2024 INSC 705

IN THE SUPREME COURT OF INDIA
CIVIL APPELLATE JURISDICTION

CIVIL APPEAL NO.7262/2012

P.N.GUPTA **Appellant(s)**

VERSUS

RAJINDER SINGH DOGRA **Respondent(s)**

JUDGMENT

1. This civil appeal arises out of the decision of the National Consumer Disputes Redressal Commission[1] in First Appeal No. 248/2002 dated 16.07.2012. By the said order, the National Commission allowed the appeal filed by the respondent-consumer by setting aside the order passed by the UT Consumer Disputes Redressal Commission, Chandigarh[2] and directed payment of compensation quantified at Rs. 7,00,000/- by the appellant, with 12% interest from the date of the order till actual payment. Questioning the decision of the National Commission, the appellant is before us. The brief facts necessary for deciding the appeal are as follows:

2. The respondent's wife had been suffering from abdominal pain. She went through an ultrasonography test, which showed

[1] **Hereinafter referred to as the National Commission.**
[2] **Hereinafter referred to as the State/UT Commission.**

stones in her gall bladder. The appellant is a doctor, who performed a surgery for removing the stones on 11.09.2000 on the basis of an ultrasonography. However, the patient developed various problems after the same, such as stomach ache, constipation and vomiting, etc. The patient re-consulted the appellant, who prescribed medications for pain and other symptoms. However, the patient's problems continued to persist. Accordingly, on the suspicion of a "biliary leak", a second ultrasonography test was conducted. The report of this test showed "more collection of fluid in the peritoneal cavity". On 04.10.2000, the appellant conducted another surgery to drain this fluid by what is known as "needle aspiration" from the "Pouch of Douglas".

2.1 However, the problems continued to persist, which is when the appellant referred the patient to a liver-specialist. On 16.10.2000, the liver-specialist conducted an ECRP (Endoscopic Cholangio Pancreatography) test. Despite the test, the patient's problems were found to continue. In fact, she was found to have developed 'contracted pancreatitis'. Eventually, due to sepsis and multi-organ failure, the patient passed away on 04.11.2000.

3. The respondent is the patient's husband, who filed a consumer complaint before the UT Commission bearing number Complaint Case No. 6 of 2001. He claimed a sum of Rs. 8.30

lakhs as compensation for loss of his wife's life due to the appellant's medical negligence, which included sums claimed for mental agony and other costs.

4. The appellant denied the submissions advanced by the respondent stating that there was no medical negligence on his part. It was argued that the appellant's conduct in treating the patient was in accordance with the prevalent medical practices. His case was that he promptly tried to address the patient's problem after the first surgery. All the problems were dealt with reasonable care, and that all the screening measures were conducted before any surgery. It was submitted that the appellant had performed multiple surgeries of similar nature in his career and his credentials as a competent doctor were proven by record. Lastly, he contended that removal of gall bladder had no relation with the patient's death.

5. The complaint was dismissed by the State Commission vide its order dated 27.03.2002. It was of the view that the respondent, as a complainant, had failed to discharge his onus. That is, it was not proved that a mistake on part of the appellant caused the death of the patient. It held that the respondent has not proved how established medical practices were deviated from. Mistakes, if any, were not proven to have a nexus with the patient's death.

6. The respondent then approached the National Commission by way of an appeal. In view of the allegations about non-compliance with standard medical practice, the National Commission had constituted a Medical Board composed of experienced doctors from the G.B. Pant Hospital, New Delhi and summoned a report on the matter. The said report concluded that the appellant had taken steps which were in accordance with the prevailing medical standards on the issue concerned. The conclusions of the Board are reproduced here for convenience:

Sr. No.	*Query*	*Opinion of Medical Board*
(1)	*(2)*	*(3)*
(i)	*Whether there was any medical negligence in the surgery of cholecystectomy performed by Dr. P.N. Gupta on the patient on 11.09.2000?*	*Bile duct injury is a well known complication in patients undergoing Laparoscopic cholecystectomy and occurs in approximately 0.5% of cases. This cannot be termed as medical negligence as some patients may have an unsuitable anatomy as a consequence of past episodes of cholecystitis.*
(ii)	*Whether there was a possibility of occurrence of post-operative biliary leakage and, if so, what were the investigative methods available to the doctor to ascertain the incidence of leakage?*	*This point is covered vide supra. Bile duct injury results in biliary peritonitis or biloma formation; the standard investigation to detect this is by doing an leakage? USG/CT examination.*
(iii)	*Whether the patient having undergone cholecystectomy on 11.09.2000 could have*	*Biliary ascites is usually not an acute event. Gradually over a period of*

	developed severe biliary leakage (leading to Biliary Peritonitis) suddenly on one date, viz., 30.09.2000?	***time the fluid goes on accumulating. When this reaches a significant level the patient becomes aware of abdominal distension or pain.***
(iv)	***Whether the management and surgical intervention by Dr. P.N. Gupta on 30.09.2000 and 03.10.2000 and upto his referral of the patient to the PGIMER on 13.10.2000 was according to the standard medical protocol?***	***The management of post-operative bile leak between 30.09.2000 to 03.10.2000 was as per standard protocol as he inserted a tube drain and then referred the patient for ERCP examination to Dr. N. Nagpal.***
(v)	***Whether there was any delay and/ or any deficiency in providing medical service in that behalf, particularly in respect of the points at (ii) and (iv)?***	***In retrospect some of the investigations if done earlier could have detected the injury /bile collection; however, from the notes it appears that on clinical examination of the patient at the time, Dr. Gupta in his wisdom did not feel that further investigations were warranted and, therefore, prescribed medication for symptomatic relief. This would be medically acceptable. In hindsight this may be construed as an error of judgment on the part of the clinician but cannot be equated with medical negligence.***

7. After considering the report in detail, the National Commission found it to be cryptic and that it did not answer the issue convincingly. It is in this context that the National Commission undertook the burden to examine the matter in detail.

It is pertinent to note that the National Commission was aware of the limitation in re-examining the report, and proceeded within the permissible legal limits to do the same. Learned counsels for the parties produced detailed material. Both parties filed medical literature to establish what the normative standard in such cases ought to be. We don't find it necessary to reproduce the entire literature referred and analyzed by the Commission. It is sufficient to consider what literature that was cited by the parties.

7.1 The respondent had produced SLEISENGER AND FORDTRAN'S GASTROINTESTINAL AND LIVER DISEASE, (Editors Mark Feldman, Lawrence S. Friedman and Marvin H. Sleisenger, 7th Edition) in support of his contention. On the other hand the appellant produced (a) BAILEY & LOVE'S SHORT PRACTICE OF SURGERY (21st Edition); (b) Z. Rayter, C. Tonge, C.E. Bennett, P.S. Robinson, and M.H. Thomas, *Bile leaks after simple cholecystectomy*, BRITISH JOURNAL OF SURGERY, 1989, Vol 76, October 1046 – 1048; (c) R. Isenmann, B. Rau and H. C. Berger, *Bacterial infection and extent of necrosis are determinants of organ failure in patients with acute necrotizing pancreatitis*, BRITISH JOURNAL OF SURGERY, 1999, 86, 1020- 1024; (d) Virendra Singh, Kartar Singh, Prakash Kumar, Vijay Prakash, H. S. Rai, A. Kumar, B.K. Agarwal, *Endoscopic Sphincterotomy for Common Bile Duct Stones with and without gallbladder/ 'T' Tube in Situ*, TROPICAL

GASTROENTEROLOGY ORIGINAL ARTICLES- Vol. 15, No. 1, 1994, Page: 19-22; and (e) Michael J. Zinner, Seymour I Schwartz, Harold Ellis, VOLUME II MAINGOT'S ABDOMINAL OPERATIONS (10TH edition). In addition to the literature supplied by the parties, the National Commission deemed it fit to consider (a) TEXT BOOK OF GASTROENTEROLOGY (VOLUME 2), (Edited by Tadataka Yamada, 5th edition, Published by Wiley Black) and (b) BAILEY AND LOVE'S SHORT PRACTICE OF SURGERY, (Edited by Norman S. Williams, Christopher J. K. Bulstrode & P. Ronan O'Connell, 25th edition).

8. After a detailed scrutiny of the literature, the National Commission summarised the position as under:

> ***"a. Anatomically, the biliary tree consists of the left and right hepatic ducts joining to form the common hepatic duct, cystic duct from the gallbladder joining the common hepatic duct to form the common bile duct (CBD) and CBD and the pancreatic duct joining together at the ampulla of Vater in the D2 (second) part of the duodenum.***
> ***b. With laparoscopic cholecystectomy widely replacing open cholecystectomy, the incidence of post-operative bile leakage due to iatrogenic (any adverse condition in a patient resulting from treatment by a physician or surgeon) injuries to the common bile duct or any of the preceding biliary ducts has increased more than two-fold. However, even then, it remains a "known complication" with a low probability/incidence (0.3% - 2.7%, i.e., 3-27 in 1000 cases of LC and 0.25% - 0.5%, i.e., 2.5-5 in 1000 cases of OC). Bile leakage due to slipping of the ligature of or injuries to the cystic duct is also a known complication. Cystic stump leaks can occur from faulty clip application, slipping of the clips or necrosis of the cystic duct stump proximal to the clip, probably related to diathermy injury.***
> ***c. 'When the anatomy of the triangle of Calot is unclear, blind dissection should stop.' The 'triangle of Calot' is the triangular anatomical***

space bounded by the cystic duct - inferiorly, cystic artery - superiorly and the common hepatic duct - medially). 'Dissection in the triangle of Calot is ill-advised until the lateralmost structures have been cleared and identification of the cystic duct is definitive. According to SESAP 12 (produced and distributed by the American College of Surgeons) dissection in the triangle of Calot is the #1 cause of common bile duct injuries' (vide http://en.wikipedia.org/wiki/Cystohepatic_triangle).

d. A major risk factor for bile duct injury is the experience of the surgeon. Bile duct injuries appear to be much more common early in a surgeon's experience with the technique. Other risk factors appear to be the presence of aberrant biliary tree anatomy and the presence of local acute or chronic inflammation.

e. 'In 85% of cases, the injury declares itself post-operatively by: (1) a profuse and persistent leakage of bile if drainage has been provided, or bile peritonitis if such drainage has not been provided; and (2) deepening obstructive jaundice. When the obstruction is incomplete, jaundice is delayed until subsequent fibrosis renders the lumen of the duct inadequate.'

f. 'Careful history-taking, clinical examination and investigations point to the cause of jaundice. Serum biochemistry confirms the diagnosis of jaundice with an elevated serum bilirubin, usually $\geq$ 40 µmol/1 when detectable clinically. An obstructive pattern is recognizable in the other liver function tests, i.e., a high alkaline phosphatase and only mild increase in the concentration of transaminases.'

g. For patients 'who have anything less than a smooth postoperative course', diagnostic imaging is warranted 'even in the absence of pain, fever, leukocytosis, or abdominal tenderness.'

h. 'It is unnecessary and undesirable to perform an exploratory laparotomy solely to diagnose or drain an abdominal bile collection. Percutaneous drainage can be as thorough, and it avoids the morbidity of a laparotomy.'

i. After drainage of bile collection but before starting any definitive line of treatment, ERCP (or, MRCP) is the procedure of widest choice to determine the source of the bile leakage and/ or the existence of stone and/or stricture in the biliary tree anatomy. The former has the added advantage of therapeutic use in certain

situation."

9. It is in the above referred context that the National Commission re-examined the report and came to the conclusion that the appellant's conduct was, in fact, negligent. In conclusion, the National Commission's findings may be summarized as follows;

i. During the patient's gallbladder surgery, the appellant switched from a minimally invasive method to an open surgery but he could not identify the relevant artery and the ducts. Despite this limitation, he went ahead with the procedure.

ii. The appellant failed to issue a proper discharge summary.

iii. The doctor disregarded the repeated complaints of stomach pain until the patient developed noticeable jaundice. He himself admitted that the patient had been suffering pain around that time and he was continually aware of the same.

iv. The appellant failed to take proper consent for the surgeries.

v. On 04.10.2000, the appellant simply tried to drain the bile leak, but made no efforts to identify its cause. His own handwritten notes and his referral to another doctor demonstrate this.

vi. The appellant delayed referring the patient to the liver-specialist by 8 days after the second surgery. Whereas,

medical standards required him to refer her to the ERCP procedure more promptly, especially when he was aware he could not have carried it out himself.

vii. Compounding all the above acts of negligence, the appellant had attempted to write the records of the case which differed with entries made in medical records.

viii. The appellant had pleaded guilty for the delay in referral to the liver-specialist, but had attempted to disguise the same with legalese.

10. For arriving at its conclusions, the National Commission applied the principles laid down by this Court in *Jacob Mathew v State of Punjab*[3] to follow the standard of medical negligence while examining the facts before it. It also considered the decision in *Samira Kohli v Dr. Prabha Manchanda & Another*[4] to analyse when a patient can be said to have given valid consent. The conclusions of the National Commission are to the follows:

> ***"19. In conclusion, we are of the view that the respondent has to be held guilty of medical negligence/ deficiency in service at least on four counts. The respondent did not pay any attention to the patient's persistent complaints of pain (as he himself admitted in his referral note for ERCP) till she presented with visible signs of jaundice and thus unduly delayed the diagnostic tests that were taken only on 02.10.2000. Secondly, having conducted an "exploratory" laparotomy on 04.10.2000, he failed to even attempt locating the cause of the bile leakage suffered by the patient though all standard literature (including that***

[3](2005) 6 SCC 1.
[4](2008) 2 SCC 11.

cited by the respondent) pointed to cystic duct stump leak as one of the most frequent causes of such leakage - such a situation was particularly likely in this case because the cholecystectomy was proceeded with by the respondent despite his inability to clearly separate the cystic duct and the cystic artery before their dissection, and ligature. Further, after conducting the laparotomy, he delayed referring the patient for ERCP for no rhyme or reason though all standard literature (and hence the corpus of knowledge and practice based thereon expected of an ordinary medical practitioner of the relevant specialty) mandated such an investigation at the earliest because that is the most widely recommended way of both diagnosing and, in some situations also treating, bile anatomy injury/ obstruction evidenced by either stricture/obstruction in the biliary tree or fistular leakage of bile flow. The respondent himself knew of this, according to his repeated admissions. It is really strange that this failure could be pleaded as an error of judgment. A physician can commit an error of judgment in a case of more than one options of (or, approaches to) diagnosis and/or treatment of a patient's condition and he honestly believing one of them to be more appropriate than the other/s for that patient, though in retrospect that may tum out to be not so appropriate or advantageous to the patient. Here, in this case, the respondent knew full well that the patient must undergo ERCP (or, an equivalent diagnostic or diagnostic- cum-therapeutic procedure), which he was not professionally competent to conduct. Why he delayed this reference to a qualified gastroenterologist/ endoscopist, or, in this case to the PGI, when he had not even been able to identify the patient's biliary anatomy injury, leave alone repair it, may be a 'judgment' of sorts of this particular surgeon but certainly not an error of judgment that an average informed and careful surgeon would make. Finally, there is incontrovertible evidence in the form of the signed consent documents that the respondent did not discharge the duty of disclosure in case of either surgery (cholecystecto1ny or laparotomy) as required of him under the law governing consent. We cannot also overlook the fact that this respondent's recording of important treatment records could be interpreted to suggest an attempt at "improving" his case but perhaps that was not deliberate. It is unfortunate that the medical

> ***board did not go into these questions with the seriousness expected of an independent body of experts. However, there is no evidence at all that the acts of the respondent /OP were the proximate cause of Reeta's eventual death and the respondent/OP cannot be held to account for that."***

11. In view of these findings, the National Commission proceeded to pass the following Order:

> **"21. …*the appeal is partly allowed and the order of the State Commission is set aside. The respondent is directed to pay to the appellant/complainant the sum of Rs.7 lakh as consolidated compensation, including cost, within four weeks from the date of this order, failing which the sum would be liable to be paid with interest @ 12% per annum from the date of this order till realisation.*"**

12. We have heard the learned counsels for the parties. Mr. T. Mahipal, counsel for the appellant, submitted that the National Commission could not have substituted the opinion of medical experts with its own. In any case, the patient was given reasonable care. This is demonstrated by multiple ultrasonography tests, an x-ray test, medical prescriptions, post-operative care and a second surgery without any charges. Furthermore, the cause of death in the patient's report was nowhere linked with the acts of the appellant. It was also stated that throughout the proceedings before the State and the National Commissions, the credentials about the appellant's competence were never disproved.

12.1 Mr. Ravi Kant Sharma, counsel appearing for the respondent, on the other hand, submitted that the patient made repeated complaints about subsisting pain in her abdominal area. More specifically, after her discharge on 12.09.2000, she visited the appellant on 20.09.2000, 25.09.2000 and 30.09.2000. However, no diagnosis was conducted by the appellant until the patient visibly developed jaundice. Despite the second ultrasonography report disclosing bile fluid, the cause was not looked into. The delay in referral to the liver-specialist compounded the patient's problems, and hence, her death has a direct nexus with the appellant's acts/omissions.

13. Having considered the matter in detail, we are of the opinion that the National Commission has not committed any error in reaching its conclusions. The judgment of the National Commission is well-reasoned, and depicts a detailed consideration of all the relevant material, including the opinion of the doctors who have been examined before it.

14. The parties had filed two different sets of medical records. The medical records filed by the appellant did not contain a detailed record of the surgical process, nor did they contain the standard notings on the closure of wounds. More significantly, the records filed by the appellant did not cite whether the patient's gall bladder contained any stones, for

which the surgery was performed to begin with. The National Commission correctly noted that the results of the first ultrasonography in the records filed by the appellant were similarly doubtful. While the report showed the presence of bile in several regions of the patient's body, the record described the presence to be 'minimal'.

15. Furthermore, the appellant failed to supply the results of the second ultrasonography, on the basis of which the second surgery to drain the fluid was conducted. Crucially, nothing was brought to the Commission's notice which demonstrated that the patient had properly consented to the second surgery. Apart from the medical records filed by the parties, the National Commission had considered the relevant medical literature on the subject and whether the appellant's conduct was in consonance with standard medical practice. As stated previously, the National Commission also considered the report of the Medical Board and concluded that the Board has not examined the medical records carefully.

16. Coming to the submissions of the parties, the National Commission found the appellant's submissions to be unreliable. It is seen that the appellant's submissions contradicted the liver specialist's submissions, insofar as the date of post-operative visits was concerned. Another contradiction was that

while the appellant denied the patient's visit on 28.09.2000 before the State Commission, his records showed an entry in the patient's name for the same date. Significantly, the patient complained to the appellant about stomach pain and constipation on 25.09.2000 and 28.09.2000. However, instead of investigating if a serious problem existed with the patient, the appellant merely gave out prescriptions of medicines to deal with the patient's symptoms. More importantly, the appellant did not offer any convincing reasons for delaying the referral to a liver-specialist, despite being aware of the medical condition.

17. Considering all the above material, the finding of the National Commission that the appellant's conduct did not meet the required standard of 'reasonable care' and that he was negligent cannot be interfered with. The National Commission considered the relevant material before itself, and correctly relied on this Court's decision in *Jacob Mathew* (supra) to conclude that medical negligence was proved in the facts of the case.

18. In light of the above, we uphold the order passed by the National Commission in First Appeal No. 248 of 2002 dated 16.07.2012 and dismiss Civil Appeal No. 7262 of 2012. However, in the facts and circumstances of the case, we deem it appropriate to modify the direction of the National Commission

with respect to payment of interest from @ 12% to 6% per annum.

19. The Civil Appeal is disposed of in terms of the above directions.

20. There shall be no order as to costs.

.....J.
[PAMIDIGHANTAM SRI NARASIMHA]

.....J.
[SANDEEP MEHTA]

New Delhi
September 5, 2024.