP-2 is equally vague in his reply to the interrogatory on this point. He does not deny that the anaesthesia given would have had effect only for eight minutes. But, says that the allegation that there was no anaesthesia effect by 8.55 AM when cardiac arrest took place cannot be said to be correct. Significantly, during the course of hearing before us, OP -2 was asked the same question. He conceded that the anaesthesia given by him to Rupa Mutha was meant to keep her anaesthetised for 8 minutes only.

29. In the written arguments submitted on behalf of the OPs, we find yet another shift. It is claimed that 8.30 AM was only the scheduled time. The preparatory steps took 10 to 12 minutes and the duration of the FTT procedure was from 8.47 to 8.55 AM. Therefore, though the effect of Pentothal lasts only around 8 minutes approximately, it covers the entire duration of the test. **By implication, the anaesthesia was given not at 8.30 AM, not even at 8.40 AM (as claimed earlier) but at 8.47 AM. In the background of admitted lapse in recording details in the Anaesthesia Notes, this can be viewed only as a transparent attempt to mislead. We deprecate and reject it.**

FINDINGS

30. From the details examined above it is evident that the OPs have denied any suggestions as to what may have happened. At the same time, they have failed to explain what would or could have triggered the onset of cardiac arrest. Nevertheless, a careful scrutiny of the evidence brought on record makes the following clear”

a. Evidence led by the OPs themselves shows that the FTT procedure started at 8.30 AM and breathing problem started at 8.55 AM, when the procedure was over. This would strongly indicate that the trigger for the breathing problem lay in the conduct of the FTT procedure.

b. OPs own records go against their claim that general anaesthesia was given on patients own request. Admittedly, it was their professional decision.

c. Despite denials in depositions, the discharge summary of OP-3 clearly shows that œDuring recovery from anaesthesia the patient developed difficulty in breathing. She was intubated immediately by the anaesthetist, placed in head low position. Bradicardia ensued and despite Inj Atropine she developed cardiac asystole.? It is therefore clear that bradycardia occurred before cardiac arrest.

d. It is admitted by OP-2 that atropine “ which is standard treatment for bradycardia “ was given to the patient. It is also admitted that medically, bradycardia can occur due to hypoxia.

e. Myoclonic jerks are mentioned in the Discharge Summary. As per medical texts, this is indicative of brain injury. (Harrisons Principles of Internal Medicine, Twelfth Edition, Vol I). The OPs have failed to explain it in any other manner.

f. A few hours after the FTT procedure at OP-3, when Rupa Mutha was brought to Care Hospital, she œwas diagnosed as post operative, post resuscitation state with **Hypoxic encephalopathy?**. Blacks Medical Dictionary defines **Encephalopathy** as a condition in which there are signs of cerebral irritation without any localised lesion to account for them. It also defines **Hypoxia** as shortage of oxygen in the body tissues. It may be caused, among others, by low concentration of oxygen or abnormal breathing pattern. Evidently, she had suffered hypoxia during the FTT procedure, because she was fit enough to have come to OP-3 hospital the same morning, on her own and unaccompanied by her husband.

g. Intubation and use of oxygen mask for control of breathlessness has been indicated in the records. It is also claimed that OP-3 had necessary equipment including Oxymeter. But, no record of pulse oxymetry (for monitoring the oxygen level in the blood) was maintained which could have helped in reaching a finding whether hypoxia had occurred or not. In this behalf, Op-2/the Anaesthetist has admitted the deficiency in maintenance of full record.

h. Admittedly, no analgesic was given to prevent any possibility of vagal reflex during dilatation of cervix. OPs have claimed that the type of general anaesthesia given to the patient was adequate to prevent vagal reflex. But, in the process of justifying their claim, they contradict their own records as to the time when the FTT procedure was started. It is also claimed that atropine was used while administering anaesthesia to prevent and depress vagal stimulation. But admittedly, no analgesic was used. While answering the interrogatory on this point OPs-1 and 2 have asserted that general anaesthesia given to Rupa Mutha was good enough and deep enough to prevent vagal reflex. **But, while denying the allegation of inadequacy of anaesthesia, the OPs have repeatedly contradicted themselves on the time when anaesthesia was actually given. But, what remains uncontroverted is that the FTT procedure started at 8.30 AM; the anaesthesia given to Rupa was meant to be effective for eight minutes only and by 8.55 AM the breathing problem had cataclysmically started.**

i. While occurrence of vagal reflex comes out as a strong possibility, suffering undergone by the patient during intubation is an admitted fact, as per the evidence of OPs, themselves. Discharge Summary shows that the patient was fighting intubation and reaching for the tube. But it does not show whether any muscle relaxant was given, which is a standard medical practice in endotracheal intubation.

31. In the course of the present proceedings, the complainants were permitted to bring on record the judgments of the Metropolitan Magistrate, Hyderabad and Honble High Court of Andhra Pradesh in the criminal prosecution launched against the OPs. We however, deem it appropriate to clarify that the findings above have been reached independently of those records.

32. The question before us is whether the findings listed above would amount to deficiency of service within the meaning of Section 2(1)(g) of the Consumer Protection Act, 1986. In terms of this provision”

œdeficiency? means any fault, imperfection, shortcoming or inadequacy in the quality, nature and manner of performance which is required to be maintained by

or under any law for the time being in force or has been undertaken to be performed by a person in pursuance of a contract or otherwise in relation to any service.?

33. In the context of medical negligence Honble Supreme Court of India has laid down the law in the following landmark decisions. In **Jacob Mathew Vs. State of Punjab, (2005) 6 SCC 1**, The Apex Court has summed it up in eight conclusions. Of them, the following conclusions will directly apply to the matter now before us :-

1. Negligence is the breach of a duty caused by omission to do something which a reasonable man guided by those considerations which ordinarily regulate the conduct of human affairs would do, or doing something which a prudent and reasonable man would not do.

2. Negligence in the context of medical profession necessarily calls for a treatment with a difference. To infer rashness or negligence on the part of a professional, in particular a doctor, additional considerations apply. A case of occupational negligence is different from one of professional negligence. A simple lack of care, an error of judgment or an accident, is not proof of negligence on the part of a medical professional. So long as a doctor follows a practice acceptable to the medical profession of that day, he cannot be held liable for negligence merely because a better alternative course or method of treatment was also available or simply because a more skilled doctor would not have chosen to follow or resort to that practice or procedure which the accused followed. When it comes to the failure of taking precautions what has to be seen is whether those precautions were taken which the ordinary experience of men has found to be sufficient; a failure to use special or extraordinary precautions which might have prevented the particular happening cannot be the standard for judging the alleged negligence. So also, the standard of care, while assessing the practice as adopted, is judged in the light of knowledge available at the time of the incident, and not at the date of trial.

3. A professional may be held liable for negligence on one of the two findings: either he was not possessed of the requisite skill which he professed to have possessed, or, he did not exercise, with reasonable competence in the given case,

the skill which he did possess. The standard to be applied for judging, whether the person charged has been negligent or not, would be that of an ordinary competent person exercising ordinary skill in that profession. It is not possible for every professional to possess the highest level of expertise or skills in that branch which he practices. A highly skilled professional may be possessed of better qualities, but that cannot be made the basis or the yardstick for judging the performance of the professional proceeded against on indictment of negligence.

4. The test for determining medical negligence as laid down in Bolams case [1957] 1 W.L.R. 582, 586 holds good in its applicability in India.?

5. The jurisprudential concept of negligence differs in civil and criminal law. What may be negligence in civil law may not necessarily be negligence in criminal law. For negligence to amount to an offence, the element of mens rea must be shown to exist. For an act to amount to criminal negligence, the degree of negligence should be much higher i.e. gross or of a very high degree. Negligence which is neither gross nor of a higher degree may provide a ground for action in civil law but cannot form the basis for prosecution.

6. The word gross has not been used in Section 304A of IPC, yet it is settled that in criminal law negligence or recklessness, to be so held, must be of such a high degree as to be gross. The expression rash or negligent act as occurring in Section 304A of the IPC has to be read as qualified by the word grossly.

7. To prosecute a medical professional for negligence under criminal law it must be shown that the accused did something or failed to do something which in the given facts and circumstances no medical professional in his ordinary senses and prudence would have done or failed to do. The hazard taken by the accused doctor should be of such a nature that the injury which resulted was most likely imminent.

8. Res ipsa loquitur is only a rule of evidence and operates in the domain of civil law specially in cases of torts and helps in determining the onus of proof in actions relating to negligence. It cannot be pressed in service for determining per se the liability for negligence within the domain of criminal law. Res ipsa loquitur has, if at

all, a limited application in trial on a charge of criminal negligence.?

34. In **Martin F DSouza Vs. Mohd. Ishfaq (2009) 3 SCC 1**, the above principles for determination of negligence by a medical practitioner were reaffirmed by Honble Apex Court. It was observed that:-

œFrom the principles mentioned herein and decisions relating to medical negligence it is evident that doctors and nursing homes/hospitals need not be unduly worried about the performance of their functions. The law is a watchdog, and not a bloodhound, and as long as doctors do their duty with reasonable care they will not be held liable even if their treatment was unsuccessful.?

35. In **V. Kishan Rao Vs. Nikhil Super Specialty Hospital and Anr. (2010) 5 SCC 513**, the question of expert evidence came up for consideration. Honble Supreme Court held that :-

œIn the opinion of this Court, before forming an opinion that expert evidence is necessary, the Fora under the Act must come to a conclusion that the case is complicated enough to require the opinion of an expert or that the facts of the case are such that it cannot be resolved by the members of the Fora without the assistance of expert opinion. This Court makes it clear that in these matters no mechanical approach can be followed by these Fora.?

In the present proceedings, eleven years after filing of the complaint and after both sides had led evidence, a request was received from the OPs on 26.9.2012 to constitute a medical board. The request was neither pressed nor was constitution of a medical board considered necessary, given the fact of the case.

36. The first allegation is that, for determination of fertility, the OPs should have followed the more contemporary procedure of Hysterosalpingography instead of the Fallopian Tube Test. According to the OPs, both procedures are in vogue and therefore available at the option of the medical practitioner. The law on this point is well established. Honble Supreme Court has held in several decision that if there are more than one way of treating the problem, the medical professional cannot be

held to be negligent merely because he chose to adopt one in preference over the other. Therefore, we hold that the decision of the OPs to choose the FTT procedure and to perform it under general anaesthesia does not, in itself, amount to deficiency.

37. In the background of the detailed consideration of the evidence on record, the findings reached by us and in the light of the applicable law discussed above, we have no hesitation in holding that the OPs have committed serious deficiency of service in the treatment of Mrs Rupa Mutha. Therefore, the complaint must succeed. The OPs need to compensate her for her medical condition resulting directly from her treatment by them.

38. While we may not agree with the quantum of compensation as claimed by the Complainants, the need would still remain to arrive at an amount, which is just and reasonable in the facts and circumstances of the present case. While considering such a situation in **State of Haryana Vs. Jasbir Kaur, (2003) 7 SCC 484**, Honble Supreme Court has observed that:-

It has to be borne in mind that compensation for loss of limbs or life can hardly be weighed in golden scales. But at the same time it has to be borne in mind that the compensation is not expected to be a windfall for the victim. Statutory provisions clearly indicate that the compensation must be just and it cannot be a bonanza not a source of profit; but the same should not be a pittance. The courts and tribunals have a duty to weigh the various factors and quantify the amount of compensation, which should be just. What would be just compensation is a vexed question. There can be no golden rule applicable to all cases for measuring the value of human life or a limb. Measure of damages cannot be arrived at by precise mathematical calculations. It would depend upon the particular facts and circumstances, and attending peculiar or special features, if any. Every method or mode adopted for assessing compensation has to be considered in the background of just compensation which is the pivotal consideration.?

39. We therefore, award the following amounts as just and reasonable compensation in this case:-

- 1.) Expenses incurred on her treatment till 28.6.2001. Rs. 6 lakhs
- 2.) Expenses on her maintenance for the same period. Rs.14.4 lakhs
- 3.) Compensation for physical and mental sufferings of herself and her family. Rs.18 lakhs

Total: Rs.38.4 lakhs

The amount of Rs.38.4 lakhs shall carry interest at 9% per year, with effect from the date of filing of the complaint in this Commission. The entire sum, inclusive of interest so calculated, shall be paid within a period of three months from the date of this order. Delay, if any, shall carry additional interest at 2% per year for the period of delay.

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