NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION
NEW DELHI

CONSUMER CASE NO. 46 OF 2006

1. DEEPAK GUPTA
S/O. LATE MR. AVINASH CHANDRA GUPTA, R/O. I-902,
AMBIENCE LAGOON,
GURGAON -122 002
2. MRS. INDU GUPTA,
W/O. LATE MR. AVINASH CHANDRA GUPTA, R/O. H-601,
AMBIENCE LAGOON,
GURGAON-122 002.
3. MRS. PUNAM KOTHARI,
D/O. LATE MR. AVINASH CHANDRA GUPTA, C/O. I-902,
AMBIENCE LAGOON,
GURGAON - 122 002.
4. KAVITA MEHTANI
D/O. LATE MR. AVINASH CHANDRA GUPTA, C/O. I-902,
AMBIENCE LAGOON,
GURGAON-122 002. .....Complainant(s)

Versus

1. INDRAPRASTHA APOLLO HOSPITALS DELHI,
SARITA VIHAR, DELHI-MATHURA ROAD,
NEW DELHI - 110 044
2. DR. JAWAHAR DAS,
NEUROSURGEON, INDRAPRASTHA APOLLO HOSPITALS
DELHI, SARITA VIHAR, DELHI -MATHURA ROAD,
NEW DELHI - 110 044.
3. DR. BROOR, GASTROENTROLOGIST,
INDRAPRASTHA APOLLOW HOSPITALS DELHI, SARITA
VIHAR, DELHI-MATHURA ROAD,
NEW DELHI - 110 044. .....Opp.Party(s)

BEFORE:
HON'BLE MR. JUSTICE R.K. AGRAWAL,PRESIDENT
HON'BLE DR. S.M. KANTIKAR,MEMBER

For the Complainant :
For the Opp.Party :

Dated : 23 Aug 2022

ORDER

Appeared at the time of arguments

For the Complainants : Ms. Shirin Khajuria, Advocate

Ms. Mallika Chdha, Advocate

For the Opp. Parties : Dr. Lalit Bhasin, Advocate &

Mr. Vijayant Sharma, Advocate for OP-1

OP-2 deleted vide Order dated 20.12.2017

Dr. Sushil Kr. Gupta, Advocate for OP-3

Pronounced on: 23rd August 2022

ORDER

DR. S.M. KANTIKAR, MEMBER

1. The present Complaint has been filed under section 21 r/w section 22 of the Consumer Protection Act, 1986 (for short "the Act") by Deepak Gupta & three others against the Indraprastha Apollo Hospital & its two doctors seeking compensation of Rs.1,08,90,299/- for act of medical negligence on the part of the Opposite Parties.

Facts:

2. Mr. Avinash Chandra Gupta, about 74 years (since deceased, hereinafter referred to as the 'patient'), the husband of Complainant No. 2 and father of the Complainants No. 1, 3 and 4 was suffering from headache, dizziness. He was examined by the Opposite Party No. 2 Dr. Jawahar Dar (Neurosurgeon) at Indraprastha Apollo Hospital the Opposite Party No. 1 (hereinafter referred to as the 'Hospital') and on 08.03.2004 MRI was conducted. It was diagnosed as 'Pituitary Gland Tumor'. The patient was operated by the Opposite Party No. 2 on 17.03.2004 and discharged from the Hospital on 20.03.2004. At the time of discharge, the pain killer tablet 'Voveron' 50mg twice a day for two weeks was advised and the patient was called for follow-up on 26.03.2004. It was alleged that tablet 'Voveron' was prescribed without taking patient's past history GI bleed or Malena. On 02.04.2004, the patient fainted because of blood in the Stool, severe GI Bleed and malena, he became anemic - hemoglobin was low as 6.2 g%. He was readmitted in the morning on 03.04.2004. Dr. Broor-Gastroenterologist the Opposite Party No. 3 conducted various diagnostic tests including Upper GI endoscopy, Colonoscopy, Capsule endocscopy, CT abdomen, pelvis and mesenteric angiography. Further Isotope study and MRCP were done, but all test results were normal. The cause of lower GI bleed remained obscure and undiagnosed in the Opposite Party No. 1 Hospital for 16 days and transfused 28 units of blood/plasma. The bleeding was stopped and the patient was discharged on 19.04.2004. It was alleged that the special test for Hepatitis C was conducted and it reported on 17.04.2004 as RNA-Hepatitis C positive. The Liver Functioning Test (LFT) was severely deranged (SGOT/SGPT and Bilirubin were high). However, the OPs never disclosed it to the Patient and/or his family, but soon after discharge, Dr. Broor (OP-3) about Hepatitis C Positive. Thus it was alleged that the patient contracted Hepatitis C infection from the hospital. After few days on 28.04.2004, the patient's BP dropped. On the next day he felt giddy and passed black stool again in the evening. Therefore for 3rd time, in the night the patient was admitted to the Hospital in ICU. One unit of blood was transfused and various tests were conducted but there was no evidence of active GI bleed. After stoppage of blood on 3.5.2004 he was shifted from ICU to the room. But prior to discharge he suffered stroke and right lip palsy, it was due to alleged lack of monitoring the vital parameters. Again he was shifted to ICU and after 3 days he was discharged on 7.5.2004 along with one brief summary. Thereafter the patient took treatment from different hospitals. On 2.3.2005 he was admitted in Ashlok Hospital, thereafter on 19.03.2006 in Umkal Hospital at Gurgaon. On investigations revealed sepsis, raised liver enzymes further renal impairment. Subsequently at the end the Patient developed deep yellow discoloration of the body and he was managed on lines of Hepatic

Encephalopathy, sepsis and multi organ failure. However, he suffered a cardiac arrest and died on 11.04.2006 in the night.

3. During July to October 2005, the Complainant No. 1 made correspondences with the Opposite Party No. 1 hospital and attempts to settle the matter amicably, but to no avail. Again on 17.04.2006, he once again wrote the Opposite Party No. 1 Hospital for an amicable settlement; however did not get response from the hospital.

4. Being aggrieved due to the gross medical negligence in the treatment by the Opposite Parties, the Complainants filed this Complaint under Section 21 of the Act, 1986 and prayed for total compensation of Rs. 1,08,90,299 with interest @ 18% per annum.

Defense:-

5. The Opposite Parties filed their respective written versions and denied the allegations of negligence.

6. **The Opposite Party No. 1 - 'Indraprastha Apollo Hospital** filed written version through the Deputy Director. The preliminary objection was about no cause of action. There was no negligence from the treating doctors, who treated the patient with due care. He submitted that the patient was a known case of Hypertension and Diabetes for more than 12 years. The patient was on regular Insulin injections. He had congenital dextrocardia, situs inversus and colonic diverticula. In past, he underwent cholecystectomy and he was also having recurrent episodes of GI bleed for last several years, but the cause was unknown and not traceable. On 17.03.2004 the patient was successfully operated for Pituitary micro-adenoma by Dr. Jawahar Dar (OP-2) and discharged on 20.03.2004. During hospitalization, the patient did not report any history of passing blood in stool. He was admitted 2nd time again on 03.04.2004 with 4 days history of malena. There was history of consuming NSAID drugs and he had similar episodes of malena 3-4 times during past three years. The patient's haemoglobin was low (6.2 g%), therefore blood transfusion and supportive treatment was given. His upper GI endoscopy revealed esophageal candidiasis and a small sessile gastric polyp. The Upper GI endoscopic gastric biopsy from the small polyp was positive for H.Pylori and showed features of chronic inflammation. The Colonoscopy also did not reveal any bleeding site and only few diverticula were seen in the left colon. On capsule endoscopy, food residue could be seen in stomach despite overnight fasting. The capsule remained in stomach for more than 5 hours, though clinically there were no features of gastric outlet obstruction. The small intestine did not reveal any lesion. The mesenteric angiography was done, it was normal. The Red Blood Cell (RBC) tagged scan also did not show any source of bleed. USG abdomen/CECT abdomen was also within normal limits. He further submitted that on 31.03.2004, the LFT was abnormal, which indicates Hepatitis C infection before 03.04.2004 i.e. 2nd admission to the hospital. It was before the blood transfusion. On 05.04.2004 Anti HCV anti body test was negative, it does not rule out Hepatitis C at that point of time. On 19.04.2004 at the time of discharge the GI bleeding was stopped. The Anti HCV becomes positive several weeks after onset of acute hepatitis C. The patient did not follow up his treatment with the Opposite Party Hospital and he was treated at various other Hospitals. Moreover, death of the patient took place in Umkal Hospital. Therefore, the allegation about acquired infection at Opposite Hospital is not sustainable.

7. **The Opposite Party No. 2 - Dr. Jawahar Das-Neurosurgeon**, in his reply denied the negligence. He submitted that the Complainants on their own have stated that the alleged Hepatitis 'C' could have been picked either through needle, injection or surgical equipment or blood transfusion. On 17.03.2004, he performed the surgery- transphenoidal hypophysectomy. During surgery blood transfusion was not given and no reusable material was used. The surgical instruments were double autoclaved and maintained highest standard of sterility. Therefore, the question of contracting Hepatitis 'C' infection from the Opposite Party No. 1 hospital did not arise. The Complainants have not produced the complete details of the treatment and the investigations conducted at other hospitals, namely, Ashlok Hospital and Umkal Hospital. The patient did not die in the Opposite Party No. 1 hospital.

8. **The Opposite Party No. 3- Dr. S.L. Broor** in the written version stated that the Complainant is bad in law for non-joinder of the necessary parties, as the patient took treatment from several hospital, subsequent to

his discharge from the Opposite Party No. 1. As the patient died at Umkal Hospital, the Opposite Party No. 3 had no knowledge about the cause of death.

Arguments:

9. We have heard the arguments from the learned Counsel for both the sides. Perused the material on record, *inter alia,* the Medical Record and gave our thoughtful consideration.

Arguments on behalf of Complainants:

10. The learned counsel for the Complainants reiterated the facts of the Complaint. He vehemently argued that the treating doctors failed to exercise care and caution while prescribing medicine 'Voveran' for 3 weeks. The doctors failed to check any past history of malena and to conduct evaluation of the GI system. Voveran was contraindicated in a geriatric patient with history of GI bleed and Hypertension. The doctors did not inform about possible side effects of Voveran. Due to GI bleed, the patient was transfused 28 units of blood/plasma. It permanently affected patient's immune system & hastened his death. The Patient developed life threatening Hepatitis 'C' the nasocomial infection (hospital acquired infection) leading to Hepatic Encephalopathy/liver failure/sepsis and consequently death. On 03.05.2004, the Opposite Party No. 3 failed to treat the neurological, facial palsy and stroke. Due to left facial palsy, the patient had dribbling of saliva, difficulty during speech and eating. It was embarrassment in his active social life and he lost further hope of life. He further submitted the burden of proof is discharged by complainants, the burden of proof shifts on to hospital/doctors to prove there was no negligence. The Opposite Parties have miserably failed to prove that the operating equipments were properly autoclaved (starilised).

11. He further argued that as per the doctrine of **Legitimate Expectation**, the Apollo Hospital, being a super specialty hospital, the expected standard of care should be high, but it was violated by the breach of duty in the instant case. In the instant case the negligence may not be the immediate cause of death but it contributed materially to the death of the patient. The learned Counsel for the Complainants relied upon the following judgements:

(i) *PGIMER Chandigarh vs Jaspal Singh**[1]*

(ii) *Sita Ram Srivastva vs. Sanjai Gandhi PGI**[2]*

(iii) *Malay Kumar Ganguly vs. Sukumar Mukherjee**[3]*

(iv) *Dr. V.K. Ghodekar vs Smt. Sumitra**[4]*

(v) *Apollo Hospital vs. Ashish Sanyal**[5]*

Arguments on behalf of the Opposite Parties:

12. The learned Counsel for the Opposite Parties reiterated their evidence and chronology of treatment administered. He submitted that during first admission the patient neither gave history of malena nor shown the previous medical record to the treating doctors and / or consultants. On 03.04.2004, during subsequent admission, the patient was thoroughly investigated but cause of bleeding due to Voveran was not detected. Subsequently, patient disclosed his past history of repeated GI bleed in the past three years but even after all investigations, the cause was not detected.

13. The Counsel further argued that on 17.03.2004 the patient underwent pituitary surgery, and on 31.03.2004 detected to have Acute Hepatitis C, which was extremely unlikely to be acquired in Apollo Hospital. The hospital maintains strict procedures for asepsis and sterilization of surgical instruments. All syringes, needles and intravenous cannulas used are sterile and disposable. The most common cause of hospital acquired Hepatitis C might be due to transfusion of blood and blood products. In the earlier days, tests for Hepatitis C

screening were not available. Thereafter, the screening of donors for Hepatitis C became mandatory and the risk of blood transfusion causing Hepatitis C became extremely low (1 in 83000000; 1 in 1935900, 1 in 425714 in different series). In the instant case, no blood was transfused during surgery. Thereafter, the patient developed GI bleed and received blood transfusion between 3.4.2004 to 19.4.2004. As per medical text on average incubation period of Hepatitis C is 2-8 weeks. Thereafter, if the HCV infection developed from instruments used during operation, it would have diagnosed after minimum 2 weeks of surgery, therefore, it was highly not possible that unlikely that he contracted Hepatitis C in the hospital. It might be several weeks prior to admission in Indraprastha Apollo Hospital. The Patient was high diabetic and receiving regular insulin Injections and frequently undergoing blood tests. In addition, patient took dental treatment on few occasions. These are known risk factors for acquired Hepatitis C. He further argued that progression of liver disease after HCV infection is usually slow and takes over a long period to develop antibodies (Anti HCV). Therefore, the test in window period show negative result, which cannot rule out HCV infection**.** He further submitted that, the Death Certificate shows that the cause of death was due to complications of diabetes and hypertension, but not due to HCV. It was due to sepsis with multi-organ dysfunction including respiratory failure and renal failure.

Observations and conclusion:

14. The Complainants main grouse was that the patient developed life threatening Hepatitis C infection in the hospital leading to hepatic encephalopathy and death. It is evident from the medical record that the viral markers were negative, whereas the positive report of HCV-RNA was received on the day of discharge. Thereafter further evaluation of patient was advised. During that period of 2 months, the patient was admitted three times and treated as per symptoms of malena. Despite all investigations, the cause of malena remained undetected. It is pertinent to note that the patient previously took treatment at GB Pant Hospital and the report dated 05.07.2000 revealed the patient was suffering from malena, but the cause was not traceable. The upper GI endoscopy did not reveal any source of bleed. The full length colonoscopy showed dark colored blood up to caecum with few diverticula in sigmoid and descending colon. However, there was no active bleed. The RBC tagged scan was done and found normal.

15. On 03.05.2004, the patient developed right hemiparesis with right 7^{th} supra nuclear palsy, but the CT Scan did not reveal any intracranial bleed. The Neurologist, Dr. Mukul Verma opined that it was due to cerebral thrombosis. Therefore, Tablet Chlopidogrel was started after explaining risk of GI bleed to the patient's son. The Carotid Doppler showed 48% stenosis of left internal carotid artery with ulcerated plaque. After supportive treatment, there was improvement in the speech and power of the right limb. There was no fresh GI bleed. The patient was accepting orally and passing stool normally. The interferon therapy for acute hepatitis was not decided as the patient was on anti-platelet drugs. Before discharge, the risks and benefits were discussed in detail with the patient's son.

16. It is pertinent to note that the patient was regularly taking insulin injections and underwent dental treatment on few occasions. Therefore, in our view Hepatitis C infection in short period cannot be attributed to the blood transfusion. As per medical literature, the average incubation period of Hepatitis C is about 6 weeks whereas in the instant case, the blood was transfused 2 weeks back.

17. It is pertinent to note that the patient or attendants did not give any past history of bleeding. They concealed the fact from the treating doctors at the Opposite Party Hospital. The Opposite Party No. 2 stated before Delhi Medical Council that *"the patient did not give any past history of GI bleed, and there was no apparent reason for him to inquire about the same and as such, when the patient was discharged he was prescribed Voveron"*. Moreover, after 7.05.2004 the patient took treatment in different hospitals and he died in Umkal Hospital on 11.04.2006 i.e. almost about 2 years after the discharge from OP Hospital.

18. It is known that elderly patients with long-standing diabetes mellitus and hypertension are substantially at higher risk and can develop stroke at any time. In the present case the stroke was possibly because of thrombosis. Patient was investigated which showed 48% narrowing of Left Internal carotid artery with presence of ulcerated plaque which corroborates the cause for stroke and neurological Palsy. From MRI and

CT-Scan, minute lacunar infarcts in the brain were seen. Therefore, we do not accept the allegation that patient developed stroke due to lack of proper monitoring patient's blood pressure and vital parameters.

19. The Delhi Medical Council after going through the entire record of the case, examining the witnesses came to a conclusion on 05.08.2008 that no medical negligence could be attributed to the doctors of Indraprastha Apollo Hospital in the treatment administered to the deceased. The Complainant appealed against the DMC order to the Medical Council of India (MCI). The Ethics Committee of MCI upheld the decision of DMC. It was held that;

> "In view of the aforesaid, it is submitted that the entire allegations made by the Complainants against the treating Consultants and the Opposite Party Hospital are incorrect and only an afterthought with sole motive to harass the Opposite Party Hospital and to extract undue monetary benefits from them. There was no negligence and deficiency in providing service on the part of the Opposite Party Hospital and its Consultants and that the claim of the Complainants is not maintainable and is liable to be dismissed."

20. We further note that the Opposite Party 3 - Dr. S.L. Broor was a Gastroenterologist working in Apollo Hospital and he had attended the patient 1st time on 04/04/2004. The patient did not submit any record of G. B. Pant hospital, PSRJ and Quest diagnostic center, USA. Therefore, the allegation that Voveron was prescribed despite having knowledge of Malena/GI bleed does hold any ground. The Gastro Entrologist - Opposite Party No. 3 had no role to play with respect to the first admission or prescribing Voveron to the patient. In fact that the patient's Hepatitis C infection was confirmed by PCR test conducted on 17.04.2004. It revealed RNA- HCV positive which was about 15 days of hospitalization. However, the incubation period for HCV is up to 8 weeks. In the instant case, in our view possibility of patient catching HCV infection from the regular injections of Insulin cannot be ruled out. Admittedly the patient was having NIDDM for last more than 15 years and / or from the treatment taken for dental problems.

21. It is pertinent to note that the Opposite Party Hospital investigated the patient thoroughly and treated as per the standards. Despite every effort, the patient could not be cured; it shall be borne in mind that **"No cure is not necessarily the negligence".** It is pertinent to note that the patient was elderly, having several co-morbidities. The death of the patient occurred almost one year after the discharge from the Opposite Party Hospital and during that period, he took treatment from different hospitals. Therefore, the cause of death and negligence cannot be attributed to the Opposite Party Hospital and the treating doctors

22. In **S. K. Jhunjhunwala vs. Dhanwanti Kaur and Anr.[6]**, wherein 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. It was further held 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.

23. Based on foregoing discussion, it is difficult to attribute medical negligence against the Opposite Parties. The Complainant failed to prove medical negligence.

24. The Complaint is dismissed. There shall be no Order as to costs.

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[1] (2009) 7 SCC 330

[2] 2017 SCC online NCDRC 274

[3] (2009) 9 SCC 221

[4] 2008 (3) CP J (NC)

[5] R.P. No. 215/2008 decided by NCDRC on l5.05.2012

[6] (2019) 2 SCC 282

.....J
R.K. AGRAWAL
PRESIDENT

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DR. S.M. KANTIKAR
MEMBER