REPORTABLE

IN THE SUPREME COURT OF INDIA
CIVIL APPELLATE JURISDICTION

CIVIL APPEAL NO.4119 OF 1999

Nizam Institute of Medical Sciences ...Appellant

Versus

Prasanth S. Dhananka & Ors. .....Respondents

With C.A. No. 3126 of 2000

J U D G M E N T

HARJIT SINGH BEDI J.,

1. This judgment will dispose of Civil Appeal No 4119 of 1999 and Civil Appeal No. 3126 of 2000 filed by the complainant, Prasanth S. Dhananka . The facts are as under :

2. The respondent Prasant S. Dhananka (hereinafter called the "complainant"), then 20 years of age and a student of Engineering, complaining of recurring fever was examined in

the hospital run by the Bharat Heavy Electricals Limited as his father was employed with that Organisation. As the cause of the fever could not be identified, he visited the appellant – Nizam Institute of Medical Sciences (NIMS) on 9th September, 1990 in the evening OPD. He was examined by one Dr. Ashish Boghani, a Chest and Tuberculosis Specialist and was advised to undergo on ultrasound guided biopsy for Neurofibroma, an innocent tumour, after an X-ray revealed a mass in the left hemithorax with posterior mediastinal erosion of the left 2nd, 3rd and 4th ribs. As several attempts at Fine Needle Aspiration Cytology (FNAC) under ultra sound guidance did not give any conclusive evidence as to the nature of the mass detected in the X-ray examination, the complainant was referred (on 5th October, 1990) for further examination to Dr. U.N. Das, who suggested another attempt at the same procedure but under C.T. guidance. This test too did not show any lesion on which Dr. U.N. Das suggested that he undergo an excision biopsy and referred him to Dr. P.V. Satyanarayana, a Cardio Thoracic Surgeon, who further advised him to report at the hospital on 16th October, 1990 for

allotment of a room. The complainant was admitted to the hospital on 19th October, 1990 and the operation was performed on 23rd October, 1990 and the tumour was excised. It appears that immediately after the surgery, the complainant developed acute paraplegia with a complete loss of control over the lower limbs, and some other related complications, which led to prolonged hospitalization and he was ultimately discharged from the hospital on 19th May, 1991 completely paralyzed with no change in his sensory deficit. The discharge record also shows that the patient required continuous physiotherapy and nursing care on account of infection of the urinary tract and the development of bed-sores etc. It is the case of the complainant that after his discharge from NIMS, he visited several other hospitals seeking relief, but to no avail. On 11th May, 1991 the complainant's father requested NIMS for a detailed report so that his son's case could be discussed with experts from other developed countries` so as to improve his quality of life. No reply was, however, forthcoming despite a reminder. Another letter dated 12th November 1991 also drew no response. Completely frustrated, the complainant filed

a complaint before the National Consumer Redressal Commission (hereinafter referred to as the "Commission") on 5th April, 1993 alleging utter and complete negligence on the part of Dr. P.V. Satyanarayana and the other attending doctors and also making NIMS vicariously liable and the State of Andhra Pradesh statutorily liable for the negligence of the doctors concerned. Allegations was primarily levelled against Dr. P.V. Satyanarayana for negligence before, during and after the operation. It was alleged that the medical record did not indicate any immediate danger to the complainant's life and health and that his father had pleaded with the doctors that the operation be postponed till such time he could complete his engineering degree course. It was further alleged that the doctors had not carried out the required pre-operative tests which were available in NIMS itself and that the complications which could possibly flow as the result of an excision biopsy had not been spelt out to the complainant prior to the procedure. It was also submitted that operating on a neurofibroma or a schwannoma which had neurological implications as well, warranted the involvement of a Neuro

surgeon but no such opinion was sought before the surgery. It was also pleaded that the consent that had been taken was only for the purpose of an excision biopsy which was an exploratory procedure, but Dr. Satyanarayana had carried out a complete excision removing the tumour mass and the fourth rib thereby destroying the inter-costal blood vessels leading to paraplegia and had a Neuro-surgeon been associated with the operation, this problem could well have been avoided. The complainant also alleged that negligence in post–operative treatment and care had led to bedsores, severe pain, and high temperature and frequent and unnecessary exposure to X-rays which could be a potential hazard later in life. He accordingly claimed compensation as follows:

A) **SPECIAL DAMAGES (PECUNIARY)**

1. Loss of future earnings (Annexure XI)	Rs.89,17,200
2. Present burden of expenses [Annexures IV(a) to(d)]	Rs. 3,38,604**
3. Damages on account of the complainant by father, mother, younger brother & maternal Uncle [Annexures VII, VIII, IX & X]	Rs. 30,34,930

4. Prospective burden of expenses Rs. 3,00,00,000
(Annexure-XII)

B) **GENERAL DAMAGES (NON PECUNIARY)**

Pain and suffering, loss of amenities & Rs.38,30,000 Enjoyment of life & shortening of life Expectancy.
(Annexures XIII, XIV, XV) - Rs.4,61,20,734

** (Later in his affidavit dated 5.2.94, this has been shown as Rs.3,49,022 and the total claim as 4,61,31,152: the present burden of expenses includes an amount of Rs.1,27,644/- paid to OPI and Rs.91,002/- to other hospitals).

3. On notice several replies were filed by the respondents. NIMS, Respondent no.1 before the Commission, filed a reply on behalf of respondent Nos. 2 to 5 and denied the allegations in the complaint and pleaded that there had been no negligence. Respondent No.6 before the Commission i.e. Chief Secretary Andhra Pradesh Government, disowned any liability and pleaded that it had absolutely no concern with the matter. Several pleas on merits were also taken by the respondents.

It was pleaded that the provisions of the Consumer Protection Act could not be attracted and that the complaint had been made after a lapse of one and half years and was, therefore, an afterthought. It was also pleaded that reasonable care had been taken in the treatment by doctors who were highly skilled in their specialties and in this view of the matter, the claim for compensation and that too running into several crores, was not justified. The respondents' then traversed the facts of the case and pleaded that though the initial examination of the patient ruled out the presence of a lymphoma which was a malignant condition, the possibility of an undetermined malignancy within a large area in the left thorax had to be examined as a benign lesion was unlikely to cause prolonged fever along with erosion of the left 2nd, 3rd and 4th ribs as shown in the X-rays' and as a rapidly growing benign lesion could also cause erosion of the ribs, a biopsy of the mass to confirm the diagnosis was essential to plan the future course of action. It was further pleaded that a history of fever for about 15 days prior to admission with loss of appetite and weight suggested that

whatever be the nature of the lesion, benign or malignant, its presence was taking its toll on the general condition of the patient which required some minimal tests. It was also pointed out that as four attempts at FNAC had not yielded any conclusive pathological diagnosis, the next best alternative was to go in for an excision biopsy by thoracotomy (an operation involving incising the wall of the thorax) which was a test which could finally determine the nature of the mass. It was, however, admitted that the complainant and his parents had pleaded during discussions in the OPD for postponement of the proposed excision biopsy to enable him to complete his education but when it was explained to them that early confirmation of the diagnosis to exclude the possibility of a malignancy was essential, the parents had consented for the surgery after they had been fully informed about all possible risks and it had also been explained to them that after the body had been opened up, a small piece of the mass would be immediately sent for histological examination and that any further procedure would be based on the report received therefrom. It was further pleaded that after the thoracotomy

had been performed, a part of the tumour had in fact been sent for a biopsy and the report had been received soon thereafter that the mass was benign but it was nevertheless decided to excise the entire tumour as the 4th rib had eroded and it had been found essential to remove the 2nd and 3rd rib as well and for this purpose some inter costal blood vessels had also been sacrificed. It was also submitted in addition, that as tumours though initially benign can cause several medical complications endangering the patient's life and can also turn malignant at a later stage, it had been thought fit to remove the tumour along with the involved ribs and that all care expected of doctors had been taken and that it was only a cardiothoracic surgeon who had the skill to perform such a surgery and that the help of a neuro surgeon had to taken if the tumour had any intra spinal extension and as in this particular case there was no such extension, the presence of a neuro surgeon was not required. It was finally pleaded that all investigations before the operation had been performed and full medical care had been provided to the complainant at the post-operative stage as well.

4. Affidavits were filed as evidence by the parties in support of their pleadings. As the complainant was (and is) a severely handicapped person and confined to a wheel-chair, the Commission directed, on consent of both parties, that the evidence be recorded by the President of the Andhra Pradesh State Commission and the depositions thereafter transferred to the Commission. In an affidavit dated June 1994 filed by NIMS a request was made to invite specialists from the All India Institute of Medical Sciences, New Delhi so that the question of negligence, if any, could be properly investigated but the affidavit also added that the deponent had no objection, if the Commission did not propose to follow this procedure. The complainant too was directed to file an application if he wished to examine any expert medical witness in support of his pleas. An application was accordingly filed on 22nd August 1994 proposing the name of Dr. A.S. Hegde, a Neurosurgeon, practicing in Bangalore and he was duly summoned and his statement recorded by the President of the State Commission at Bangalore. On 19th

September 1996, the counsel for respondent Nos. 1 to 5 undertook to produce the entire record before the Commission but it was noticed on 25th April 1997 (when the case came up for hearing) that the record had not been submitted. The Commission accordingly directed that the record be filed that very day. The case was finally heard on 4th September 1998 and after arguments had been concluded, the parties were given two weeks time to file written submissions. The Commission declined (at this belated stage) to accept the prayer of some of the respondents made on 5th October 1998 (i.e. after arguments had been concluded) to summon experts from the AIIMS as Court witnesses.

5. During the course of arguments before the Commission, allegations pertaining to negligence at different stages, that is, before, during and after the operation, were raised. The main contention of the complainant was that pre-operative diagnostic investigation had not been fully carried out and after four futile attempts at needle biopsies had not given any conclusive result, a C.T. Scan

or an MRI by an experienced Radiologist would have revealed the existence of the tumour and that in any case, since Neurofibroma or Schwannoma tumours were basically neurological in nature, the complainant ought to have been referred to a Neurophysician and if necessary to a Neurosurgeon. The respondents, however, pleaded that the investigations relating to biopsies were to be conducted by a Radiologist and not by a Surgeon and that the complainant had been referred to a cardio – thoracic Surgeon as the tumour was in the thorax and that further investigations by an MRI were not necessary as sufficient information about the extent of the tumour had already been revealed. On the basis of these broad facts, the Commission went into the question as to whether the consent for the operation for the removal of the tumour had been obtained from the complainant or his attendants. The Commission observed that admittedly some discussion had taken place between Dr. Satyanarayana and the complainant and his parents about the possibility of deferring the operation till the

completion of the complainant's education but after Dr. Satyanarayana had explained the gravity of the situation to them, they had impliedly given their consent for the operation. The Commission then examined the question of negligence at the stage of the operation itself on 23rd October, 1990 and observed that the record of the case showed that there had been erosion of the ribs and this had been confirmed during the operation which indicated that the tumour had spread into the spinal area and as this required the intervention of a Neurosurgeon, the neglect in associating one was clearly a case of negligence. The Commission also noted that a Neurosurgeon had, in fact, been called in though at a belated stage. The Commission finally went into the question of negligence at the post-operative stage and the plea of the complainant that lack of care had led to bed sores, very high fever and other related complications, and rendered its opinion on this aspect as well.

6. The Commission, in its order dated 16th February, 1999 concluded as under:

"From the aforesaid discussion, we are clear in our mind that there was negligence and deficiency of service on the part of the OPs in the different stages of the case.

(i) OP 2 had stated that had he known pre-operatively about the extension of the tumour into intervertebral foramen, he as a CT surgeon would not have chosen to deal with it and that on noticing vertebral erosion while operating, he requested OP3 into the theatre. Thus, according to OPs cases of vertebral erosion and/or extension into intervertebral foramen, warranted the performance of surgery by the neurosurgeon along with the CT Surgeon.

(ii) There was information pre-operatively before both OP4 and OP2 about vertebral erosion at T 4 level and affectation of vertebrae. On the basis of this information alone, OP4 should have referred the case to the neurosurgeon as well as to the CT Surgeon; instead, he had referred only to the CT Surgeon. When the case was referred to OP2 by OP4, OP2 should have himself discussed the case with OP3, the neurosurgeon, who was also the Director of the Institute at the relevant time, in view of the aforesaid clinical information, and the team of OP2 and OP3 should have planned and performed the surgery. This, however, was not done.

(iii) Not only did they fail to utilize the available pre-operative clinical information, OP4 and OP2 also failed to conduct necessary pre-operative diagnostic tests like MRI and myelogram which would have provided the information pre-operatively on the extension of the mass into intervertebral foraman and which information would have even according to OP2 brought the neurosurgeon as the prime surgeon. This failure on the part of OP4 and OP2 deprived the Complainant of the services of neurosurgeon in the entire surgery right from the beginning.

(iv) After failing thus miserably in the pre-operative stage, there was negligence in the operative stage too. Although the surgery was admittedly to know about the pathology of the tumour, almost the entire tumour seems to have been excised before knowing its pathology as a benign Schwannoma. We had earlier noted that some Schwannoma form dumbbell extensions through the inter-vertebral foramen, and there is admission by OP2 that he noticed extension into intervertebral foramen. Although the practical significance of distribution of nerves in Schwannoma which enabled its removal without transaction of nerves was admitted, yet two inter-costal vessels were sacrificed in the surgery.

(v) We have already noted that the case records were not produced by Ops

until they were again directed to do so through our Order dated 25.4.97. Thus, the medical expert who was examined in 1994 had based his views on discharge summary, evening special clinic record, pre-operative X-rays and CT Scan reports, post-operative X-rays, CT Scan and MRI. The case records containing the copy of discharge record which varied from the original discharge record, the OPD morning clinical record, the operation notes, the histopathology report were submitted by the OPs only after April, 1997 and these records contained vital information regarding erosion of vertebra and extension of tumour into intervertebral foramen etc. There is force in the Complainant's allegation that there was suppression of vital information and only half information made available to the medical expert witness which allegation has not been rebutted by the Ops. Thus, the medical witness's deposition is to be deemed to have been based on incomplete data.

(vi) It is also found that the operating surgeon OP2 and the neurosurgeon OP3 who joined at the end of the surgery left the theatre without meeting the anxious parents waiting outside the operation theatre from 9 A.M. to 12.45 P.M. and without appraising them about the removal of tumour and the rib, the pathological nature of the tumour for which

purpose the surgery was done etc. The parents came to know from another attending doctor in the T.R.R. at about 6 p.m., that day who reported that the Complainant had come out of anaesthesia but that he has got paraplegic. It was left to the shell-shocked father of the Complainant to collect OP2 and OP3 to know about the developments and the condition of the patient; in effect, the parents could meet these Ops only at about 10 P.M. that day. One gets the impression that had these Ops know known about the onset of paraplegia in the operation theatre itself as they contended, they could have normally come out of the operation theatre, met the parents and relatives and reported about the outcome of the surgery. It is difficult to brush aside the feeling that as senior surgeons and faculty members they would have not comprehended the serious outcome of the operation which is perhaps why they left without meeting the parents.

(vii) OP1 as an institution failed to carry out its statutory function of exchanging opinion on the case with sister institutions in India and abroad for post operative management to retrieve the patient from the damage to the extent possible.

In the light of aforesaid, we hold that there was negligence on the part of OP1, OP2, OP3,OP4 and OP5 and deficiency of service to the Complainant – patient.

Since OP6 is already represented through OP1 (according to notification establishing the institute), we do not consider it necessary to bring OP6 separately under the purview of the Complainant. In the result, OP1 to OP5 are liable to pay the compensation as determined hereunder. Since, however, OP1 is the institution in which OP2 to OP5 are employed, we hold that OP1 is singularly responsible for payment of compensation. In the written submissions filed after arguments were concluded, Ops have observed that should the Commission decide to award any compensation, they reserve the right of making further observations. We are of the opinion that OPs were at liberty to make whatever submissions they wanted to make on the point of quantum of compensation during the arguments stage itself; at that stage. Ops only stated that the claim was exaggerated and ill founded. In their written submissions, Ops have also informed that NIMS as medical institution during the period in question is covered by a medical insurance policy to a tune of Rs.10 lakhs for the period 25.5.90 to 24.5.91 with the United India Insurance Company, Hyderabad, the maximum liability being Rs.10 lakhs subject to one claim out of any one event of Rs.5 lakhs.

The complainant has claimed compensation for i) present burden of medical expenses, ii) prospective burden of expenses, iii) loss of future earnings, iv) pain, suffering, loss of amenities and

enjoyment of life and shortening of life expectancy and v) damages / compensation for father, mother, brother and maternal uncle. The complainant claimed for medical expenses on hospital and related charges; Complainant's father was an employee of BHEL at the relevant time and these would be reimbursed by them. We do not propose to interfere in such an arrangement. Complainant has claimed for future burden of expenses including physiotheraphy, nursing, washer woman, aya etc. We feel that the items mentioned under this category such as regular dressing material, bags and tape for urine drainage, cotton rolls for defeacation, material for loin clean up and treatment, dressing, nursing services including cleaning, giving bath, bed sores etc. physiotheraphy and extra nourishment are necessary and allowable. The Complainant has estimated the future burden of expenses for a period of 50 years. It may be mentioned here that the neurosurgeon from Bombay, Dr. Sanghal, a Specialist in Spinal Cord who examined the Complainant – patient, opined that the damage was severe but that there was some chance of at least partial recovery because the patient is young. Although the complainant's parent mentioned there has been no iota of improvement, yet there appears to be hope for some betterment with a proper rehabilitation plan. Regarding the compensation claimed on account of loss of future earnings, we realize that the incident has severely affected the career of the

complainant which, as seen from his academic record prior to the operation, would have been a good one otherwise. We also perceive the anxiety, agony and distress of the parents on the condition of the Complainant consequent to the operation. It is stated in the complaint that the Complainant's mother had to give up her teaching job in a school so as to look after the Complainant who is totally bred-ridden and requires round the clock assistance and attention. It has also been stated that Complainant's brother was mentally upset which affected his performance in his examination and resulted in securing admission in a college by paying huge fee. Further, the Complainant's maternal uncle had to supplement the physical efforts of his parents in attending on the complainant and also bring food to the hospital even on curfew-bound days with great difficulty. In short, the entire family was put in a disarray.

While determining the compensation to the Complainant as also to his parents, we have kept in view the broad parameters followed by us in an earlier case of medical negligence (Original Petition No.292 of 1994, Harjot Ahluwalia (Minor) vs. Spring Meadows Hospital & Anr.) { II (1997) CPJ 98 (NC)} which was upheld by the Hon'ble Supreme Court of India { Civil Appeal No.7708 of 1997 with Civil Appeal No.7858 of 1997 { I (1998) CPJ 1 (SC)}. The Apex Court in their judgment while upholding our order have also dealt with the question of

compensation to be awarded in favour of the parents of the minor child for their acute mental agony and life long care and attention on the minor child. In the aforesaid case the Apex Court held that the parents of the child having hired the services of the hospital, are also the consumers within the meaning of section 2 (1)(d)(ii) and that they would also be entitled to award of compensation due to negligence of the Ops to the Complainant. A similar situation has arisen in the case on hand where the complainant had been given financial support by the parents for hospitalization and associated expenses; although an adult he has to be given physical support for a very long period by the parents in view of his physical immobilization and sensory deficit consequent to the surgery. As for the claim for the Complainant's brother and maternal uncle, the same cannot be sustained, as they are not covered by the definition of "Consumer" under the Act.

We are of the view that the facts and circumstances of the case justify (i) the award to the Complainant of an amount of (a) Rs.8 lakhs (expected to yield a monthly interest of about Rs.8,000/-) towards prospective charges for physiotheraphy, nursing and associated expenses, (b) Rs.4 lakhs (expected to yield a monthly interest of about Rs.4,000/-) for supplementing the complainant's future earnings and (c) Rs.2 lakhs as compensation for his mental agony, physical suffering and pain and also for physiotheraphy, nursing and associated

> expenses already incurred by him and ii) award of compensation of Rs.1.5 lakhs to the parents for their perpetual mental agony, stress and depression and for the continued support, care and attention they have to provide to the complainant and for the income loss of the mother due to dislocation in her job to look after her son. We, therefore, direct OP1 to pay a total compensation of Rs.14 lakhs to the complainant and compensation of Rs.1.5 lakhs to the complainant's parents jointly, within a period of 2 months from the date of receipts of this order failing which interest at the rate of 15 per cent per annum shall become payable by OP1 until the date of payment. We also impose costs of Rs.25,000/- on OP1. Complaint is allowed."

7. We may, at this stage observe, that the complainant's plea that no consent for the excision of the tumour had been taken was rejected holding that prior 'implied' consent had indeed been taken.

8. Two appeals have been filed in this Court against the order of the Commission; Civil Appeal No.4119 of 1999 by NIMS disowning any liability and Civil Appeal No.3126 of 2000 by the complainant Prasanth S. Dhananka asking for an enhancement of the compensation. Both these matters are being disposed of by this judgment.

9. Mr. Prasanth Dhanaka, the appellant in Civil Appeal No. 3126/2000 and the respondent No.1 in C.A. No.4119/1999 has supported the finding of the Commission on the question of negligence, but has, in addition, challenged the observation of the Commission that the implied consent of the complainant and his parents had been taken for the excision of the tumour. He has, however, primarily pleaded that the compensation given by the Commission was inadequate and not commensurate with the damage and agony that he and his family had undergone and which had cut short the promising and lucrative career which lay ahead for him.

10. Mr. Anil Kumar Tandale, the learned counsel appearing for the NIMS, the appellant in C.A.No.4119/1999 has, however, challenged the entire basis of the findings recorded by the Commission both on the question of negligence and on the quantum of compensation. It has been pleaded that all requisite procedures had been adopted before, during and after the operation and in this view of the matter, there was no negligence on the part of any doctor. He has also pleaded that the quantum of

compensation claimed by the complainant on the basis of the calculations submitted before this Court in the form of a separate Paper Book was wholly unjustified, and that, if at all, any compensation had to be awarded, it had to be under the multiplier method, a procedure which had been adopted in several decisions of this Court.

11. As the primary issue at this stage would be the negligence or otherwise of the Doctors of NIMS we have extensively heard the parties on this question keeping in mind that the present proceedings are in the nature of a first appeal from the orders of the Commission. In this background, we have examined the three issues raised before us (closely interlinked as they are) under the three broad parameters adopted by the Commission, the alleged negligence before, during and after the operation.

12. The first stage would be that of diagnosis. As already observed above, we have carefully and independently evaluated the findings of negligence arrived at by the Commission. The main plea of the complainant is that the pre-operation examinations had revealed a situation which

required the intervention of a Neuro Surgeon. The case of Dr. Satyanarayana, however, is that the involvement of the vertebral column had been revealed only after the removal of the tumour. We find this assertion to be incorrect. It may be mentioned that the operation had been performed on 23rd October 1990 but in the pre-operative discharge record dated 19th September 1990 (Annexure P-29) there is a reference to a mass lesion in the left upper chest with erosion of ribs and vertebrae and no masses anywhere else. This document has to be read in conjunction with Annexure P-27, a discharge record dated 19th May 1991 wherein it was specifically recorded that during the operation on 23rd October 1990 a huge tumour had been noticed in the left hemithorax with the second and third ribs eroded and that the vertebral body was eroded and the tumour mass along with extensions into chest wall and the fourth rib were all excised. These two documents when read together belie Dr. Satyanarayana's statement in his cross-examination that the erosion had been revealed for the first time after the tumour had been removed. It has

been the positive case of the complainant that had an MRI or Myclography test been carried out, the possibility that the surgery was not required could have been revealed. The complainant has referred us to an Article "Diagnosis and Treatment Options for Neurofibromas"- published by Robert R. Chase, M.D., Stephen Bosacco, M.D., Richard Levenberg, M.D., three eminent Doctors in which it has been observed as under:

> "Spinal neurofibromas may mimic intraspinal neoplasms. Dural ectasia creates bony changes, including foraminal widening, vertebral body scalloping and pedicle thinning. In addition, neurofibromas may be associated with intrathoracic meningoceles, spondylolosthesis, scoliosis, and kyphosis. On plain films, bony changes may be evident, i.e. scalloping or foraminal enlargement. Computerized axial imaging will reveal bony changes, in addition to the mass representing the neurofibroma. MRI will provide further delineation of the soft tissue and mass. Myclography can demonstrate the nerve roots or cord level in question."

13. Similar observations have been made in "Principles of Surgery" Sixth Edition by Seymour I. Schwartz, M.D. in

which it has been observed that a MRI is a noninvasive diagnostic modality, especially for vascular lesions and that in addition Myclography may be required to confirm intraspinal findings. It is also clear from the document P-30, a letter addressed by Doctor D. Raja Reddy, Director of NIMS to the Director General, Military Hospital, Paraplegia Special Care Centre, Poona that "the patient Mr. Prashant had plexiform Neurofibroma of the Posterior Mediastinum with intra spinal extension. Following Mediastinal tumour excision he developed Paraplegia. I thought he should benefit from the intensive Physiotherapy care that your institute offers for such patients". Undoubtedly, it is clear from this document it transpires that after the removal of the tumour, the intra spinal extension had been revealed but the complainant's seems to be correct in saying that had a MRI or Myclography been performed, the intraspinal extension could well have been revealed at the pre-operative stage which could have led to the intervention of a Neuro Surgeon at the time of removal of the tumour and the paraplegia perhaps avoided.

14. Mr. Tandale has, however, in his written submissions, raised additional pleas, (which had not been argued by him during the course of the hearing), and has also referred us to some texts which too had not been referred to by him. He has submitted that the decision to recommend a thoractomy despite the fact that FNAC had not disclosed any lesion was only a tentative opinion and not conclusive and that the final opinion was only made available during the operation which had revealed the extent of the tumour. The learned counsel has placed reliance on Chapter 34 titled "Chest Wall Tumours" in "Glenn's Thoracic and Cardiovascular Surgery" (Ed. Arthur E. Baue, et al), Sixth Edition, Volume –II, to submit that needle biopsies could miss a Neurofibroma, so excisional biopsy (as in this case) should be resorted to. The relevant passage reads thus:

> "Neurofibromas can occur as an isolated lesion, but usually these tumours are multiple and are associated with von Recklinahausen's multiple neurofibromatosis. Although most lesions are benign, malignant degeneration can occur. When new symptoms appear – an enlarging mass or pain – excision is recommended. *Needle biopsy may miss*

> *the significant spot, so excisional biopsy should be done*. When these tumours occur near the vertebral body, the presence of a "dumbbell" tumour with extension into the spinal canal must be documented by CT or MRI scan. If present, neurological consultation is needed for combined resection."
> (Emphasis supplied)

15. These observations do undoubtedly justify an excision biopsy but equally support the case of the complainant inasmuch that his case too was that had an MRI been performed, the extent of the tumour and its extension into the spinal cord would have been revealed. We have, therefore, no hesitation in holding that the complete investigations prior to the actual operation had not been carried out.

16. Allied to this finding is the question as to whether the required consent for the excision of the tumour had been taken from the complainant or his parents. The Commission has noted that some discussion between the complainant, his parents and Dr. Satyanarayana had taken place in the OPD and the possibility of deferring the operation had been mooted but notwithstanding this discussion, the complainant had been admitted to hospital on the 19th October, 1990 and

operated upon on 23rd October 1990. The Commission has observed that as blood had been donated by the relatives of the complainant, it was likely that they had the information that a surgery was planned, as they were educated and enlightened persons. The Commission has, accordingly, held on the basis of the evidence of Dr. Satyanarayana "that once the consent for excision biopsy through thoractomy was given, the consent for a moment (sic) (removal?) of the mass was implied."

17. We see from the cross examination of the complainant that no consent for the operation had been taken. Moreover, it is significant that even though the record of the case had been produced before the Commission, it was with some reluctance and after several specific orders, but the written consent which had allegedly been taken is not a part of the record. It is equally significant that in the written submissions which had been filed, a copy of the consent form of NIMS has been appended but not the actual consent taken from the complainant. It must, therefore, be held that the withholding of the aforesaid document raises a presumption against the

NIMS and the attending Doctors. We find that the consent given by the complainant for the excision biopsy cannot, by inference, be taken as an implied consent for a surgery (save in exceptional cases), as held by this Court in **Samira Kohli vs. Dr. Prabha Manchanda & Anr.** (2008) 2 SCC 1. The two issues which are relevant for our purpose and raised before the Bench were:

> (i) Whether informed consent of a patient is necessary for surgical procedure involving removal of reproductive organs? If so, what is the nature of such consent?
>
> (ii) When a patient consults a medical practitioner, whether consent given for diagnostic surgery can be construed as consent for performing additional or further surgical procedure – either as conservative treatment or as radical treatment – without the specific consent for such additional or further surgery?

These two questions were answered in the following terms:

> "Consent in the context of a doctor-patient relationship, means the grant of permission by the patient for an act to be carried out by the doctor, such as a diagnostic, surgical or therapeutic procedure. Consent can be implied in some circumstances from the action of the patient. For example, when a patient

enters a dentist's clinic and sits in the dental chair, his consent is implied for examination, diagnosis and consultation. Except where consent can be clearly and obviously implied, there should be express consent. There is, however, a significant difference in the nature of express consent of the patient, known as "real consent" in UK and as "informed consent" in America. In UK, the elements of consent are defined with reference to the patient and a consent is considered to be valid and "real" when (i) the patient gives it voluntarily without any coercion; (ii) the patient has the capacity and competence to give consent; and (iii) the patient has the minimum of adequate level of information about the nature of the procedure to which he is consenting to. On the other hand, the concept of "informed consent" developed by American courts, while retaining the basic requirements of consent, shifts the emphasis on the doctor's duty to disclose the necessary information to the patient to secure his consent. "Informed consent" is defined in *Taber's Cyclopedic Medical Dictionary* thus:

> *"Consent that is given by a person after receipt of the following information: the nature and purpose of the proposed procedure or treatment; the expected outcome and the likelihood of success; the risks; the alternatives to the procedure and supporting information regarding those alternatives; and the effect of no treatment or procedure, including the effect on the prognosis and the material risks associated with no treatment. Also included are*

> *instructions concerning what should be done if the procedure turns out to be harmful or unsuccessful."*

The next question is whether in an action for negligence/battery for performance of an unauthorized surgical procedure, the doctor can put forth as defence the consent given for a particular operative procedure, as consent for any additional or further operative procedures performed in the interests of the patient. In *Murrary v. McMurchy* (1949) 2 DLR 442: (1949)1 WWR 989, the Supreme Court of British Columbia, Canada, was considering a claim for battery by a patient who underwent a caesarean section. During the course of caesarean section, the doctor found fibroid tumours in the patient's uterus. Being of the view that such tumours would be a danger in case of future pregnancy, he performed a sterilization operation. The Court upheld the claim for damages for battery. It held that sterilization could not be justified under the principles of necessity, as there was no immediate threat or danger to the patient's health or life and it would not have been unreasonable to postpone the operation to secure the patient's consent. The fact that the doctor found it convenient to perform the sterilization operation without consent as the patient was already under general anaesthesia, was held to be not a valid defence. A somewhat similar view was expressed by the Court of Appeal in England in *F., In re*, (1933) 3DLR 260: 60 CCC 136. It was held that the additional or further treatment

> which can be given (outside the consented procedure) should be confined to only such treatment as is necessary to meet the emergency, and as such needs to be carried out at once and before the patient is likely to be in a position to make a decision for himself. Lord Goff observed (All ER p.566*g-j*)
>
> > "…Where, for example, a surgeon performs an operation without his consent on a patient temporarily rendered unconscious in an accident, he should do no more than is reasonably required, in the best interests of the patient, before he recovers consciousness. I can see no practical difficulty arising from this requirement, which derives from the fact that the patient is expected before long to regain consciousness and can then be consulted about longer term measures."

18. The Court also considered the possibility that had the patient been conscious during surgery and in a position to give his consent, he might have done so to avoid a second surgery but observed that this was a non-issue as the patient's right to decide whether he should undergo surgery was inviolable. This is what the Court had to say:

> "It is quite possible that had the patient been conscious, and informed

> about the need for the additional procedure, the patient might have agreed to it. It may be that the additional procedure is beneficial and in the interests of the patient. It may be that postponement of the additional procedure (say removal of an organ) may require another surgery, whereas removal of the affected organ during the initial diagnostic or exploratory surgery, would save the patient from the pain and cost of a second operation. Howsoever practical or convenient the reasons may be, they are not relevant. What is relevant and of importance is the inviolable nature of the patient's right in regard to his body and his right to decide whether he should undergo the particular treatment or surgery or not. Therefore at the risk of repetition, we may add that unless the unauthorized additional or further procedure is necessary in order to save the life or preserve the health of the patient and it would be unreasonable (as contrasted from being merely inconvenient) to delay the further procedure until the patient regains consciousness and takes a decision, a doctor cannot perform such procedure without the consent of the patient."

19. It is clear from the evidence in the case before us that there was no urgency in the matter as the record shows that discussions for the deferment of the proposed excision biopsy had taken place between the complainant, his parents and Dr.

Satyanarayana in the OPD and the consent for the procedure had been obtained. Also in the light of the observations in the cited cases, any implied consent for the excision of the tumour cannot be inferred.

20. The broad principles under which medical negligence as a tort have to be evaluated, have been laid down in the celebrated case of **Jacob Mathew vs. State of Punjab & Anr. (2005) 6 SCC 1**. In this judgment, it has been observed that the complexity of the human body, and the uncertainty involved in medical procedures is of such great magnitude that it is impossible for a doctor to guarantee a successful result and the only assurance that he "can give or can be understood to have given by implication is that he is possessed of the requisite skill in that branch of profession which he is practicing and while undertaking the performance of the task entrusted to him he would be exercising his skill with reasonable competence." The Bench also approved the opinion of McNair,J in *(Bolam v. Friern Hospital Management Committee (1957) 2 All ER 118 (QBD)*, in the following words:

> "[W]here you get a situation which involves the use of some special skill or competence, then the test as to whether there has been negligence because has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill … It is well-established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art." *(Charlesworth & Percy, ibid.*, para 8.02)

The Bench finally concluded its opinion as follows:

> "We sum up our conclusions as under:
>
> > (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. The definition of negligence as given in *Law of Torts*, Ratanlal & Dhirajlal (edited by Justice G.P. Singh), referred to hereinabove, holds good. Negligence becomes actionable on account of injury resulting from the act or omission amounting to negligence attributable to the person sued. The essential components of negligence are three: "duty", "breach" and "resulting damage".

(2) Negligence in the context of the 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. Similarly, when the charge of negligence arises out of failure to use some particular equipment, the charge would fail if the

equipment was not generally available at that particular time (that is, the time of the incident) at which it is suggested it should have been used.

(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 Bolam case *(1957) 2 All ER 118 (QBD)*holds good in its applicability in India.

21. The observations in the aforesaid case were reiterated in **State of Punjab vs. Shiv Ram & Ors. (2005) 7 SCC 1**. In this case, a suit had been filed against State of Punjab and a lady doctor, a State Government employee, claiming damages for a failed tubectomy as the woman conceived and gave birth to a child notwithstanding the procedure. The suit was decreed against the State Government. This is what this Court had to say while allowing the appeal:

> "The plaintiffs have not alleged that the lady surgeon who performed the sterilization operation was not competent to perform the surgery and yet ventured into doing it. It is neither the case of the plaintiffs, nor has any finding been arrived at by any of the courts below that the lady surgeon was negligent in performing the surgery. The present one is not a case where the surgeon who performed the surgery has committed breach of any duty cast on her as a surgeon. The surgery was performed by a technique known and recognized by medical science. It is a pure and simple case of sterilization operation having failed though duly performed. The learned Additional Advocate General has also very fairly not disputed the vicarious liability of the State, if only its employee doctor is found to have performed the

> surgery negligently and if the unwanted pregnancy thereafter is attributable to such negligent act or omission on the part of the employee doctor of the State."

22. The Court further held forth a caution that if doctors were frequently called upon to answer charges having criminal and civil consequences, it would frustrate and render ineffective the functioning of the medical profession as a whole and if the medical profession was "hemmed by threat of action, criminal and civil, the consequence will be a loss to the patients…….. and no doctor would take a risk, a justifiable risk in the circumstances of a given case, and try to save his patient from a complicated disease or in the face of an unexpected problem that confronts him during the treatment or the surgery."

23. The evidence in the present case has to be evaluated in the background of the above observations. It is clear that a mere misjudgment or error in medical treatment by itself would not be decisive of negligence towards the patient and the knowledge of medical practice and procedure available at the time of the operation and not at the date of trial, is

relevant. It is also evident that a doctor rendering treatment to a patient is expected to have reasonable competence in his field. (Bolam's principle). It is the case of the complainant that it is the lack of care and caution and the neglect on the part of the attending doctors, and Dr. Satyanarayana in particular, to make the necessary pre-operative investigations that had led to the complications at the time of the operation and thereafter.

24. We now come to the allegation with regard to the negligence shown at the stage of the operation itself. The record shows that the tumour 4x4 cm in dimension was located on the left upper chest side of the thorax and there had been erosion of the 2nd, 3rd and 4th ribs. The discharge record pertaining to the operation also reveals that there was a one cm size opening in the vertebral body exposing the spinal cord at the thorax level and that the tumour had been excised along with the 4th rib. The record also shows that the tumour was not only confined to the thorax but had extended into the posterior mediastinal column as well, showing that it had some connection with the spinal cord. It is in this background

that the complainant has argued that whereas a cardio – thoracic Surgeon was undoubtedly competent to perform the surgery for the excision of the tumour but as the tumour had extended into the posterior mediastinal column containing inter-costal blood vessels and nerves, the involvement of a Neuro Surgeon was essential and as this procedure had not been adopted a case of negligence or indifference on the part of the attending doctors had been proved. It has also been highlighted time and again that the information that the 2nd, 3rd and in particular 4th ribs had eroded was available with the doctors long before the operation and thus the fact the tumour had extended into the mediastinal column was a clear possibility. In answer to the aforesaid allegations, it has been submitted that as the CT scan and X-ray had shown a lesion in the thorax with the erosion of the ribs and as no involvement of the vertebral column had been revealed, and further that the fact the tumour had penetrated into the vertebral body had been noticed only after the tumour mass had been excised, the involvement of a neuro surgeon was not called for. In the written submissions filed on behalf of Dr.

Satyanarayana, it has been pointed out that when it was noticed that there was some involvement of the vertebral body, Professor I Dinaker a Consultant Neuro Surgeon had been requested to join the operating team in the operation theatre and on examination he had found that no further intervention as per his specialty was required.

25. We have considered the opposing submissions very carefully. It appears to us that Dr. Satyanarayana's evidence shows a great measure of negligence in the operation. In his affidavit, he has stated that if it had been found that the tumour had penetrated into the spinal column the patient would have been referred to a Neuro Surgeon as well. To our mind, this statement itself when read with the incomplete diagnostic procedures that had been adopted, show that had the necessary tests been performed, the fact that the tumour had penetrated into the vertebral column, would have been revealed. Dr. Satyanarayana further goes on to say that it was not a case of interference with the spinal cord and in justification he has stated that after operation of the tumour had been removed Professor I. Dinaker, had been called in and

on examination he had noticed only a bony erosion and no involvement of the spinal cord. We are of the opinion that this half-baked diagnosis at the stage of the operation only after the excision of the tumour does no credit to the Doctor. It is also significant that the operation record dated 23rd October, 1990 shows that the tumour mass had extended into the inter-vertebral foramen and that there was an opening one cm in size in the vertebral body exposing the spinal cord. In this connection the complainant has placed reliance on an Article titled "Central Neurogenic Tumours of the Thoracis Region" by Farid M. Shamji, M.D., FRCSC, Thomas R. Todd, MD, FRCSC, Eric Vallieres, MDFRCSC, Harold J. Sachs, MD FRCSC, Brien G. Benoit, MD FRCSC. wherein it has been observed as under:

> "Thoracic neurogenic tumours differentiate from the neuroepithelium that originates in the neural crest during the development of the peripheral nervous system. Most of the peripheral nervous tissue in the thorox is situated in the posterior mediastinum in the paravertebral gutters. Consequently, this is the commonest location for the majority of intrathoracic neurogenic tumours – at the site of the sympathetic

chain and in the path of the spinal and intercostals nerves.

The histologic type of neurogenic tumour is less important to the thoracic surgeon than the anatomical relationship of the tumour to other posterior mediastinal structures and, in particular, to the intervertebral foramen. The possibility of intraspinal extension through the foramina is the single most important factor affecting surgical intervention.

We present our experience, albeit small, because it outlines the importance of thorough anatomic assessment of these tumours. It stresses the involvement of the neurosurgeon in the assessment, decision making and surgical intervention."

and

"Patients with neurogenic tumours arising in the thorax should undergo early surgical exploration and complete resection of the tumour if possible. Arising within the confines of the narrow thoracic spinal canal or the intervertebral foramen, these lesions may become symptomatic quite early on, with spinal-cord compression or segmental radicular pain caused by early spinal-nerve involvement. Neurosurgical consultation is a prerequisite for safe removal of these tumours when the intervertebral foramina are traversed. Fortunately, most

intrathoracic neurogenic tumours are small, benign, unilateral,extrapleural. The diagnosis can often be established readily with current diagnostic imaging techniques, and the tumour can be removed safely with adequate exposure through a posterolateral thoracotomy. When the thoracic surgeon suspects preoperatively that the tumour has an intraspinal extension, the neurosurgeon should be consulted before exploration is considered. Indeed, in all patients who have a lesion adjacent to the inter-vertebral foramen, a neurosurgical consultation should be obtained. In these circumstances, the patient's spinal cord is at considerable risk of permanent damage from ill-advised surgical manoeuvres. The procedures that should not be attempted without intraoperative assistance of a neurosurgeon include enlarging the intervertebral foramen (foraminectomy), application of undue traction on the tumour during dissection, tamponading the bleeding vessels in the foramen when hemorrhage is difficult to control and partial removal of the tumour. Consequently, it is of utmost importance that all neurogenic tumours arising in the posterior location be studied very carefully with special reference to the intervertebral foramen and possible intraspinal extension. The value of computed tomography and magnetic resonance imaging has been well established. Prior knowledge of a dumbbell tumour or of a predominantly intrathoracic tumour with foraminal extension dictates a combined thoracic-

neurosurgical procedure. The approach consists of a standard posteroloteral thoracotomy and laminectomy. Dural defects should be closed meticulously to prevent the development of a subarachnoid-pleural fistula and possible meningitis.

Controversy exists over the urgency of excising neurogenic tumours in the posterior mediastinum. Those that are lateral to the costovertebral gutter may be managed conservately with surgery reserved for when enlargement occurs. For the more centrally located tumours such as those presented here, we advise surgical intervention for the following reasons:

An increase in the size of the tumour mass, which may increase the risk or difficulty of surgery from osseous erosion or intraspinal extension.

The possibility of malignancy must be taken into account, realizing that most neurogenic tumours are benign (overall rate of malignancy ranging from 3% to 19%). Furthermore, the possibility of malignant degeneration should be borne in mind, and it is difficult to find exact data on this point in the literature.

The risk of permanent damage to the spinal cord from compression due to intraspinal tumour or intraspinal extension from an intrathoracic lesion. Nearly 10% of neurogenic tumours of the posterior mediastinum extend into the

spinal canal through the intervetebral foramen; neurologic sumptoms indicating intraspinal extension occur in about 60% of dumbbell tumours, therefore the dual location should always be considered and defined preoperatively.

Conclusions

Careful evaluation and surgical resection of benign neurogenic tumours of the thorax result in a low morbidity and excellent long-term results. Collaboration between thoracic surgeons and neurosurgeons is recommended. For malignant lesions, if resection is incomplete, further treatment in the form of radiotherapy or chemotherapy should be instituted."

Likewise, in another Article "The Principles of Surgical Management in Dumbbell Tumours" by Yuksel M, et al, it has been stated:-

"**METHODS**: In all patients that have been operated in our clinic during 1992-93, we preferred one stage removal described by Akwari that consists of posterior laminectomy by neurosurgical team to free the tumour within the spinal cord followed by a posterolateral thoracotomy and excision of the tumour by thoracic surgeons in the same setting. **RESULTS**: All three patients are alive and

free of symptoms after 23, 16 and 13 months respectively. According to the pathological examinations of the specimens in the three patients, the exact diagnosis were reported as neurofibroma, paraganglioma and pheochromocytoma respectively. **CONCLUSIONS:** In recent reports, a combined surgical approach is recommended for dumb-bell neurogenic tumours in posterior mediastinum. We also recommend a combined and one stage removal of dumb-bell neurogenic tumours if possible. A team-work of thoracic and neurosurgeon will minimize the morbidity and mortality after the surgical procedure, as well as giving the opportunity to remove the tumour totally in one session,"

Likewise in "Dumbbell neurogenic tumours of the mediastinum, Diagnosis and Management" by Akwari OE, ct al, it has been stated:-

"Among 706 collected cases of mediastinal neurogenic tumous were 69 patients (9.8%) with extension through an intervertebral foramen, so that the composite neoplastic mass was dumbbell-shaped. Although only 10% f these dumbbell tumours were malignant, the majority of the patients presented with neurologic symptoms of spinal cord compression. In about 40% of reported cases, the intraspinal component, although present, was not clinically apparent. Such cases of asymptomatic intraspinal extension should be suspected when special roentgenologic

views of the spine demonstrate erosion of the vertebral pedicle or enlargement of the intervertebral foramen adjancent to the posterior mediastinal mass. Workup of these patients should include myelographic studies to determine whether a dumbbell tumour is indeed present; if it is, surgery should be carried out by a team of thoracic surgeons and neurosurgeons in a one stage combined resection of both the intraspinal and the mediastinal component of the tumour. With early diagnosis and surgical intervention, long term survival is the rule. When the patient is in the pediatric age bracket, an orthopedic surgeon should be included on the team to help minimize subsequent skeletal growth deformity."

In "Combined Laminectomy and Thoracoscopic Resection of Dumbell Neurofibrema: Technical Case Report" by Citow is, et al, the authors have observed:-

"We describe combined laminectomy and thoracoscopic surgery for removal of a dumbbell thoracic spinal tumour to demonstrate the feasibility of such an approach. **CLINICAL PRESENTATION**: We present the case of a 29-year-old man who developed chest pain and spinal cord compression from a thoracic dumbbell neurofibroma. **TECHNIQUE**: Surgical approaches for benign nerve sheath tumours that extend from the spinal cord into the thoracic cavity include combined

> laminectomy and thoracotomy either in one or two stages, or a lateral extracavitary approach involving laminectomy, facetectomy, and rib resection in a single stage. We performed a combination laminectomy and thoracoscopic tumour resection in a single stage with good results."

A reading of all three texts pointedly refer to the fact that in a case of a tumour in the posterior mediastinal, the possibility of the extension of the tumour into the foramen and the vertebral column must be kept in mind and a neuro surgeon must be associated with the diagnosis and the actual operation.

26. Mr. Tandale, the learned counsel for the NIMS has, however, raised certain issues before us in his written submissions. He has pointed out that a FNAC performed on a neurofibroma was often indeterminate and an excision biopsy was called for and this is precisely the procedure that had planned on the crucial day. In this connection, he has relied on several texts including Glenn's Thoracic and Cardiovascular Surgery, Sixth Edition, Volume II (supra) and Harrison's General Principles of Internal Medicine 11th Edition,

Chapter 214 titled Diseases of the Pleura, Mediastinum and Diaphragm, at pages 1127 and 1128 and in particular the following passages :

> "Neurogenic tumors are the most common primary mediastinal neoplasms and are found almost exclusively in the posterior mediatenum near the paravertebral gutter. The majority of these tumours are benign, Neurofibromas, Schwanomas, ganglionomas are the commonest tumors see,(page 1128).
>
> The Mediastinum occupies the central portion of the chest and is anatomically defined by the thoracic inlet above the diaphragm below, the mediastinal pleura laterally, the paravertebral gutter posteriorly, and the sternum aneteiorly. The Mediastinum is divided into four compartments for descriptive purposes (fig.214-2). The superior Mediastinum is bounded above by the plane of the first rib and below by an imaginary line drawn anterioposteriorly from the sternal angle to the lower edge of the fourth thoracic vertebra. It contains the trachea, upper esophagus, thymus gland, thoracic duct, great veins, arch of the aorta and its branches, and the phrenic, vagus, and left recurrent laryngeal nerves. Below the superior Mediastinum lie three further compartments. The anterior Mediastinum contains fibroareolar tissue and lymph nodes, but no major structures. The middle Mediastinum contains the heart, ascending aorta, great venis, pulmonary artery, and pleuric nerves. <u>The posterior Mediastinum contains the esophagus, thoracic</u>

duct, descending aorta, symphathetic chain, and intercostals and vagal nerves(Page 1127).

27. He has also referred us to the cross examination of Dr. A.S. Hegde, the expert witness examined at the instance of the complainant that there was nothing wrong in the procedure adopted by Dr. Satyanarayana even after he had seen the tumour in the chest cavity. We are of the opinion that the very portions that have been relied upon by Mr. Tandale in fact support the argument that has been raised by the complainant that the Neurofibromas which are Neurogenic tumours were to be found exclusively in the posterior mediastinal near the paravertebral gutter, and that the tumor had extended into the vertebral column was therefore a possibility. We also see from the statement of Dr. A.S. Hegde that Ischemic Myleopathy which had resulted in Paraplegia was on account of the cutting off of the blood supply to the spinal cord as a result of the operation to remove the tumor. The cross-examination of Dr. A.S. Hegde, cannot therefore, be looked at in isolation. It must, therefore, be concluded that the attending doctors were seriously remiss in not associating a

neuro-surgeon at the pre-operative as well as at the stage of the operation.

28. It has also been submitted that in the face of complicated questions of fact involving medical procedures, it was inappropriate for the Commission to have entered into the dispute and that the matter ought to have been relegated to the civil court. Mr. Tandale in his written submissions has also raised some pleas and levelled allegations which are wholly uncalled for. We reproduce some of these herein under:-

> "As mentioned in the list of events above, after the cross examination of the complainant and his father on 23rd and 24th May 1994, the affidavits of examination in chief of Dr.P.V. Satyanarayana and Dr. U.N.Das were filed on 22.6.1994 about 7 years later, on 16.8.94, the National Commission directed the complainant to file an application for examination of expert medical witness. Thereafter Dr.A.S. Hegde was examined as PW3 on 23.12.94.
>
> This sequence would be sufficient to indicate that the National Commission had already reached a decision to award compensation to the complainant; hence

it intended to secure support to its already reached conclusions.

Such an approach is unheard of in judicial adjudications. The complainant was represented by a designated Senior Advocate as seen from the title page of the judgment under appeal. The complainant therefore did not need any legal advice from the Commission. The institute was denied equal and even treatment.

The cross examination of Dr.P.V. Satyanarayana and Dr.U.N.Das was recorded on 20.05.1996, and thereafter on 25.4.1997, the entire case record of diagnostic, medial and surgical procedures pertaining to the complainant was filed in the National Commission. The arguments were heard on 4.9.1998 and written submissions were filed by the Institute on 5.10.1998.

While appreciating the evidence of Dr. P.V.Satyanarayana and Dr.U.N.Das, the National Commission has referred to (i) Gray's Anatomy, Angiology and Neurology, (ii) Text Book of General Thoracic Surgery by Thomas W. Shields 3rd Edition page 1106, (iii) Annals of Thoracic Surgery Vol. 1995 (59) Division of Thoracic & Cardio-Vascular Surgery & Short Trauma Centre University of Maryland, (iv) Complications of Intra Thoracic Surgery, and (v) King & Smith: Contemporary Imaging Techniques (632), (750-753).

> The National Commission had taken recourse to picking up sentences from the examination in chief as well as of the cross examinations of Dr. P.V. Satyanarayan and Dr.U.N.Das, and compared those fragmented portions with the passages from the above text books and recorded findings of negligence."

29. These submissions have absolutely no merit. This Court in **Dr. J.J.Merchant & Ors. Vs. Shrinath Chaturvedi (2002) 6 SCC 635** while dealing with the argument that the matter should be relegated to the civil court observed:

> "In the present case, there is inordinate delay of about nine years in disposal of complaint. However, if this contention raised by the learned counsel for the appellants is accepted, apart from the fact that it would be unjust, the whole purpose and object of enacting the Consumer Protection Act, 1986 (hereinafter referred to as "the Act") would be frustrated. One of the main objects of the Act is to provide speedy and simple redressal to consumer disputes and for that a quasi-judicial machinery is sought to be set up at the district, State and Central level. These quasi-judicial bodies are required to observe the principles of natural justice and have been empowered to give relief of a specific nature and to award, wherever appropriate, compensation to consumers. Penalties for non-compliance with the

> orders given by the quasi-judicial bodies have also been provided. The object and purpose of enacting the Act is to render simple, inexpensive and speedy remedy to the consumers with complaints against defective goods and deficient services and the benevolent piece of legislation intended to protect a large body of consumers from exploitation would be defeated. Prior to the Act, consumers were required to approach the civil court for securing justice for the wrong done to them and it is a known fact that decision in a suit takes years. Under the Act, consumers are provided with an alternative, efficacious and speedy remedy. As such, the Consumer Forum is an alternative forum established under the Act to discharge the functions of a civil court. Therefore, delay in disposal of the complaint would not be a ground for rejecting the complaint and directing the complainant to approach the civil court."

30. Mr. Tandale has, however, relied on **Indian Medical Assn. vs. V.P.Shantha & Ors. (1995) 6 SCC 651**, and in particular on the following observations:

> It has been urged that proceedings involving negligence in the matter of rendering services by a medical practitioner would raise complicated questions requiring evidence of experts to be recorded and that the procedure which is followed for determination of consumer

disputes under the Act is summary in nature involving trial on the basis of affidavits and is not suitable for determination of complicated questions. It is no doubt true that sometimes complicated questions requiring recording of evidence of experts may arise in a complaint about deficiency in service based on the ground of negligence in rendering medical services by a medical practitioner; but this would not be so in all complaints about deficiency in rendering services by a medical practitioner. There may be cases which do not raise such complicated questions and the deficiency in service may be due to obvious faults which can be easily established such as removal of the wrong limb or the performance of an operation on the wrong patient or giving injection of a drug to which the patient is allergic without looking into the out patient card containing the warning (as in *Chinkeow v. Government of Malaysia* (1967) 1 WLR 813 P.C.) or use of wrong gas during the course of an anesthetic or leaving inside the patient swabs or other items of operating equipment after surgery. One often reads about such incidents in the newspapers. *The issues arising in the complaints in such cases can be speedily disposed of by the procedure that is being followed by the Consumer Disputes Redressal Agencies and there is no reason why complaints regarding deficiency in service in such cases should not be adjudicated by the Agencies under the Act.* In complaints involving complicated issues requiring recording of evidence of

> experts, the complainant can be asked to approach the Civil Court for appropriate relief. Section 3 of the Act which prescribes that the provisions of the Act shall be in addition to and not in derogation of the provisions of any other law for the time being in force, preserves the right of the consumer to approach the Civil Court for necessary relief. We are, therefore, unable to hold that on the ground of composition of the Consumer Disputes Redressal Agencies or on the ground of the procedure which is followed by the said Agencies for determining the issues arising before them, the service rendered by the medical practitioners arc not intended to be included in the expression 'service' as defined in Section 2(1)(o) of the Act.

31. It has been argued that the present case was one which ought to be relegated to the civil court in view of the above observations. We find that a bare reading of the judgment in J.J. Merchant's case itself gives an answer to the question posed. It is significant that the operation had been performed on the 23rd October, 1990 and the complaint filed on 9th April, 1993 and after arguments had been concluded on 4th September 1998 the decision had been rendered on 16th February 1999. As a matter of fact, it appears from the record

that NIMS did not, at any stage, seriously challenge the propriety of the Commission going into the dispute and even consented to the recording of the evidence by the State Commission. It is even more significant that in an affidavit of June 1994 filed on behalf of NIMS, a request had been made that a specialist from AIIMS, New Delhi be called so that the question of negligence, if any, could be properly investigated, but the deponent further stated that he had no objection if the Commission did not propose to follow this procedure. A similar option to name some expert witness or witnesses was given to the complainant who, accordingly, on an application filed on 27th August, 1994 proposed the name of Dr. A.S. Hegde who was examined as a witness. The record also reveals that after arguments had been concluded on 4th September 1998 and two weeks' time had been given to the parties to file written submissions, that an application had been made on 5th October 1998 to summon an expert witness from the AIIMS. This application had been declined. We are, therefore, of the opinion that the remarks about the procedure followed by the National Commission which have been quoted

above, are to say the least uncharitable and uncalled for. The judgment in **Indian Medical Association**'s case (supra), cited by Mr. Tandale, primarily explains the concept of 'service' as defined under the Customer Protection Act and on the contrary, some of the observations made therein support the complainant's case all the way.

32. We are also cognizant of the fact that in a case involving medical negligence, once the initial burden has been discharged by the complainant by making out a case of negligence on the part of the hospital or the doctor concerned, the onus then shifts on to the hospital or to the attending doctors and it is for the hospital to satisfy the Court that there was no lack of care or diligence. In **Savita Garg (Smt.)vs. Director, National Heart Institute (2004) 8 SCC 56** it has been observed as under:

> "Once an allegation is made that the patient was admitted in a particular hospital and evidence is produced to satisfy that he died because of lack of proper care and negligence, then the burden lies on the hospital to justify that there was no negligence on the part of the treating doctor or hospital. Therefore, in any case, the hospital is in a better

> position to disclose what care was taken or what medicine was administered to the patient. It is the duty of the hospital to satisfy that there was no lack of care or diligence. The hospitals are institutions, people expect better and efficient service, if the hospital fails to discharge their duties through their doctors, being employed on job basis or employed on contract basis, it is the hospital which has to justify and not impleading a particular doctor will not absolve the hospital of its responsibilities."

33. In the light of the above facts, we have no option but to hold that the attending doctors were seriously remiss in the conduct of the operation and it was on account of this negligence that the Paraplegia had set in. We accordingly confirm the findings of the Commission on this score as well.

34. The Tribunal has also found that the complainant had to undergo great agony and inconvenience for lack of proper post operative medical care. We, however, see that no specific case has been spelt out on this score and only general observations, stemming from the complications arising out of an operation gone wrong, have been made. We need to say nothing more on this aspect.

35. The question of compensation which has been hotly debated and discussed during the course of arguments, now needs to be dealt with. Before the Commission, the complainant assessed his claim at a little over Rs.4.61 cores. As already observed above, the Commission has thought it fit to award compensation under the following heads:

(a) Rs.8 lakh (expected to yield a monthly interest of about Rs.8,000/-] towards prospective charges for physiotherapy, nursing and associated expenses;

(b) Rs.4 lakh (likewise expected to yield a monthly interest of about Rs.4,000/-) for supplementing the complainant's future earnings, and

(c) Rs.2 lakh as compensation for mental agony, physical suffering and pain and also for physiotherapy, nursing and associated expenses already incurred by him.

36. In addition, a sum of Rs.1.5 lakh has been given as compensation to the complainant's parents for their agony, stress and depression and the future care they may have to bestow on their son. A total sum of Rs.15.5 lakh has,

accordingly been determined payable by NIMS, the appellant before us.

37. The complainant, who has argued his own case, has submitted written submissions now claiming about 7.50 Crores as compensation under various heads. He has, in addition sought a direction that a further sum of Rs. 2 crores be set aside to be used by him should some developments beneficial to him in the medical field take place. Some of the claims are untenable and we have no hesitation in rejecting them. We, however, find that the claim with respect to some of the other items need to be allowed or enhanced in view of the peculiar facts of the case. Concededly, the complainant is a highly qualified individual and is gainfully employed as an IT Engineer and as per his statement earning a sum of Rs.28 Lakh per annum though he is, as of today, about 40 years of age. The very nature of his work requires him to travel to different locations but as he is confined to a wheel chair he is unable to do so on his own. His need for a driver cum attendant is, therefore, made out. The complainant has worked out the compensation under this head presuming his working life to be

upto the age of 65 years. We feel that a period of 30 years from the date of the Award of the Commission i.e. 16th February, 1999, rounded off to Ist March, 1999, would be a reasonable length of time. A sum of Rs.2,000/- per month for a period of 30 years (rounded off from 1st of March 1999) needs to be capitalized. We, accordingly, award a sum of Rs.7.2 Lakh under this head. The complainant has also sought a sum of Rs.49,05,800/- towards nursing care etc. as he is unable to perform even his daily ablutions without assistance. He has computed this figure on the basis of the salary of a Nurse at Rs. 4375/-per month for 600 months. We are of the opinion that the amount as claimed is excessive. We, thus grant Rs.4,000/- per month to the appellant for a period of 30 years making a total sum of Rs.14,40,000/-. The complainant has further sought a sum of Rs.46 Lakhs towards physiotherapy etc. at the rate of Rs.4,000/- per month. We reduce the claim from Rs.4,000/- to Rs.3,000/- per month and award this amount for a period of 30 years making a total sum of Rs.10,80,000/- At this stage, it may be pointed out that some of the medical expenses that had been incurred by the complainant have

already been defrayed by the employer of the complainant's father and we are, therefore, disinclined to grant any compensation for the medical expenses already incurred. However, keeping in view the need for continuous medical aid which would involve expensive medicines and other material, and the loss towards future earnings etc., we direct a lump sum payment of Rs.25/-lakhs under each of these two heads making a total of Rs.50 lakhs. In addition, we direct a payment of Rs.10 lakh towards the pain and suffering that the appellant has undergone. The total amount thus computed would work out to Rs.1,00,05,000 (Rs.1 crore 5 thousand) which is rounded off to Rs. One Crore plus interest at 6% from Ist March, 1999 to the date of payment, giving due credit for any compensation which might have already been paid.

38. The complainant has also claimed a sum of Rs.2 crore to be put in deposit to be utilized by him in case some developments in the medical field make it possible for him to undergo further treatment so as to improve his quality of life. This claim is unjustified and hypothetical and is declined.

39. We must emphasize that the Court has to strike a balance between the inflated and unreasonable demands of a victim and the equally untenable claim of the opposite party saying that nothing is payable. Sympathy for the victim does not, and should not, come in the way of making a correct assessment, but if a case is made out, the Court must not be chary of awarding adequate compensation. The "adequate compensation" that we speak of, must to some extent, be a rule of the thumb measure, and as a balance has to be struck, it would be difficult to satisfy all the parties concerned. It must also be borne in mind that life has its pitfalls and is not smooth sailing all along the way (as a claimant would have us believe) as the hiccups that invariably come about cannot be visualized. Life it is said is akin to a ride on a roller coaster where a meteoric rise is often followed by an equally spectacular fall, and the distance between the two (as in this very case) is a minute or a yard. At the same time we often find that a person injured in an accident leaves his family in greater distress, vis-à-vis a family in a case of death. In the latter case, the initial shock gives way to a feeling of resignation and acceptance, and

in time, compels the family to move on. The case of an injured and disabled person is, however, more pitiable and the feeling of hurt, helplessness, despair and often destitution enures every day. The support that is needed by a severely handicapped person comes at an enormous price, physical, financial and emotional, not only on the victim but even more so on his family and attendants and the stress saps their energy and destroys their equanimity. We can also visualize the anxiety of the complainant and his parents for the future after the latter, as must all of us, inevitably fade away. We, have, therefore computed the compensation keeping in mind that his brilliant career has been cut short and there is, as of now, no possibility of improvement in his condition, the compensation will ensure a steady and reasonable income to him for a time when he is unable to earn for himself.

40. Mr. Tandale, the learned counsel for the respondent has, further, submitted that the proper method for determining compensation would be the multiplier method. We find absolutely no merit in this plea. The kind of damage that the complainant has suffered, the expenditure that he has incurred

and is likely to incur in the future and the possibility that his rise in his chosen field would now be restricted, are matters which cannot be taken care of under the multiplier method.

41. Civil appeal No.3126 of 2000 is allowed in the above term with costs of Rs.50,000/-. It is also clarified that the complainant parents would be entitled to the sum awarded to them by the Commission. CA No.4119 of 1999 is dismissed.

42. Before we end, a word of appreciation for the complainant who, assisted by his father, had argued his matter. We must record that though a sense of deep injury was discernible throughout his protracted submissions made while confined to a wheel-chair, he remained unruffled and with behaved quiet dignity, pleaded his case bereft of any rancour or invective for those who, in his perception, had harmed him.

43. As the complainant is severely handicapped and has appeared in person, we direct that a copy of this judgment be sent to his address, free of cost, under registered cover.

.....J.

(B.N. AGRAWAL)

…….J.
(HARJIT SINGH BEDI)

…….J.
(G.S. SINGHVI)

New Delhi,
Dated: 14th May, 2009