NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION
NEW DELHI

Original Petition No. 61 of 1996

Smt. Saroj Chandhoke …. Complainant
Wife of Sh. Kul Kamal Chandhoke
R/o 50C/82 (Ground Floor)
New Rohtak Road
New Delhi.

Versus

1. Sir Ganga Ram Hospital
   Poorvi Marg, Rajinder Nagar
   New Delhi/

2. Dr. S.K. Bhandari
   D-245, Defence Colony,
   New Delhi110 024. … Opposite Parties

Original Petition No. 51of 1996

1. Kul Kamal Chandhoke
2. Ms. Rakhi Chandhoke
3. Ms. Ankur Chandhoke
4. Ms. Neha Chandhoke

   R/o 50C/82 (Ground Floor)
   New Rohtak Road
   New Delhi. … Complainants

Versus

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BEFORE :

HON'BLE MR. JUSTICE M.B. SHAH, PRESIDENT
MRS. RAJYALAKSHMI RAO, MEMBER

For the Complainant(s) in both the Petitions .. Mr. Ashwani Kumar Mata Sr. Advocate with Ms. Ankur Chandhoke and Mr. Girish Kaul, Advocates

For the Opposite Party No.1 in both the Petitions .. Mr. Vinay Bhasin, Sr. Advocate with Mr. H.L. Raina, Advocate.

For the Opposite Party No.2 in both the Petitions .. Mr. V.N. Kaura, Advocate with Mr. Paramjeet Benipal, Advocate.

Dated the 9th July, 2007

O R D E R

M.B.SHAH, J. PRESIDENT.

Original Petition No. 61 of 1996

I. In a simple hysterectomy operation performed on the Complainant on 21.6.1993, she lost her kidney; her ovaries; she was

required to undergo various further curative operations, because there was uncontrollable fecal discharge from vagina from 29.6.1993 onwards; and she suffered pain for months together after the operation. `It is pointed out by the learned Counsel for the Complainant that her large intestines were exposed and small intestines were infected with adhesions at various places. A further surgery was carried out for repair of fistula and closure of fistula on 17.11.1993 and for closure of colostomy operation was performed on 21.2.1994. She remained in pitiable condition in the hospital. She was finally discharged on 14.3.1994.

Hence, complaint is filed contending that due to alleged deficiency in service by the expert Doctors in the known hospital, the Complainant, her husband and three young daughters suffered and experienced immense trauma and hardship. For this deficiency, she has claimed compensation of Rs.25,50,000/-.

II. **Brief Facts**:

Complainant, who was 43 years at the relevant time was suffering from bleeding for the last 2 to 3 months till she consulted the

Opposite Party No.2, Dr.S.K.Bhandari, a senior Doctor in Sir Ganga Ram Hospital and was diagnosed for Dysfunctional Uterine Bleeding (DUB). As the DUB was not responding to medical therapy she was advised for hysterectomy – removal of uterus. Her consent was taken for removal of uterus through abdominal route (Total Abdominal Hysterectomy, i.e. TAH). Operation was performed on 21.6.1993. The contention of the Complainant is that in a simple hysterectomy operation, the Complainant suffered a lot and the following operations were performed:

(i). Dilation and Curettage (D&C);

(ii). Hysterectomy - without consent through vaginal route, and thereafter, via abdominal route, TAH

(iii). Bilateral Salpingo Oophorectomy (BSO) – i.e. removal of both fallopian tubes and the ovaries.

(iv). Lapratomy; and

(v). Left Nephrectomy.

(vi). Surgery for repair of fistula; and

(vii). Surgery for closure of colostomy.

Hence, the questions which require consideration are:

(i). Whether a Doctor who is an expert Gynecologist, was justified in carrying out operation of hysterectomy via vaginal route even though specific consent was obtained for Total Abdominal Hysterectomy (TAH)?

(ii). Secondly, whether the Doctor was justified in removing healthy ovaries while performing the operation for hysterectomy, that too, without the consent of the Complainant?

(iii). Thirdly, whether the vein can avulse to such an extent that kidney is required to be removed? Or

(iv). As there is no explanation as to how the vein had avulsed to such an extent that it could not be traced and clamped, whether the principle of 'res ispa loquitor' (facts speak for themselves) could be applied as observed in the case of Savita Garg (Smt.) vs. Director, National Heart Institute, (2004) 8 SCC 56.

For finding out whether there was deficiency in service by the Doctors, we would first refer to the facts narrated by the Complainant and the contentions of the Doctors as well as the Hospital.

III. Contentions of the Complainant:

The Complainant, Smt. Saroj Chandhoke states that she had the history of two cesarean deliveries. As she was suffering from Dysfunctional Uterine Bleeding (DUB) she contacted an expert Gynaecologist, Dr.Bhandari, at Ganga Ram Hospital, who, after examining the Complainant and keeping in view the previous cesarean deliveries and after having discussed with her and her husband, advised for removal of uterus (hysterectomy) through abdominal route (TAH). Her specific consent was taken for TAH under general anaesthesia.

It is her contention that she was not advised on the alternative routes of surgery, their comparative benefits, and denies the contention of Dr.Bhandari that the Complainant and her husband left the decision to Dr.Bhandari to choose the appropriate route. Fees were paid and an

advance of Rs.700/- was deposited in the hospital and Dr.Bhandari issued a slip on 14.06.1993 to the patient to be given in the hospital for admission of patient for TAH surgery.

Thereafter, the Complainant was admitted in the hospital on 20.6.1993 and her husband deposited Rs.6,000/- in the hospital. On that day, pre-anaesthetic check up (PAC) was carried out by Dr.Chand Sahai, Anesthetist. It is pointed out that the PAC notes indicates that the patient was admitted for TAH surgery. On the same day, she was examined by Dr.Nayantara at about 3.30 pm. The Complainant informed the said Doctor that TAH should be performed under general anesthesia to which Dr.Nayantara responded affirmatively. Again, her consent was obtained and recorded by Dr.Nayantara for TAH. This is not controverted by Dr.Nayantara.

On the next day, i.e. on 21.6.1993, the surgery for TAH was performed. It is the case of the Complainant that in the labour room, in the OT complex, she was given lumber epidural anesthesia (LEA) forcefully much against her objections, protests and to her consternation. It is pointed out that as the Complainant has agreed for general anesthesia,

administration of LEA was without her consent. She further protested when Dr.Bhandari came. It is her say that she was under the impression that after the internal examination, she would be wheeled into the Operation Theatre (OT) for TAH. However, within moments, she experienced excruciating and intolerable pain and screamed and fainted and thereafter she was not in a position to recollect further events which occurred in the OT complex.

Subsequently, she found that a series of operations were performed on her, i.e. at first **Dilation and Curettage** (D&C) was carried out; subsequently, hysterectomy - initially through **vaginal route, and, thereafter, through abdominal route**; her **ovaries were removed**; and, **her left kidney was also removed**. **No consent was taken for hysterectomy through vaginal route, nor for removal of ovaries nor for removal of kidney**.

She contends that: (a) no organs or body parts that were removed were ever shown or disclosed to the patient or to her relatives; (b) secondly, the surgery expanded beyond the domain of consent and removal of ovaries and fallopian tubes through vaginal route resulted in rupture of a blood vessel; (c) the rupture of blood vessels which was

encountered by the Doctors was not during hysterectomy but during removal of ovaries for which there was no planned surgery and no consent; (d) the left ovarian vein connects the left ovary to the left renal vein and is not connected with the uterus. The length of this vein in an adult woman is approximately 8 to 10 inches. Hence, avulsion could not be to such an extent.

It is, therefore, contended that there was no consent for enlarged surgery undertaken by the Doctors; there was no consent to adopt vaginal route; there was no consent to proceed for surgery under the epidural anesthesia; there was no consent for BSO or D&C. However it is contended that even there was no consent for nephrectomy, yet, no claim is made for removal of the kidney, because, it was necessitated due to turn of events. It is submitted that such eventuality would not have been encountered if the surgery remained within the domain, as agreed.

It is next contended that if avulsion of vein in such surgery is known for complications, expert Doctors like Mrs.Bhandari ought to have kept in readiness and preparedness the services of a Vascular Surgeon to meet such an eventuality.

It is, therefore, submitted that there is apparent negligence or deficiency in service on the part of the Doctor and the hospital and for this deficiency, the Complainant should be awarded compensation, as prayed for.

IV. Submissions of Opposite Party No.2, Dr. (Mrs.) Bhandari:

As against this, Dr.Bhandari has exhaustively stated in her affidavit which was filed by way of her evidence before this Commission, as to how various operations were performed, which includes her defence, and why operations for repair of fistula and closure of fistula, and closure of colostomy were required to be performed. We would refer to relevant part as it throws light on the aspects as to how and why a series of operations were performed and also on her say that she had obtained the oral consent of the Complainant. The same is as under:

> "18. I would like to state that in Gynecological practice, the commonest reason for hysterectomy in this age group is

Dysfunctional Uterine Bleeding, 'DUB', which does not respond to hormone therapy and for which there is no organic pathology.

.19. According my records Mrs.Chandhoke who was accompanied by Mr.Chandhoke saw me again on 14.6.93 and told me that she was taking hormone tablets and was still bleeding. She again enquired whether D & C will cure the bleeding and I explained to her that D & C is only done in such cases to determine the cause of bleeding and not as a curative procedure, and that if the bleeding is continued, hysterectomy may have to be considered as the best option. The patient told me that she and her husband wanted complete and permanent cure **of her bleeding problem and would like to opt for hysterectomy**. She also enquired from me whether instead of having two visits to the operation theatre, one for D & C, and another for hysterectomy, if it was possible to perform both procedures in one visit. I would like to state that in **every case where hysterectomy is performed, D & C is done prior to hysterectomy** as a routine, with a view to mould the procedure according to the findings of D & C, if necessary. I accordingly, informed Mrs.Chandhoke that since, at that stage, she did not want

D & C to be done separately, it could be done immediately before hysterectomy. I also said that we have the facility in the hospital for immediate examination of the uterus (frozen section) when the result is known within 15-20 minutes.

20(a) I told Mrs. Chandhoke that since she had agreed to the removal of uterus, and clinical findings showed that Mrs.Chandhoke could possibly have vaginal hysterectomy, but **since she had had two previous caesarean sections, she should also be prepared for Abdominal hysterectomy, if indicated either as a result of her re-examination in the operation threatre** [Patient is normally re-examined again before undertaking hysterectomy when patient is sedated (EUA) or as a result of D & C. Re-examination is to check if there were any contraindications to vaginal hysterectomy. If so, then it is necessary to do only abdominal hysterectomy. A slip was accordingly issued by my office to Mrs.Chandhoke that she should be prepared for abdominal hysterectomy. A copy of this slip is annexed as Annexure R2 ‘E2

20(b) I say that in all cases of hysterectomy vagina is always

cleaned and prepared, as this area is a source of infection. If there is a possibility of abdominal hysterectomy then abdomen is also prepared.

21. Also annexed hereto and marked Annexure R2-F are extract of the experience and observations of other surgeons and authors who have recommended a similar practice to finally determine the route to be adopted for the hysterectomy.

22. Once the operation of hysterectomy was decided upon I directed for further tests such as Blood urea, Chest X-ray, ECG, and repeat haemoglobin, to be performed (routinely done for all patients who are undergoing hysterectomy)."

Thereafter, reliance is placed on "Book of Operative Gynaecology" written by John Howkins under whom she had training in Gynaecoloy and Obsterics. Page 167 quoted in the affidavit is as under:-

"The real argument on the matter can be summerised as

follows: If a uterus can be removed equally by vaginal as well as by abdominal hysterectomy and the surgeon is an experienced vaginal operator, the vaginal route may be preferred. The absence of an abdominal incision with its possible complications of haematoma, wound sepsis incisional hernia and even rupture is a major recommendation ….."

Thereafter, in affidavit it is stated that:

"29. Every surgical operation is fraught with risk. No operation can be considered to be safe as any complication, during the operation may appear any time. This is so in best of centers all over the world and with best of surgeons. This has also been accepted by the courts and reiterated in their judgments.

30. If abdomen is opened, as in case of hysterectomy, it is a major operation and far from being called 'safe.' The more the invasiveness, the greater the risk. No two human bodies are exactly alike. Each has its own deviation and distinctive features. Human bodies are as individual and

different in their details as are human beings.

31. I also mentioned to Mr. & Mrs.Chandhoke that even though, there are many advantages of vaginal hysterectomy over abdominal, still each and every patient cannot undergo vaginal hysterectomy as there are certain parameters which have to be satisfied before undertaking vaginal hysterectomy. If there is any contraindication to the vaginal hysterectomy then only abdominal hysterectomy is done. I told Mrs. & Mrs.Chandhoke if there is no contraindication to vaginal hysterectomy and no requirement of abdominal hysterectomy found on re-examination of the patient in the operation theatre, I would prefer to adopt the route of vaginal hysterectomy.

I again **told Mrs. Chandhoke that since she had** two previous **caesarean sections she should also be prepared** for **abdominal hysterectomy**. The final decision will be taken only after re-examination in the operation theatre. All such patients are preoperatively prepared for abdominal as vaginal preparation is always done in respect of all hysterectomies.

32. On 17.6.93, I also discussed with Mr. And Mrs. Chandhoke the removal of the ovaries at the time of hysterectomy, as part of the operation for hysterectomy.I told Mrs.Chandhoke that the function of the ovaries starts to decline from the age of 40 years so when at her age i.e. at the permenopausal age, hysterectomy is done on any woman, with regard to the ovaries there are two approaches, either the ovaries are taken out too (fallopian tubes come out along with ovaries) or they are left behind.

49. Ovaries were removed at hysterectomy as Mrs.Chandhoke had asked me to do so, after hearing the advantage/disadvantages of removal/retention of ovaries. This is proved that:

a) Mr. Chandhoke met a journalist of “The Hindu” on 1st September 1993 and discussed the hysterectomy with him. This was published in “The Hindu” dated 2nd of September 1993 and was exhibited by the complainant as her exhibit along

with OP 61/96. No mention was made during the discussion about the hysterectomy concerning the removal of ovaries.

b) Similarly in the original petition 96/1996 no mention was made about removal of ovaries either by Mr. or Mrs. Chandhoke as obviously they knew that they themselves had asked me for their removal at hysterectomy.

50. In vaginal hysterectomy operations I have re moved ovaries, where they were to be removed, vaginally.

In a book called 'Vaginal Hysterectomy' by S.S. Sheth and John Studd published by Martin Dunitz, London 2002 it says about ovaries removal that 95% of ovaries were removed vaginally by the author.

51. Coming to the operation, when the ovarian vessels were being clamped, cut and ligated, on the left side, one of the ovarian veins avulsed resulting in profuse bleeding. Haemorrhage at that point is a possible complication both in

abdominal and vaginal hysterectomics (Annexed at Annexure R2-‘O’).

Women, after a normal delivery or caesarean section have had to have an emergency hysterectomy (removal of uterus) because of profuse haemorrhage in some cases when even if there is no living child and irrespective of their age, in order to save the life.

.52. I say that bleeding or haemorrhage and its consequences are one of the major risks inherent in every surgery. Haemorrhage is an expected complication in Hysterectomy because of the type and location of blood vessels in the region. In one of the major causes of haemorrhage during Hysterectomy arises out of brittleness of the veins in the region, which can be as thin and brittle as a wet tissue or blotting paper which cracks, breaks and/or shears off at the least pressure.

“The complication of haemorrhage in hysterectomy is

recognised in most of the textbooks. I refer the following excerpts in this behalf:

Telinde's "Operative Gynaecology 8th edition published by Lippincott Raven Phildelphia USA 1997, page 216 says:-

1. Despite adequate technical skills and careful dissection, serious hemorrhage can suddenly appear, especially during retroperitoneal dissection on the lateral pelvis side walls and around the sacrum …. Hemorrhage in the pelvis is a difficult problem that occurs because of the laceration of deep pelvic veins, such hemorrhage can vary in magnitude from trivial to life threatening. Pelvic veins can be fragile tortuous hidden from view, and distended.

2. In the Book "Complications in Obstetrics and Gynaecologic surgery by George Shaefer and Edward A Grabber at page 381 it is written:

"Occasionally, some tension is necessary, and veins in the broad ligaments may tear in spite of the operator's efforts".

3. In the Book 'Abdominal Trauma' by F. William Blaisdell And Donald D. Trunkey published by Thieme Medical Publishers incorporated USA page 372 it says:

"Veins often have the consistency of wet tissue paper and tear with the application of clamps or **when sutured under tension**".

(**It is to be stated that in spite of knowing this fact, the Opposite Party No.2 did not keep any 'Vascular Surgeon' ready to meet any eventuality**.)

The Opposite Party No.2, Dr.Bhandari, in her written submissions stated that:

"After the Complainant was sedated and she did the pelvic examination, and found her tissues lax, the uterus was normal in size, mobile and there was no suspicion of adhesions; the uterus had already partially descended into the vagina and has also dragged part of the urinary bladder which has just in front of the uterus (Cytocele). At this stage she told the team of

Anaesthesists, Dr.S.Sindhu (Senior Consultant, Anaesthesia), and Dr. A.K.Jain (Consultant) and the patient that she would be doing the vaginal hysterectomy. Anaesthesists decided to give Mrs.Saroj Chandhok epidural anaesthesia (E.A.). The epidural anaesthesia is given by a needle into the back in the spine. By this technique all the area where the operation is carried out is fully anaesthesied. This is a world wide accepted mode of anaesthesia for vaginal hysterectomy. With this anaesthesis post operative pain, vomiting and abdominal disturbance is very little, as compared to general anaesthesia. Prior to hysterectomy, it is a normal practice to do a Dilatation and Curettage (D&C) to check on the condition of uterus lining before proceeding for hysterectomy. D&C was done on Mrs.Saroj Chandhoke also, which showed a small amount of lining with blood clots. At this point, Mrs.Chandoke was apprehensive and nervous of being conscious. Hence, the Anaesthesists supplemented epidural anaesthesis with light general anaesthesis".

Thereafter, in continuation of the above, in the affidavit she

stated that :

"53. I say that in the present case I commenced vaginal Hysterectomy on Mrs. Chandhoke at around 8.45 a.m. on 21st June, 1993. To remove the uterus it had to be detached from the surrounding tissue and blood vessels. The blood vessels feeding blood to and draining blood from the uterus and the ovaries had to be clamped and cut/litigated to detach them from the uterus **and ovaries** so that these **could be removed**. In the present case, I had completed the removal of the uterus and the ovaries after operating for about an hour and was in the last stage of the operation which involved ligating the left **infudibulopelvic ligament**, **when one of the clamped veins suddenly avulsed leading to profuse bleeding**. **I tried to catch** the **bleeder through the vaginal passage but could not trace** as **the bleeder had retracted upward**. **I then decided to open** the abdomen (Laparotomy) of **Mrs. Chandhoke to try to catch** the bleeder **from above, which is commonly adopted procedure** in such cases. This is annexed at Annexure R2-'P'. On opening the abdomen, I noticed a haematoma (blood clot) spreading, and extending

upwards towards the kidney which indicated retrogade blood flow (reverse blood flow) taking place from the left renal vein. I tried again to control the bleeding by applying pack pressure and to trace the bleeder, but without success. At this stage I considered it necessary to call for assistance in controlling the bleeding. I, therefore, called Dr.K.C. Mittal Senior Consultant General Surgeon, who was operating in the next theatre, for assistance. He immediately came and took charge of the patient. The bleeding was retrograde from the left renal vein. He also applied pack pressure to stop the bleeding, while I explained to him what had happened. He, however, could not control the bleeding either, which continued profusely despite the pack pressure. Since the bleeding was retrograde from the left renal vein, he requested for the assistance of Dr. Rajesh Khullar, Consultant General Surgeon on duty and Dr.Sudhir Chaddha, Consultant Urologist Surgeon present in the hospital at the time."

As they were not successful in controlling the bleeding, and as the blood pressure was dropping, they decided collectively to remove the

left kidney, as a life saving procedure, after checking the right kidney was in position.

After the bleeding had been controlled, though unfortunately the left kidney had to be sacrificed to save the patient's life, Dr.S.K.Bhandari completed the operation. Patient received 9 units of blood and one unit of plasma during the operation. Another 4 units of blood were given in ICU (Intensive Care Unit). The lost blood had to be replaced promptly. All possible and prompt measures to meet the situation and save the valuable life were employed without any loss of time, which action has actually saved the life of the Complainant.

On the night of 30.6.1993, Mrs. Chandhoke complained of palpitation when she was examined by Dr.V.K.Chopra, Consultant Cardiologist. He found her heart & ECG normal but advised observation in ICU for 24 hours, as a precautionary measure. She was shifted back to the room on 2.7.1993.

Mrs. Chandhoke had complained of vaginal discharge on 29.6.1993. It became clear in the next few days that she had developed a

small communication with upper part of the rectum and upper part of vagina. This is known as the Rectovaginal fistula. The upper part of vagina and rectum are in close proximity to each other. Even a minor infection here can lead to small abscess formation which can result in Rectovaginal fistula. Over a period of time, Rectovaginal fistula can heal spontaneously. Senior Consultant Surgeons Dr. K.C.Mittal, Dr. Trilochan Singh, Dr. Goel saw and advised that conservative treatment of keeping the area clean, dietary couts and administering of antibiotics to continue. X-ray study including C.T.Scan was done on 15.7.1993 to find the exact site of fistula. This showed small communication between upper part of Rectum and upper part of vagina. On 17.7.1993, she was seen by Dr.K.C.Mahajan, FRCS, Emeritus Consultant, General Surgeon, Sir Ganga Ram Hospital. After examination he gave the patient a choice of single stage surgery (Closing the fistula and diverting the stool, if necessary by doing colostomy simultaneously) or preliminary colostomy followed by repair of fistula and then closure of colostomy. It is on record that the patient then consulted Dr.Sandeep Mukherjee on 31.7.1993 and gave her consent for multistage operation on 3.8.1993. On 4.8.1993, and after 5 weeks of conservative treatment, Dr.K.C.Mahajan performed colostomy. Dr.S.K.Bhandari

continued to visit Mr.Chandhoke as the Complainant always said that she had full faith in Dr. S.K.Bhandari and wanted Dr.Bhandari to be there at every stage of surgery. It was Dr.K.C.Mahajan who provided the active professional advice and management.

On 15.2.1994 Barium Enema was done which showed the fistula had healed. On 21.2.1994 the final operation of closure of colostomy was performed. Mrs.Chadhoke was discharged on 14.3.1994 taking normal food and passing stool from the normal passage.

C. Findings:

(i). Law on the subject:

Before discussing the contentions, we would reproduce the law as settled by the Apex Court in Spring Meadows Hospital & Anr. Vs. Harjol Ahluwalia & Anr. (1998) 4 SCC 39 SC:

> "……The relationship between the doctor and the patient is **not always equally balanced. The attitude** of a **patient is poised between trust in the learning of another and the general distress of one who is in a state of uncertainty and**

such ambivalence naturally leads to a sense of inferiority and it is, therefore, the function of medical ethics to ensure that the superiority of the doctor is not abused in any manner. It is a great mistake to **think that doctors and hospitals are easy targets for the dissatisfied patient**. It is indeed very difficult to raise an action of negligence. Not only there are practical difficulties in linking the injury sustained with the medical treatment but also it is still more difficult to establish the standard of care in medical negligence of which a complaint can be made. All these factors together with the sheer expense of bringing a legal action and the denial of legal aid to all but the poorest operate to limit medical litigation in this country. With the emergence of the Consumer Protection Act no doubt in some cases patients have been able to establish the negligence of the doctors rendering service and in taking compensation thereof but the same is very few in number. **In recent days there has been increasing pressure on hospital facilities**, falling standard of professional competence and **in addition to all, the ever-increasing complexity of**

therapeutic and diagnostic methods and all this together are responsible for the medical negligence. That apart there has been a growing awareness in the public mind to bring the negligence of such professional doctors to light. Very often in a claim for compensation arising out of medical **negligence a plea is taken that it is a case of bona fide mistake which under certain circumstances may be excusable, but a mistake which would tantamount to negligence cannot be pardoned**. In the former case a court can accept that ordinary human fallibility precludes the liability while in the latter the conduct of the defendant is considered to have gone beyond the bounds of what is. expected of the reasonably (sic) skill of a competent doctor. In the case of Whitehouse V. Jordan ((1981) 1 AIR ER 267 : (1981) 1 WLR 246 HL) an **obstetrician had** pulled **too hard in a trial of forceps delivery and** had thereby **caused the a plaintiff's head** to become wedged with **consequent asphyxia and brain damage**. The trial Judge had held the action of the defendant to be negligent but this judgment had been **reversed by** Lord Denning, **in the Court of**

Appeal, emphasising that an error of **judgment would not tantamount to negligence**. When the said matter came before the **House of Lords**, the **views of Lord Denning on the error of judgment was rejected and it was held that an error of judgment could be negligence if it is an error which would not have been made by a reasonably competent professional man acting with ordinary care**. Lord Fraser pointed out thus :

"The true **position is that an error of** judgment may, or may not, be **negligent; it depends** on the nature of the error. If it is **one that would** not have been made by a reasonably **competent professional man** professing to have the standard and type of skill that the defendant held himself out as having, and acting with ordinary care, then it is negligence. If, on the other hand, it is an error that such a man, acting with ordinary care, might have made, then it is not negligence."

In the present case, the Complainant, aged about 43 years, was having the problem of Dysfunctional Uterine Bleeding (DUB), i.e. she was suffering from bleeding, apart from periods. Therefore, she

approached, along with her husband, the expert, Dr.Bhandari, in a big known hospital, with the hope that the simple operation of hysterectomy would be the safest in their hands. However, it endangered the life of the Complainant and finally for saving her life her left kidney was required to be removed and she had to suffer various other problems. Keeping this in mind and the law on the subject as stated in the case of Spring Medows Hospital (Supra) wherein the Apex Court referred to the observations of the House of Lords to the effect that **an error of** judgment may, or may not, be **negligent; it depends** on the nature of the error. But, if it is **one that would** not have been made by a reasonably **competent professional man** professing to have the standard and type of skill, **then it is negligence**.

Undisputedly, it is the contention of the Respondent No.2 that she is an expert Gynaecologist possessing various qualifications, i.e. Dr. S.K.Ghai (Mrs. Bhandari), MBBS., FRCS., FRCOG., Senior Consultant, Gynaecologist & Obstetrician, and has carried out large number of operations. Hence, she being an expert, was required to act more skillfully and at least her superiority ought not to have given her over confidence which finally resulted in a number of complications and endangered the life

of the patient. As an expert Doctor, she is expected to be more careful and skillful and that has not been done. Hence, deficiency in service.

(ii). <u>Consent</u>:

These days, complete information with regard to surgery is required to be given to the patient so that the patient becomes aware of the procedure which is sought to be followed by the Surgeon. It should not be presumed that a patient may not/need not know the procedure or is incapable of understanding the medical terms and, therefore, there is no use in explaining them. There cannot be a presumption that all patients are ignorant about their anatomy or the adverse effects or benefits of surgery, and, in any case, those days are over. **Hence, properly informed written consent before operation is the necessity**.

The Complainant, with regard to relevance of consent, has quoted excerpts of the Medical Code of Ethics, as under:

> "The followings acts of commission or omission on the part of the physician shall constitute professional misconduct rendering him/her liable for disciplinary action. 7.16: Before performing an operation the physician should obtain in **writing**

the consent from the husband or wife, parent or guardian in the case of minor, or the patient himself as the case may be ……." [(The Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002, Chapter 7 – 'Misconduct'].

In this case, it is beyond reasonable doubt that consent of the Complainant was taken for TAH and operation was performed on 21.6.1993. This is borne out by:

.(i). admission slip dated 14.6.1993;

.(ii). Physician progress notes and order dated 20.6.1993 at 3.30 pm. as noted by Dr.Nayantara;

.(iii). consent form dated 20.6.1993;

.(iv). Pre-anaensthetic record dated 20.6.1993 carried out by Dr.Chand Sahai;

.(v). Nurse's daily record dated 21.6.1993 stating TAH on 21.6.1993;

.(vi). Operation notes of Dr.Anil Jain, Anaesthetist (TAH).

From this, it is apparent that express consent was taken only for

TAH.

However, it has been contended by Respondent No.2, Dr.Bhandari that oral consent was obtained from the Complainant.

In our view, if oral consent was obtained before two days of the operation, at least some notes would have been made and that is not produced on record.

Further, for the time being assuming that vaginal hysterectomy may be by a simple procedure and less complicated than TAH, but the Physician is required to carry out the same after obtaining informed consent and that has not been done in the present case.

The Opposite Party No.2 has not produced any material on record as to why she chose vaginal route instead of TAH. But, she in her written submissions has laid stress on advantages of vaginal hysterectomy over abdominal hysterectomy.

In this regard she has stated that consent was taken for TAH in view of previous two caesarean sections; Mrs.Chandhoke (or for that matter any other patient in similar circumstances) was told that she would tentatively be prepared for abdominal hysterectomy but the final decision of the route would be made after re-examining Mrs.Chandhoke in the operation theatre to assess the feasibility of vaginal hysterectomy. This protocol was followed, at that time, for any patient where the final decision of route of hysterectomy is made in the operation theatre, i.e. where there is no absolute indication for abdominal hysterectomy and no absolute contraindication for vaginal hysterectomy. She further stated that 'had the final decision been only for abdominal hysterectomy then orders would have been "Please admit Mrs.Saroj Chandhoke on 20.6.1993 for Abdominal Hysterectomy on 21.6.1993".

She had stated that actually what was written is "Please admit Mrs.Saroj Chandhoke on 20.6.93, and prepare her for Abdominal hysterectomy on 21.6.93". In this connection her contention is that the patient was 'prepared' only for the ultimate eventuality, i.e. TAH, i.e. when the vaginal hysterectomy could not have been possible.

In our view, the aforesaid contention cannot be accepted. It is to be stated that as contended by Dr.Bhandari, she is an experienced Gynaecologist. Hence, she was expected to take express informed consent to perform hysterectomy via vaginal route. Further, it is difficult to accept her contention that because the general consent is taken, she can perform the operation in the way she likes. General consent is – while operating if some difficulty or any contemplated difficulty arises, then she can adopt such further or alternative operative measures or treatment to save the life of the patient or for patient's benefit. But, that would not give her any discretion to do whatever she chooses. This would also be against the medical ethics, as quoted above and the purpose for which express consent is obtained.

In the additional written submissions regarding 'consent', it has been stated as under:

"I also **consent to such further or alternative operative measures** or treatment as may be found necessary **during the**

course of the operation or treatment and to the administration of general or other anaesthetics for any of these purposes".

Thus, as per consent form, if found necessary, the surgeon can do alternative procedure. Even though consent form read TAH (Total Abdominal Hysterectomy) on examination by answering respondent in operation theatre it was found, as appearing in the operation notes also, (page 130-131 file OP 61 Vol.10 of Court record) that all findings favoured vaginal hysterectomy so the anaesthetists and the patient were informed by answering respondent that she would be proceeding with vaginal hysterectomy. This is done in all cases where re-examination in the theatre is done."

The aforesaid part of the consent form permits the surgeon to search further alternative measures during the course of the operation, as may be found necessary. But that would not mean that if consent is taken for TAH, straightaway the doctor can proceed to VH i.e. a totally different route, for which no consent is taken. Consent form only provides that 'during the course of the operation', if it is found that the abdominal

hysterectomy is risky because of some reasons, the doctor can switch over to an alternative route. But before starting of the operation, switching over to an alternative operative measure, cannot be said to have been consented, even as per the aforesaid consent form.

Further, the aforesaid contentions with regard to obtaining oral consent are denied by the Complainant in her replies to the interrogatories. She has specifically stated that she was in the hospital with clear understanding that she was to undergo only abdominal hysterectomy. She also stated that Dr.Bhandari never informed her and her husband that as she had undergone two previous caesarian sections and she was aged about 45 years ovaries should be removed at the time of hysterectomy, nor she requested Dr.Bhandari to remove her ovaries. The only discussion that took place between her and Dr.Bhandari was regarding abdominal hysterectomy. She admitted that in the Original Petition she has not stated with regard to removal of ovaries, nor she had given consent for removal of ovaries. She has admitted that Mr.Jagdish Tytler, the then State Minister of Surface Transport, had visited her in the hospital as he was a family friend and a well-wisher. He has written a letter with regard to her condition in the hospital and demanded that her good health may be restored and strict

action be taken against the guilty.

.**A**. From the aforesaid evidence, it is difficult to believe the say of Dr.Bhandari that oral consent was taken for removal of ovaries or oral consent was taken for performing hysterectomy through vaginal route.

At this stage, we would refer to some portion of the letter written by Mr.Jagdish Tytler, as under:

> "It is with a heavy heart and total sense of disgust and dismay that I approach your for justice in favour of Mr.Saroj Chandhoke and for the severest action possible against Dr.Mrs.S.K.Ghai (Bhandari). It is with a sense of outrage that I wish to record this complaint. I wonder if any one can see, without an extreme feeling of anger, a patient for an operation of only hysterectomy, still in hospital after 65 days, suffering from:-
>
> - a part of her large intestine exposed into a waste disposal bag to the right side of her abdomen;
> - with one of her kidneys removed;
> - with her small intestines infected and with adhesions at

various places;

- with an unimaginable communication built between her urinary passage and the colon;
- with her operational incision stretch right from the lower abdomen to her rib cage;
- part of her internal organs damaged".

Tears of anguish will force anyone who sees such a patient into fits of anger. I cannot believe that the lady, Mrs.Chandhoke was subjected to an eight hour operation for hysterectomy. Somebody has to be answerable for this. The family has been totally unsettled, wrecked emotionally and physically, and would like to have answers for the following questions:-

.1. Why was an eight hour operation needed for hysterectomy when they were told it would take an hour or 1-1/ 2 hrs at best?

.2. Why the operation had started through the public opening with only local anaesthesia having been administered to the patient? When an understanding had been given to the patient

a simple caesarean type operation by cutting the lower abdomen will be performed for her hysterectomy as she had two of her three children by caesarean.

.2a. Why was her abdomen opened up and that to upto her rib cage?

.3. How come for hysterectomy the relatives were urgently asked to arrange about 20 units of whole blood and 4 units of fresh frozen plasma during operation? Quantity being practically equivalent to the whole blood in the human body.

.4. How come a healthy kidney was removed without asking or informing the relatives of the patient while she was still on the operation table crying for help? The only possible answer can be that the hospital indulges in such a racket and possibly sells healthy human parts for unheard of prices?

.5. My impression is strengthened by the fact that no uterus or the kidney or other organs which were removed, were shown to the relatives of the patient after the operation?

.6. How was the colon damaged; due to which, as late as 44 days after the first operation, another operation for colostomy had to be done?

.7. What was the reason for moving the patient to the intensive cardiac care unit after she was discharged from the ICU?"

.**B**. Secondly, the Complainant, at the relevant time, was 43 years old with diagnosis of DUB (Dysfunctional Uterine Bleeding), having two previous cesarean operations. Therefore, it was more advisable to perform operation as agreed, i.e. to say, by TAH and not by vaginal route. Even in the affidavit filed by Dr.Bhandari it has been stated that as the Complainant had two previous caesarian sections she was informed to be prepared for abdominal hysterectomy.

.**C**. Thirdly, there is no justifiable ground for not carrying out D&C (Dilation and Curettage) on the earlier day, before carrying out the hysterectomy operation. Admittedly it was carried out at the time of hysterectomy.

.**D**. Fourthly, it has been pointed out that, in medical literature, for BSO, i.e. **Bilateral Salpingo Oophorectomy**, it being a separate surgical

procedure, it should be specifically and separately mentioned by the doctors, and also requires the specific consent of the patient. The medical literature also states that even where ovary removal is recommended for prophylatic reasons, i.e. where there is no apparent problem with the ovaries but they are advised to be removed to prevent future possibility of ovarian cancer, **the consent of the patient for removal of ovaries should always be obtained**. Excerpts of medical literature stating the above principles are reproduced herein below:

- The term 'total hysterectomy' means the removal of the uterine body and all the cervix. If a surgeon **removes the uterus plus the appendages, let him say so without any equivocation and use the term 'total hysterectomy plus bilateral salpingo-oophorectomy'** (or right or left salpingo – oophorectomy, if only one appendage is removed). Similarly, he may remove one or both the tubes and conserve one or both ovaries – for example, 'total hysterectomy plus bilateral salpingectomy". (Shaws Textbook of Operative Gynecology – John Howkins (mentor of Respondent No.2), Chapter 9, p.165, Vol.III, O.P. 61 of 1996, 1st Column 3rd line from the top.).

- "Certainly, all patients undergoing prophylactic Oophorectomy should **consent to the procedure**". (Vaginal Hysterectomy by Shirish Sheth and John Studd Chapter 13, The place of Prophylactic Oophorectomy at hysterectomy, page 767, 2nd column, 13th line from the bottom, Respondent No.2's evidence affidavit, Vol.III O.P. 51 of f1996].

- "Studd is of the opinion that prophylactic oophorectomy should be offered to all women over 40 years having abdominal hysterectomy **and should only be performed after full discussion and consent**." [Chapter 18, Vaginal Hysterectomy, by SS Sheth, p.618 – Oophorectomy at vaginal hysterectomy, 2nd Column, 3rd sub-para, 3rd line, Respondent No.2's evidence affidavit, Vol.III, OP 51 of 1996].

Hence, for such operation informed consent after full discussion is must.

(iii). **<u>Avulsion of vein – Infundibulopelvic Ligament</u>**.

Further, it is to be stated that if only hysterectomy was performed whether by abdominal route or by vaginal route, the question of avulsion of vein would not have arisen. That question arose only because of removal of ovaries.

For this, the Complainant has pointed out that:

> "Infundibulopelvic ligament contains the ovarian artery and vein. The ligament is attached to the ovaries and not to the uterus. This ligament does not come into the picture at the time of a Total Hysterectomy operation whether by the abdominal route or by the vaginal route. This ligament is clamped only when BSO i.e. Bilateral Salpingo Oophorectomy operation (removal of both fallopian tubes and both ovaries) is to be performed.
>
> As per the medical records filed by the Respondent No.1 Hospital, when the left infundibulopelvic ligament was being clamped one of the veins avulsed. This ligament was being clamped despite the fact that there was neither any planning

but also no consent of the patient for removal of ovaries and fallopian tubes. The record Operation at p.11 (internal p.210) Vol.II, O.P. No. 61 of 1996, states, "….. left infundibuloplvic ligament which was clamped, cut and transfixed. There were multiple veins, one vein from the pedicle avulsed resulting in brisk hemorrhage.".

Medical literature and the statement of Respondent No.2 establishes that the Infundibulopelvic ligament is clamped only when a BSO i.e. Bilateral Salpingo Oophorectomy operation (removal of both fallopian tubes and both ovaries) is to be performed and the same is reproduced herein below:

> "This operation is performed in cases when the indications for hysterectomy are present and the appendages are **found to be diseased at the time of operation**." AND "Technique: The first step is to identify the infundibulopelvic fold which contains the ovarian vessels and lymphatics." (Shaws Text book of Operative Gynecology – John Howkins (mentor of Respondent No.2), Chapter 9, pg. 165, Vol.III, OP 61 of 1996, 1st

column, under the heading, 'Total Hysterectomy together with the removal of the appendages'.]

"Infundibulopelvic ligament is the tissue through which the ovarian vessels (artery and vein) pass while returning the blood from the ovary to drain into the renal vein on the left side which is located in the upper part of abdomen. The clamp is applied on this ligament in both abdominal and vaginal hysterectomies, when the ovaries are being removed." [Pg 33, Vol.III (Respondent No.2's evidence affidavit), OP 51 of 1996, 2nd line from the top.].

Thus, from the above discussion, it can safely be held that avulsion of vein was encountered when the Respondent No.2 transgressed the authority and consent given by the patient for TAH, i.e. Total Abdominal Hysterectomy alone and went on to perform the operation known as Bilateral Salpingo Oophorectomy (removal of both ovaries and fallopian tubes) without the knowledge and consent of the patient.

Dr.Bhandari admitted in her evidence that after operating for about an hour when she was in the last stage of operation which involved

ligating the left infudibulopelvic ligament, the clamped veins suddenly avulsed leading to profuse bleeding. She tried to catch the bleeder through the vaginal passage but could not trace as the bleeder had retracted upward. At that stage she decided to open the abdomen to try to catch the bleeder from above.

It is pointed out by the learned Counsel for the Complainant that the left ovarian vein leaves from the end of the ovary (which lies inferior to the pelvic inlet, i.e. inferior to the start of the Sacrum (S1), at about S3) and joins the left renal vein (which lies between LI and LII). Moreover, the ovaries lie very close to the bladder and the length of the ureters (from the bladder to the kidney) is 10 inches. The uterus and the left renal vein join the kidney at almost the same location (between LI and LII). Thus, the length of the left ovarian vein in an adult woman is approximately 8 to 10 inches.

It is pointed out by the learned Counsel for the Complainant and rightly that if the abdomen was opened at the beginning of the operation, this problem would not have arisen and unnecessary effort to remove uterus through vaginal route would have been avoided, that too, in a case

where the Complainant had two cesarean deliveries.

Secondly, he rightly contended that in a big well-equipped hospital like the Respondent No.1, in case of vein avulsion, the Respondent No.2, ought to have kept or called an expert Vascular Surgeon ready to manage the situation.

Further, it may be presumed that functioning of the Complainant is not affected by the removal of Ovaries or that ovaries can be removed in case of necessity. But, at the same time, in a planned surgery, before removing the ovaries, consent ought to have been obtained.

Finally, for removal of the kidney, as it is submitted that it was required to be removed because of compulsion, i.e. to save the life of the Complainant, the learned Counsel for the Complainant has not pressed that there was deficiency on this ground.

(iv). <u>Contentions raised by the Opposite Party No.2 in her Additional Written submissions dated 30.5.2007</u>:

Opposite Party No.2 has submitted that she was having 32

years experience and had performed a large number of operations, hence could not tell the patient that the operation is 'safe and risk free' especially when the abdomen is to be opened in abdominal hysterectomy. Opposite Party No.2 has also placed reliance upon the decision of this Commission in Original Petition No. 152 of 1997 15.10.2004 in the case of *Mrs.Shakuntalaben Muljibhai Patel & Ors. Vs. Breach Candy Hospital & Ors.* wherein it has been observed that:

> "It is to be accepted that every surgical operation involves risk. When a person who is ill and is going to be treated in a hospital, no matter what care is taken, there always exists some risk. Simply because a mishap had occurred, neither the hospital nor the Doctors can be made liable. **A Doctor is not guilty of negligence if he has acted in accordance with the practice accepted as proper by a responsible body of medical men skilled in that particular art**."

In our view, the general principle laid down in the case of Breach Candy Hospital (supra) has no bearing in the present case. It is settled law that while performing the operation, if a mishap occurs due to

apparent error or negligence of the doctor, that too by a very skilled person, then the Medical Officer would be liable for deficiency in service. Even the bona fide act if performed negligently by a skilled person, then it would amount to deficiency in service as held by the Apex Court in Spring Medows case (supra) relying on the Judgment of the House of Lords, wherein it is held that an error of judgment could be negligence if it is an error which would not have been made by a reasonably competent professional man acting with ordinary care.

Deficiency in service arises because an expert or a very skilled person commits mistake, which mistake would not have been committed even by an ordinary skilled person, because everyday number of such hysterectomy operations are being performed all over the country. Secondly, if complications in abdominal hysterectomy were more, at least express consent ought to have been taken for alternative route, namely, VH.

(v). **Motive**:

The learned Counsel for the Respondent No.2 further contended in the additional submissions that there was no other motive (i)

but to give to the complainant benefits of vaginal hysterectomy; and (ii) complications in abdominal hysterectomy are more than in vaginal hysterectomy.

In our view, motive is not an ingredient for finding out whether there was deficiency in service. Motive may be relevant in case of an offence punishable either under the Indian Penal Code or under the provision of any other Act. But, it has no bearing with regard to loss or injury caused due to deficiency in service. If there is a motive to do something wrong and if it is done, it may amount to an offence. We are not concerned with it, as we have to find out whether there was deficiency in service or not. Hence, this contention has no substance. As stated above, proper consent ought to have been obtained if alternative route of operation, namely, VH was less complicated.

(vi). <u>Removal of Ovaries</u>:

From the above discussion, it can be concluded that entire deficiency in service arises because

of removal of ovaries and the mishap occurred at that time. If ovaries were to be removed, the doctor ought to have informed the patient in advance, but that has not been done. How this mishap has occurred is not known but something wrong had happened at the stage when ovaries were being removed and that has resulted in avulsion and retraction of the ovarian vein. In such a case, the principle laid down in the case of Savita Garg Vs. National Heart Institute, (2004) 8 SCC 56 would be applicable. In that case the Apex Court held that in such a case the principles of res ipsa loquitor (facts speak for themselves) will apply and the burden is on the hospital or doctors concerned who treated the patient, in defence to substantiate their allegation that there was no negligence. The relevant observations of the Judgment are as under:

"It is the hospital which engages the treating doctor, thereafter, it is their responsibility. The burden is greater on the institution / hospital than that on the claimant. 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." ….. "Even otherwise also given that, as held above, the burden to absolve itself shifts on to the hospital / doctor, the Institute has to produce the treating physician concerned and has to produce evidence that all care and caution was taken by it or its staff or justify that there was no negligence involved in the matter".

In the present case, neither the Hospital nor the Doctor has given any reason as to why ovaries were removed without taking consent of the Complainant. It is for the Surgeon who operates to explain as to why the ovaries were required to be removed and how such a mishap has occurred; and, why the Doctors were not in a position to handle the bleeding vein. They have failed to establish the cause except by merely stating that such complications may arise in such operations. In our view, that would hardly be a plausible explanation for such a mishap.

(vii). <u>Oral evidence</u>:

In support of her contention with regard to avulsion of vein, reliance is sought to be placed upon the affidavits of Dr.Subrata Das, Dr.O.P. Sharma, Dr.Kamal Buckshee, Dr.K.C. Mahajan, Dr.R.S. Rana, Dr.K.C. Mittal, Dr.K.P. Jain, Dr.V.K. Chopra, Dr.Sudhir Chaddha, Dr.Trilochan Singh, Dr.G.D. Goel, Dr.Rajesh Khullar, Dr.Raj Kumar, Dr.S.K. Bhandari, Dr.Sarla Sindhu and Dr.Chand Sahai.

In our view, the aforesaid oral evidence does not throw any light on the points which are discussed above. Further, the learned Counsel for the Opposite Party No.2 has particularly placed reliance on the affidavit of a doctor, Dr. K.C.Mittal with 50 years experience whose affidavit is at Vol.9 O.P. 61 wherein the doctor has stated as under:

"I would like to clarify that complications can occur at any time during the operation, at any center in the world and in the hands of best of surgeons. Haemorrhage or bleeding is the most common surgical complication."

“I myself had an abdominal operation last year performed by a very eminent surgeon. Thereafter I developed serious complications and had to be re-operated and was in the hospital for two months. After discharge I was readmitted in the hospital 3 times because of further complications. It has taken me nearly one year to recover fully. Being a surgeon myself, who has put in nearly 50 years of practice in General surgery, I do realize that complications can and do occur in any surgery, minor or major, being done by any surgeon, even of highest repute, without any fault of the surgeon as occurred in my case.”

For the aforesaid affidavit, there is no dispute.

We agree that Opp.Party No.2 is a highly skilled Gynaecological Surgeon. It is also true that complications can occur during the operation, but at the same time, there should be a reasonable explanation as to how the said complications had occurred. Merely stating that during the operation haemorrhage or bleeding is a most common surgical complication would not absolve the operating doctor from his/her duties to be skillful all-throughout. Hemorrhage or bleeding may be common in

surgical complications. But, to say that there would be avulsion of vein to such an extent and that it could not be clamped is not justified. From the avulsion of the vein to such an extent the kidney is required to be removed, an inference can be drawn that some wrong vein was cut during the operation. There is no reason given why ovaries were required to be removed in a planned operation of hysterectomy without the consent of the patient or her husband.

Opposite Party No.2 has also relied upon the evidence of Dr.K.Buckshee wherein it is stated that:

"In case where clinical findings showed that vaginal hysterectomy is possible, the operating Gynaecologist would still re-examine the patient, under anaesthesia, in the Operation Theatre and then finally decide the route for the hysterectomy. All patients are required to be prepared for abdominal hysterectomy, prior to being taken to the Operation Theatre. Vaginal preparation is done in all hysterectomies."

She further deposes in Paras 18 and 19 of her

affidavit that –

"Under the circumstances Gynaecologists, with experience in vaginal surgery, would certainly prefer to perform hysterectomy through vaginal route. In the same situation, I would have also performed, vaginal hysterectomy, as it would have been in the interest of the patient."

In the present case, the question is not whether TAH is preferable to VH. The main question is when the patient is prepared for TAH and has given written consent for TAH, and when no consent is obtained or no information is given to the patient for adopting the VH route or removal of ovaries; whether a different route could be adopted and the ovaries could be removed? In our view, it cannot be done. Then, in such set of circumstances, it cannot be said that the operating surgeon can carry out the surgery of his/her choice, because he/she may be expert in the field. If he/she does so, he/she does it at his/her risk and mishap.

(viii). **<u>Limitation</u>**:

A contention has been raised with regard to limitation in filing the complaint. It is pointed out that the incident took place on 21.6.1993 and the complaint was filed on 13.3.1996, that means, after lapse of 2 years and 9 months and no condonation of delay application is filed. Hence, the complaint is required to be dismissed.

As against this, it has been pointed out that after performing the operation on 21.6.1993, she was required to stay in the hospital up to 14.3.1994 and the complaint is filed on 13.3.1996. So, it cannot be said that the complaint is barred by limitation.

In our view, the contention raised by the Opposite Party that the complaint is barred by limitation is without any substance. It is to be stated that after the first operation which was performed on 21.6.1993, the Complainant was required to stay in the Hospital for various ailments suffered by her. Thereafter, she was finally discharged on 14.3.1994. No doubt, it is contended by the Opposite Party that the Complainant remained

in the hospital even though she was given permission to take discharge after the serious complications which have arisen from a simple hysterectomy operation, in our view, the Complainant has rightly not taken the risk of going home by taking discharge. Otherwise, it would have been contended by the Opposite Parties that complications arose because she took discharge. In any set of circumstances, the period of limitation would start after the Complainant was discharged from the hospital, and hence, the complaint is within time.

VI. **Conclusion**:

In conclusion it is held that:

(i) In a simple Hysterectomy operation, the Complainant lost her ovaries and left kidney. She was required to undergo other operations for control of fecal discharge from vagina. She was required to stay in the hospital for complete cure for months.

(ii) Informed consent was obtained only for TAH. There was no necessity of trying to operate via vaginal route.

(iii). No consent was obtained for removal of ovaries in advance

planned surgery.

.(iv). In the present case, the question is not whether TAH is preferable to VH. The patient was prepared for TAH and had given written consent for TAH and no consent was obtained or no information was given to the patient that her ovaries would be removed. In such set of circumstances, it cannot be said that because a surgeon is expert in the field he/she can carryout the surgery of his choice. If he/she does so, he/ she does it at his/her risk in case of mishap.

No doubt, in case of emergency there can be deviation in mode of surgery, but not in a planned surgery where express consent for a particular mode is taken from the patient, particularly, when there is no emergency.

(v) **Before performing surgery, properly informed written consent is must. No doubt, while operating, to control adverse situation or to save the life of the patient or for benefit of the patient, other procedure could be followed or other part of the body could be operated.**

(vi). As held in Spring Midwos Hospital (supra) it is to be seen that superiority of the Doctor is not abused in any manner. Further, if during the operation any mishap occurs because of error of judgment, it would be deficiency in service or negligence, if that would not have been committed by a reasonably competent professional man professing the standard and type of skill that a surgeon held out as having. The Opposite Party No.2 is an expert Gynaecologist who has performed many such operations as contended by her and Opposite Party No.1 is a known big Hospital. In such a case, it is difficult to accept that for no fault there was avulsion of vein to such an extent that left kidney was required to be removed. Inference could be that there was some error which resulted in cut of a vein.

(vii). Further, it was the duty of the Doctor to advise the patient that D&C should be performed reasonably well in advance of performing the operation for hysterectomy.

(viii). For finding out deficiency in service, motive is not relevant

ingredient. Act may be bona fide. But, if it is performed negligently or if any error is committed which the ordinary skilled person would not commit, then it is deficiency in service.

For the reasons discussed above, there is apparent deficiency in service on the part of the Opposite Party Hospital – Opposite Party No.1 and Dr. S.K. Bhandari-Opposite Party No.2. For this, the Complainant is entitled to have reasonable and adequate compensation, after taking into consideration the fact that some error was committed by the Doctor – Opposite Party No.2, while performing operation, but at the same time, adequate steps were also taken to save the life of the patient. In these set of circumstances, we hold that Rs.5 lakhs would be just and proper compensation.

In the result, Original Petition No. 61 of 1996 filed by Smt.Saroj Chandoke is allowed. Both the Opposite Parties 1 and 2 are jointly and severally held liable to pay a sum of Rs. 5 lakhs to the complainant. There shall be no order as to costs.

Original Petition No. 51of 1996

Original Petition No.51 of 1996 filed by the husband and the daughters would not survive in view of the aforesaid discussion and order passed in Original Petition No.61/96, and it is rejected. There shall be no order as to costs.

Sd/-

……J
(M.B. SHAH)
PRESIDENT

Sd/-

……..
(RAJYALAKSHMI RAO)
MEMBER