2021 INSC 451

NON-REPORTABLE

IN THE SUPREME COURT OF INDIA

CIVIL APPELLATE JURISDICTION

CIVIL APPEAL NO.7380 OF 2009

Dr. Harish Kumar Khurana ....Appellant(s)

Versus

Joginder Singh & Ors. .... Respondent(s)

With

CIVIL APPEAL NO.8118/2009

CIVIL APPEAL NO.6933/2009

J U D G M E N T

A.S. Bopanna,J.

1. The appellants in all the above three appeals are assailing the order dated 13.08.2009 passed by the National Consumer Disputes Redressal Commission, New Delhi ("NCDRC" for short) in Original Petition No.289/1997. Through the said order, the NCDRC has held the appellants herein guilty of medical negligence and has directed payment

of Rs.17,00,000/- (Rupees Seventeen Lakhs only) with interest at the rate of 9 % per annum from the date of filing the complaint till the date of payment. The appellant in Civil Appeal No.7380/2009 is the doctor who administered anaesthesia to the patient. The appellant in C.A. No.6933/2009 is the hospital wherein the operation was performed. The appeal bearing C.A. No.8118/2009 is filed by the New India Assurance Company Limited from whom the anaesthetist and the hospital had taken separate policy to the extent limited under the policy.

2. The brief factual matrix leading to the above case is as here below. The patient Smt. Jasbeer Kaur, wife of the first claimant and mother of claimants 2 and 3 before the NCDRC visited the appellant hospital on 08.10.1996 and was diagnosed with kidney stone in her right kidney. She was advised to undergo surgery by the treating surgeon Dr. R.K. Majumdar. The patient who was examined as an outpatient had come back to the hospital only on 03.12.1996. On being examined again at that point, it was noticed that the right kidney had been severely damaged and the left kidney was also diagnosed with a stone. In medical terms, the diagnosis

was referred as Hydronephrosis, Grade IV with renal stone in the right kidney and Hydronephrosis of Grade II in the left kidney. As advised earlier, the patient was again advised surgery.

3. Accordingly, the patient admitted herself on 06.12.1996 and she was declared fit for surgery. On 07.12.1996, Dr. H.K. Khurana informed the patient as also her husband that both the kidneys could not be operated at the same time due to the severe damage. They were advised that as per the medical practice, the less affected kidney that is the left kidney would be operated in the beginning since complete removal of the right kidney cannot be ruled out. In such eventuality, the left kidney if rectified would be able to function. The appellants contend that on 09.12.1996 an informed consent of high-risk surgery was obtained from the patient as well as her husband. The respondent No.1 and Dr. R.K. Majumdar were involved in performing the surgery of the left kidney, which was a successful operation. As per the say on behalf of the hospital and the doctors, the condition of the patient improved by 12.12.1996 due to which the possibility of the second surgery to the right kidney was considered. The

necessary tests conducted by the anaesthetist, the physician and the surgeon resulted in clearing the patient for the second surgery.

4. The second surgery was prepared to be conducted on 16.12.1996 and the patient was taken to the operation theatre around 9:45 a.m. The appellant in C.A. No.7380/2009, namely Dr. H.K. Khurana administered the injections of Pentothal Sodium and Scolin as per the medical practice. Subsequent thereto, an endotracheal tube of 7.5 mm diameter was inserted in the trachea to give nitrous oxide and oxygen. The appellants contend that the said standard procedure was also followed during the first surgery but on the present occasion the condition of the patient deteriorated, the blood pressure fell and pulse became feeble. The cardiac respiratory arrest was noticed. The efforts said to have been made by the doctors including the physician did not yield result, though the patient had been put on Boyle's machine and necessary oxygen was supplied using the same. In the evening, the patient is stated to have been put on an automatic ventilator and was shifted to critical care unit. Despite the best efforts, the patient expired on 23.12.1996.

5. The appellants contend that an issue arose with regard to the payment of the balance medical bills. When the same was demanded, since the respondent No.1 i.e the husband of the deceased was a union leader at Whirlpool India, a demonstration was held by the workers at the hospital on 06.02.1997 which resulted in the criminal charges in a criminal complaint being filed against the appellant hospital and also a magisterial enquiry was conducted. The appellant hospital is stated to have filed a suit for recovery of the balance of the medical bills due in C.S. No.332/1997 on 13.08.1997 which according to them had triggered the criminal complaint and claim for compensation was made as a counter blast. The criminal complaint is said to have been filed in FIR No.128 on 27.09.1997. The complaint before the NCDRC was filed thereafter alleging medical negligence and claiming compensation which is dated 06.12.1997. The NCDRC having entertained the same has passed the order impugned herein.

6. The allegation against the appellant doctor and the hospital is that they did not exercise the care which was

required in treating the patient. Though, the operation on the left kidney conducted on 09.12.1996 was successful, it is contended that the surgeon who had conducted the operation namely, Dr. Majumdar had recorded in the case sheet that the patient has poor tolerance to anaesthesia. It was the further grievance of the claimants before the NCDRC that the second operation within the short duration was forced upon the patient which led to the consequences. Despite the observation of the surgeon relating to the poor tolerance to anaesthesia, appropriate care was not taken and the required medical equipments more particularly the ventilator was not kept available. Further, the consent of the patient had not been obtained for the second operation. It was contended that even after the patient suffered a cardiac arrest proper care was not taken in having the presence of the cardiologist or a neurologist. The physician who attended the patient had also taken some time to change and attend to the patient. It was therefore contended that the said negligence on the part of the doctors as well as the hospital had resulted in the death of the patient.

7. The appellants herein, who were the respondents before NCDRC filed their version denying the case put forth on behalf of the claimants. It was contended that the high risk involved in the second operation was made known to the patient and the cardiac arrest which occurred in the present case is likely to occur in certain cases for which appropriate care had been taken by the doctors. The observation relating to poor tolerance to anaesthesia was explained as not being a major issue inasmuch as the earlier operation was successful and was not eventful though anaesthesia had been administered in the same manner for the first surgery.

8. The claimants as well as the respondents before the NCDRC had filed their respective affidavits and had also exchanged interrogatories. No medical evidence was tendered on behalf of claimants. Based on the same, the NCDRC arrived at its conclusion.

9. The learned counsel for the appellants in C.A.No.7380/2009 and C.A. No.6933/2009 made detailed reference to the history of the patient and the patient's sheet maintained by the hospital. In that regard it is pointed out

that on 13.12.1996 the doctor had recorded that the surgical recovery which related to the first operation conducted on 09.12.1996, to be excellent. On 14.12.1996, the observation recorded also indicated that the patient is insisting for surgery of the other side. In that light, also keeping in view the requirement of the surgery to the right kidney which was damaged, a decision was to be taken in that regard. The informed consent was obtained from the husband of the patient where the risk factor had also been recorded. It is contended that every untoward incident cannot be considered as medical negligence. The learned counsel for the hospital also has referred to the documents and the facilities available in the hospital and the care taken by the doctors.

10. The learned counsel for the respondent No.1 would however dispute the position and contend that the entire aspect has been taken note by the NCDRC. It is contended that the observation on 14.12.1996 that the patient is insisting for surgery of the other side is an insertion. The learned counsel refers to the circumstances and the sequence of events that unfolded on 16.12.1996 to contend that immediately on the anaesthesia being administered, the

patient had suffered cardiac arrest and the hospital which did not possess a ventilator was negligent. The Boyle's apparatus was not sufficient and the anaesthetist claiming to have manually operated the same for such long time cannot be accepted as a correct statement. It is further contended that the hospital did not possess public address system or paging service which resulted in the delay in securing the physician to attend and revive the patient.

11. In the background of the rival contentions, the fact that a second operation was performed on 16.12.1996 and the patient had suffered a cardiac arrest after she was administered anaesthesia appears to be the undisputed position from the medical records as well as the statement of the parties. Every death of a patient cannot on the face of it be considered as death due to medical negligence unless there is material on record to suggest to that effect. It is necessary that the hospital and the doctors are required to exercise sufficient care in treating the patient in all circumstance. However, in unfortunate cases though death may occur and if it is alleged to be due to medical negligence and a claim in that regard is made, it is necessary that

sufficient material or medical evidence should be available before the adjudicating authority to arrive at a conclusion. Insofar as the enunciation of the legal position on this aspect, the learned counsel for the appellant had relied on the decision of the Hon'ble Supreme Court in ***Jacob Mathew vs. State of Punjab and Anr.*** (2005) 6 SCC 1 wherein it has been held that the true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of, if acting with ordinary care. The accident during the course of medical or surgical treatment has a wider meaning. Ordinarily an accident means an unintended and unforeseen injurious occurrence, something that does not occur in the usual course of events or that could not be reasonably anticipated. The learned counsel has also referred to the decision in ***Martin F.D'Souza vs. Mohd. Ishfaq*** (2009) 3 SCC 1 wherein it is stated that simply because the patient has not favourably responded to a treatment given by doctor or a surgery has failed, the doctor cannot be held straight away liable for

medical negligence by applying the doctrine of *Res Ipsa Loquitor.* It is further observed therein that sometimes despite best efforts the treatment of a doctor fails and the same does not mean that the doctor or the surgeon must be held guilty of medical negligence unless there is some strong evidence to suggest that the doctor is negligent.

12. The learned counsel for the respondents, on the other hand, referred to the decision in ***V. Kishan Rao vs. Nikhil Super Speciality Hospital and Another*** (2010) 5 SCC 513 to contend that the decision in the case of ***Martin F.D'Souza*** (supra) wherein general directions is given to secure medical report at preliminary stage is held to be not treated as a binding precedent and those directions must be confined to the particular facts of that case. It is held that in a case where negligence is evident, the principles of *res ipsa loquitur* operates and the complainant does not have to prove anything and in the said case it is held that in such event it is for the respondent to prove that he has taken care and done his duties, to repel the charge of negligence. Though such conclusion has been reached on the general direction,

we take note that in ***V. Kishan Rao*** (supra) the fact situation indicated that RW1 had admitted in his evidence that the patient was not treated for malaria. In that background, it was taken into consideration that the patient had been treated for typhoid though the test in that regard was found negative and the test for malaria was positive. The said fact situation therefore indicated that the principle of *res ipsa loquitur* would apply. It would be apposite to note that in the very decision this Court has expressed the view that before forming an opinion that expert evidence is necessary, the Fora under the Act must come to a conclusion that a case is complicated enough to require the opinion of an expert or the facts of the case are such that it cannot be resolved by members of the Fora without the assistance of the expert opinion. It is held that no mechanical approach can be followed and each case has to be judged on its own facts.

13. In ***S.K. Jhunjhunwala vs. Dhanwanti Kaur and Another*** (2019) 2 SCC 282 referred by the learned counsel for the respondent, the negligence alleged was of suffering ailment as a result of improper performance of surgery. It was

held that there has to be direct nexus with these two factors to sue a doctor for negligence. In, ***Nizam's Institute of Medical Sciences vs. Prasanth S. Dhananka and Others*** (2009) 6 SCC 1 relied upon by the learned counsel for the respondent, broad principles under which the medical negligence as a tort have to be evaluated is taken note, as has been laid down in the case of ***Jacob Mathew*** (supra). The ultimate conclusion reached in the case of ***Nizam's Institute*** (supra) relating to the lack of care and caution and the negligence on the part of the attending doctors was with reference to the medical report which was available on record which indicated the existence of tumour located at left upper chest and in that circumstance the presence of neuro surgeon was essential and the said procedure not being adopted, a case of negligence or indifference on the part of the attending doctors had been proved.

14. Having noted the decisions relied upon by the learned counsel for the parties, it is clear that in every case where the treatment is not successful or the patient dies during surgery, it cannot be automatically assumed that the medical

professional was negligent. To indicate negligence there should be material available on record or else appropriate medical evidence should be tendered. The negligence alleged should be so glaring, in which event the principle of *res ipsa loquitur* could be made applicable and not based on perception. In the instant case, apart from the allegations made by the claimants before the NCDRC both in the complaint and in the affidavit filed in the proceedings, there is no other medical evidence tendered by the complainant to indicate negligence on the part of the doctors who, on their own behalf had explained their position relating to the medical process in their affidavit to explain there was no negligence. The reference made is to the answers given by Dr. Khurana to the interrogatories raised by the complainant. In respect of the first operation, it was clarified that the patient did not have any side effects/complications during the first operation which was described as uneventful. On leaving the operation theatre, the patient was in the custody of surgeon. After the operation he had not been called for any complication related to anaesthesia. Since he had written the anaesthesia notes in the register during the first operation,

he did not see reason to see the hospital record after the first operation. With regard to the comment of the surgeon after the first operation in the treatment sheet regarding the patient being 'poorly tolerant to anaesthesia', he has replied that the said observation had no meaning since the first operation was uneventful and was successful. There was no anaesthesia related complication of any kind. With regard to the emergency which occurred during the second operation and the manner in which he had alerted the hospital and requisitioned the help of cardiologist, he has answered that the full operation theatre team was already there and the cardiologist was summoned by one of the members of the team and the specific details could not be answered by him since the entire team was busy in attempting to save the patient.

15. The NCDRC having noted the reply has arrived at the conclusion that since there was a note that the patient had poor tolerance to anaesthesia, he had disregarded the observation without holding any discussion with any other anaesthesiologist and other specialist. Insofar as the facility of the paging system the NCDRC had taken note that the

magisterial enquiry has come to a conclusion that there is no paging system. The conclusion reached by the NCDRC on first aspect appears to be an assumption without the backing of medical evidence. The anaesthetist Dr. Khurana has claimed to be experienced in the field and in the contention put forth before the NCDRC has claimed to have successfully administered anaesthesia to more than 25,000 patients in elective as well as emergency surgical procedures. Even if the same is accepted to be a tall claim, the fact remains that he had sufficient experience of administering anaesthesia. However, the question was as to whether he was negligent. That aspect of the matter as to whether in the background of the medical records, the manner in which he had proceeded to administer the anaesthesia amounted to negligence could have been determined only if there was medical evidence on record. In the instant case it is not a situation that the diagnosis was wrong. The fact of both the kidneys requiring to be operated is the admitted position. The two aspects which are the foundation for allegation of negligence is that no care was taken despite the observation of the surgeon after the first surgery that the patient is poorly tolerant to

anaesthesia. The second aspect is as to whether the patient's life was exposed to risk by advising and preparing for the second operation without sufficient gap after the first operation. Any of the shortcoming relating to infrastructure as mentioned in the report of the magisterial enquiry will become material only if the medical evidence is to the effect that the said two aspects were not the normal situation and that undertaking operation in such situation with reference to the medical condition of the patient was a high-risk procedure, the backup that ought to have been ensured and whether the medical equipments that were available at that point in time were sufficient. Without reference to the evidence, mere assumption would not be sufficient is the legal position laid down in the decisions referred above. Principle of res ipsa loquitur is invoked only in cases the negligence is so obvious.

16. The next aspect on which the NCDRC has found fault with the appellants is regarding the consent being taken only of her husband for the second surgery. Though the NCDRC has referred to an earlier decision rendered by the Commission on this aspect, what is necessary to be taken

note is that in the instant facts the first operation had been performed on 09.12.1996 during which time an informed consent was taken from the patient as also from her husband. During the second operation the patient was in the process of recovery from the first operation and the requirement of second surgery was informed to her. In that circumstance the informed consent was obtained from the husband. The noting in the document at Annexure RA-3 also indicates that he has noted that he has been informed about the high risk of his patient in detail and his consent is given. Though it was contended before the NCDRC that there was an interpolation in the patient's sheet on 14.12.2016, the informed consent form indicates that it has been written in hand and signed by the patients' husband i.e., the first complainant before NCDRC and consent was given and the patient was also kept in the loop. The complainant who was throughout with the patient and who had given his consent did not make any other contrary noting therein so as to hold the non-taking of the consent from the patient against the appellants herein.

17. On the aspect relating to the noting regarding poor tolerance to anaesthesia though the NCDRC has reached the conclusion that he had not taken care of such observation, the very fact that the NCDRC had noted that Dr. Khurana was the anaesthetist during the first surgery could not have been held against him since in the said circumstance he was aware about the details of the patient to whom he had administered anaesthesia for the first surgery. When it is shown that the earlier operation was uneventful, in the absence of any medical evidence brought on record to the contrary regarding the failure on the part of Dr. Khurana in taking any steps while administering anaesthesia for the second operation, the observation of poor tolerance in the case sheet by itself cannot be assumed as negligence. It is no doubt unfortunate that the patient had suffered cardiac arrest. The procedure which was required to be followed thereafter has been followed as per the evidence put forth by the appellant and the consequences has been explained by them. To arrive at the conclusion that there was negligence, the medical evidence to point out negligence in administering anaesthesia even in that situation was required to be

tendered since the adjudicating authority is not an expert in the field of medicine to record an independent opinion.

18. The NCDRC has placed much reliance on the enquiry report which cannot be treated as contra medical evidence as compared to the evidence tendered by the appellants. The observation contained in the judgment of the criminal case decided on 27.11.2006, which has been referred to by the NCDRC to form its opinion that the said observation amounts to a situation that there was some serious medical negligence is not the correct position. The conclusion is not that there was negligence but keeping in view the standard of proof that is required in a criminal trial to establish gross negligence, an alternate statement was made by the Court stating that even if there is some negligence the same cannot be considered as gross negligence. Such observation was not a finding recorded that there was negligence. So far as the reliance placed on an enquiry that was conducted by the District Magistrate, the same cannot be considered as medical evidence to hold negligence on the part of the doctors or the hospital in the matter of conducting the second surgery and the condition of the patient in the particular facts of this

case. Though, the civil surgeon was a member of the two-member committee which conducted the enquiry and certain adverse observations were made therein, the conclusion therein is not after assessing evidence and providing opportunity to controvert the same. Based on the statements that have been recorded and the material perused, an opinion has been expressed which cannot be the basis to arrive at a conclusion in an independent judicial proceeding where the parties had the opportunity of tendering evidence. In such proceeding before the NCDRC the appellants have tendered their evidence in the nature of affidavit and if the same is insufficient the cause would fail. The observations contained in the order of NCDRC is in the nature of accepting every allegation made by the claimant regarding the sequence and delay in the doctors attending to rectify the situation as the only version and has not been weighed with the version put forth by the doctors.

19. On the principle of *res ipsa loquitur*, the NCDRC has taken note of an earlier case wherein the conclusion reached was taken note in a circumstance where the anaesthesia had killed the patient on the operating table. In the instant facts,

the patient had undergone the same process of being administered anaesthesia for the first operation and the operation had been performed successfully and the entire process was said to be uneventful. Though in the second operation, the patient had suffered a cardiac arrest, the subsequent processes with the help of the Boyle's apparatus had been conducted and the patient had also been moved to the CCU whereafter the subsequent efforts had failed. The patient had breathed her last after few days. As already noted, there was no contrary medical evidence placed on record to establish that the situation had arisen due to the medical negligence on the part of the doctors.

20. The very questions raised by the NCDRC at issue Nos.2 to 7 would indicate that in the present fact situation the first operation performed by the same team of doctors in the same hospital was successful and the unfortunate incident occurred when the second operation was scheduled. Hence what was required to be determined was whether medically, the second operation could have been conducted or not in that situation and whether the medical condition of the patient in the present case permitted the same. The issues

raised by framing the other questions would have arisen depending only on the analysis of the medical evidence on those issues at 2 to 7 more particularly issues 2 and 3.

21. In addition to what has been noted above, in the context of the issues which had been raised for consideration, the verbatim conclusion reached by the NCDRC would be relevant to be noted. The issues No. 2 and 3 which were raised for consideration are the crucial issues which entirely was on the medical parlance of the case. The said issues were to the effect as to whether the second surgery should have been undertaken since it was recorded that the patient has poor tolerance to anaesthesia and whether the surgery of the second kidney should have been taken within eight days from the first surgery though it was not an emergency. As noted, the appellants being doctors had tendered their affidavits indicating that as per the medical practice the same was permissible. On behalf of the claimants no medical evidence was tendered. Though from the available records the NCDRC could have formed its opinion with reference to medical evidence if any, the nature of the conclusion recorded is necessary to be noted.

> “We are surprised to note that the treating doctor after recording that the patient had poor tolerance to anaesthesia has tried to defend his action by stating that poor tolerance to anaesthesia means nothing.”

> “However, we cannot be oblivious of the fact that Dr. Khurana was the Anaesthesiologist during the first surgery also and he was fully aware of the conditions of the patient. In reply to the interrogatories, he has clearly admitted that he has gone through the notings of Dr. Mazumdar wherein he has said the patient has poor tolerance to anaesthesia. We are stunned to note that he has stated in the reply to interrogatories that in medical parlance poor tolerance to anaesthesia means nothing'.”

> “It is common knowledge that a person can survive with one kidney, just as a person can survive with one lung. There are cases where a patient suffers from failure of both the kidneys and nephrectomy is performed to replace one of the damaged kidneys by a kidney of a donor after proper test and verification. Therefore, there was no hurry to perform the second surgery.”

The extracted portion would indicate that the opinion as expressed by the NCDRC is not on analysis or based on medical opinion but their perception of the situation to arrive at a conclusion. Having expressed their personal opinion, they have in that context referred to the principles declared regarding Bolam test and have arrived at the conclusion that the second surgery should not have been taken up in such a hurry and in that context that the appellants have failed to clear the Bolam test and therefore

they are negligent in performing of their duties. The conclusion reached to that effect is purely on applying the legal principles, without having any contra medical evidence on record despite the NCDRC itself observing that the surgeon was a qualified and experienced doctor and also that the anaesthetist had administered anaesthesia to 25,000 patients and are not ordinary but experienced doctors.

22. On the aspect relating to the observation of poor tolerance to anaesthesia and the period of performing the second operation from the time of first operation was conducted it was a highly technical medical issue which was also dependant on the condition of the patient in a particular case which required opinion of an expert in the field. There was no medical evidence based on which conclusion was reached with regard to the medical negligence. The consequential issues with regard to the preparation that was required and the same not being in place including of having a cardiologist in attendance are all issues which was dependant on the aspect noted above on issues No.2 and 3. The observations of the NCDRC in their

opinion appears to be that the second operation ought not to have been conducted and such conclusion in fact had led to the other issues also being answered against the appellants which is not backed by expert opinion.

23. In the above circumstance when there was no medical evidence available before the NCDRC on the crucial medical aspect which required such opinion, the mere reliance placed on the magisterial enquiry would not be sufficient. Though the opinion of the civil surgeon who was a member of the committee is contained in the report, the same cannot be taken as conclusive since such report does not have the statutory flavour nor was the civil surgeon who had tendered his opinion available for cross-examination or seeking answers by way of interrogatories on the medical aspects. Therefore, if all these aspects are kept in view, the correctness or otherwise of the line of treatment and the decision to conduct the operation and the method followed were all required to be considered in the background of the medical evidence in the particular facts of this case. As indicated, the mere legal principles and the general standard of assessment was not sufficient in a matter of the present

nature when the very same patient in the same set up had undergone a successful operation conducted by the same team of doctors. Hence, the conclusion as reached by the NCDRC is not sustainable.

24. For the aforesaid reasons, the order dated 13.08.2009 passed in O.P. No.289 of 1997 is set aside. The appeals are accordingly allowed. There shall be no order as to costs.

25. Pending application, if any, shall stand disposed of.

……………………..J.
(HEMANT GUPTA)

……………………J.
(A.S. BOPANNA)

New Delhi,
September 07, 2021