NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION
NEW DELHI

FIRST APPEAL NO. 183 OF 2019

(Against the Order dated 28/12/2018 in Complaint No. 94/2011 of the State Commission West Bengal)

1. PROVAT KUMAR PAL
S/O. LATE MADHUSUDAN PAL, FLAT NO. B-408, 156/1,
MAHARAJA NANDA KUMAR ROAD, P.S. BARANAGAR,
KOLKATA-7000036
WEST BENGAL ....Appellant(s)

Versus

1. DR. NILAABHA BHADURI & ANR.
UMA MEDICAL RELATED INSTITUTE PRIVATE LTD.,OF
VIP ROAD, TEGHORIA, P.S. BAAGHIHATI,
KOLKATA-700157
2. UMA MEDICAL RELATED INSTITUTE PRIVATE LTD.,
OF VIP ROAD, TEGHORIA, P.S. BAAGUIHATI,
KOLKATA-700157 ....Respondent(s)

FIRST APPEAL NO. 394 OF 2019

(Against the Order dated 28/12/2018 in Complaint No. 94/2011 of the State Commission West Bengal)

1. DOCTOR NILABHA BHADURI & ANR.
UMA MEDICAL RELATED INSTITUTED PVT LTD, VIP
ROAD TEGHORIA PS BAGUIHATI
KOLKATA 700157
2. UMA MEDICAL RELATED INSTITUTED PVT LTD
VIP ROAD, TEGHORIA, PS BAGUIHATI
KOLKATA 700157 ....Appellant(s)

Versus

1. PROVAT KUMAR PAL
S/O. LATE MADHUSUDAN PAL FLA TNO B-408, 156/1,
MAHARAJA NANDA KUMAR ROAD , PS BARANAGAR
KOLKATA 700 036 ....Respondent(s)

BEFORE:

HON'BLE MR. JUSTICE A. P. SAHI,PRESIDENT

FOR THE APPELLANT : MR. T. V. GEORGE, ADVOCATE
MR. PANKAJ BIST, ADVOCATE
MR. VIJAY RAWAT, ADVOCATE

FOR THE RESPONDENT : MR. RABIN MAJUMDER, ADVOCATE

Dated : 12 January 2024

ORDER

Two appeals have been filed, one appeal (FA/183/2019) by the complainant alleging deficient and disproportionate compensation having been awarded by the State Commission in spite of the findings of medical negligence against the doctor and the hospital, and the other (FA394/2019) has been filed by the doctor running the hospital to set aside the impugned order dated 28.12.2018 in its entirety.

2. The matter was heard on 06.11.2023, when the following order was passed:

> *"Heard learned Counsel for the Complainant.*
>
> *First Appeal No. 183 of 2019 is an appeal arising out of an order of the West Bengal State Consumer Disputes Redressal Commission (hereinafter referred to as the State Commission) dated 28.12.2018 whereby the Complainant's contention of negligence on the part of the Opposite Parties was accepted and the complaint was allowed but with a substantial deduction in the claim made with regard to compensation. This appeal has been filed by the Complainant for enhancement of the compensation and setting aside that part of the impugned order whereby the compensation stood considerably reduced.*
>
> *The Opposite Parties have filed First Appeal No. 394 of 2019 questioning the correctness of the impugned order of the State Commission contending that it does not decide any issue and rather records conclusions without there being any discussions either on the pleadings or the evidence led and therefore the impugned order does not qualify as an order in terms of the Consumer Protection Act 1986 as it does not deal with the analysis and the reasoning of the reasons so as to arrive at the conclusions as recorded therein. The contention is that this is a fit case for remand and the learned Counsel submits that he shall assist the Bench with further arguments on the appeal filed by the Opposite Parties after obtaining information with regard to the criminal proceedings that were initiated and were subject matter of contest at various levels as the learned Counsel at present does not have the exact status of the proceedings pending before the Trial Court or its culmination or otherwise.*
>
> *Learned Counsel for the Complainant (Appellant in First Appeal No. 183 of 2019) in his appeal has advanced his submissions inviting the attention of the Bench to the narrative in the manner in which the deceased came to be admitted in the hospital of the Opposite Parties and the treatment which was commenced ultimately resulting in her death on account of the alleged negligence on the part of the Opposite Parties. Primarily two major concerns have been expressed namely that the entire medical opinion on record including that of the Ethics Committee as well as the statements recorded before the Committee which examined this grievance indicate that the surgery was performed hurriedly and was incorrectly adopted as the first option. The second major ground of challenge is that on the basis of the findings arrived at by the Ethics Committee and the Doctors therein the deceased was administered 5 units of blood and after transfusion, she developed complications which were reactions on account of contaminated blood that was infused and which had also been stored in the refrigerator of the concerned nursing home against Government norms. The*

contention is that the findings unequivocally indicate the same and as a matter of fact the opposite party no. 1 in his statement before the Ethics Committee in the concluding paragraph has admitted the fact of death of the deceased on account of such defective blood transfusion. The submission is that in the wake of the aforesaid facts and the evidence on record, the conclusion drawn by the State Commission may not contain a specific reason except the report of the Medical Ethics Committee, but nonetheless the conclusion drawn on negligence by the Opposite Party is correct.

Learned Counsel for the Opposite Parties refutes the submissions and he prays that the matter be taken up after a week in order to enable him to advance his submissions in response to the contentions which have been raised on behalf of the Complainant.

As agreed, list on 05.12.2023 at 2:00 pm.

The information regarding the criminal proceedings, if possible, may be tendered by way of affidavit after serving an advance copy of the same on the learned Counsel for the Complainant."

3. The parties thereafter advanced their submissions on 05.12.2023, whereupon the orders were reserved.

4. The deceased patient is the wife of the complainant (Provat Kumar Pal). They visited Dr. Nilaabha Bhaduri, who was arrayed as the opposite party no. 1 in the complaint for getting the deceased patient examined for severe gynaecological problems. The doctor prescribed pathological tests and ultrasonography of the lower abdomen. The same was assessed on 19.04.2010 and accordingly the patient was advised to undergo hysterectomy. The opposite party no. 1, doctor performed the same through laparoscopic method (TLH) on 23.04.2010.

5. Post-operative, the condition of the patient deteriorated and she became unconscious on 25.04.2010 and was shifted to Apollo Glen Eagle Hospital, Kolkata where she expired the next day, i.e., 26.04.2010.

6. The cause of death indicated in the death certificate is distributive shock and Disseminated Intravascular Coagulation (blood clotting) in a case of TLH (total laparoscopic hysterectomy).

7. The complainant before the State Commission alleged that firstly the very attempt and advice of hysterectomy was against usual norms without attempting any alternative medicinal treatment. The advice for surgery was hasty and was performed in a hurried manner. The second contention of the complainant was that the patient was having low haemoglobin and hypertension, yet the surgery was undertaken by the opposite party no. 1 casually without exercising due diligence. It is further submitted that in spite of pathological and other clinical reports indicating a high blood pressure of 140/100 mg and very low haemoglobin percentage of 6% mg/dl, the same was overlooked and the doctor went ahead with the surgery which was yet another aspect of negligence.

8. The next submission made deserves more attention than the other allegations, namely, that the opposite party no. 1 and under her directions by the hospital staff one bottle of blood was transfused to the patient on 25.04.2010 which had been carelessly stored in the ward refrigerator and was severely infected. As a matter of fact the patient immediately collapsed on the transfusion of this contaminated blood that was the final nail in the coffin. With the aforesaid allegations the complainant also led evidence and filed documents to support the submissions and also relied on the medical expert opinion reports that have been brought on record to demonstrate that finally the death of the patient occurred on account of the contaminated blood apart from the other deficiencies as indicated above.

9. The defence taken by the doctor and the hospital that all due care was taken and medicines were prescribed to control high blood pressure. The haemoglobin according to the defence was 9.0 mg/dl as per the blood report dated 24.04.2010 and was 11.3 mg/ dl on 25.04.2010. Thus, even post-operative, the haemoglobin level of the patient was normal and was not alarming. It has further been pointed out that the West Bengal Medical Council report was bereft of an assessment without records and cannot be accepted as reliable. The State Commission has committed an error in accepting the same and recording negligence against the opposite parties. It was further submitted that the complaint deserves to be dismissed.

10. The State Commission after assessing the documents on record came to the conclusion that there was clear negligence on the part of the doctor and the hospital in transfusing blood that was stored in a routine hospital fridge and reliance was placed on the West Bengal Medical Council report dated 24.11.2017 to record medical negligence resulting in deficiency on that count. The State Commission allowed the complaint by directing the opposite party no. 1 to pay a sum of Rs.8,00,000/- as compensation with a further liability of Rs.4,00,000/- on the hospital on the same count.

10 a. Aggrieved by the aforesaid orders, both the parties have filed their respective appeals as indicated above.

11. Learned Counsel for the Complainant/Appellant, Provat Kumar Pal, has advanced his submissions inviting the attention of the Bench to three deficiencies. The first is that the doctor hurriedly advised removal of the uterus through surgery without taking any other step for an alternative line of treatment inasmuch as there was no serious complication or bleeding to opt for surgery at once. This was therefore a clear negligent approach in haste.

12. The second argument advanced is that even assuming that it was a case of surgery, it was not urgent and even otherwise no pre-operative precautions as per medical protocol were taken nor post-operative care was observed as per medical protocols. According to the learned Counsel, there was complete mismanagement, carelessness and gross negligence that compounded the deficiency as alleged.

13. The third argument is that according to the medical expert reports and the opinion of the Medical Council, the aforesaid negligence escalated when contaminated blood was transfused to the patient that worsened her condition immediately and she passed away finally within 24 hours of the transfusion. According to the learned Counsel neither was the hospital authorized to store blood which was done for two days in its routine refrigerator nor

any care was taken while transfusing the blood which was already severely contaminated. The cause of death on this count has practically been admitted by the Respondent in his statement before the Medical Council.

14. Advancing his submissions learned Counsel relying on the reports and the statement of the witnesses before the State Commission urged that neither any appropriate pre-anesthetic check-up was done nor any steps were taken to stabilize the patient whose hemoglobin percentage was considerably low and the surgery was carried out in haste resulting in the deteriorating the condition of the patient.

15. Mr. Majumder, learned Counsel for Doctor and the Hospital urged that the criminal proceedings which were initiating against them were quashed by the High court but was later on set aside by the Apex Court and the said criminal proceedings have still not concluded. He submits that there was no professional negligence, no blood samples of the alleged contaminated blood was examined nor was any postmortem of the deceased conducted to substantiate the allegations of medical negligence.

16. It is urged that a medical report was also submitted at the district level headed by the CMO and the said report nowhere finds medical negligence on the part of the doctor and the hospital.

17. Learned Counsel for the Appellant denied the counter allegations and it is urged that the deceased was a highly qualified lady, was a post graduate in commerce and was also registered with the cost accounts organization. She was 43 years of age and her expected life being 70 years, she could have possibly added to the assets of the Appellant substantially through her earnings but even otherwise being a housewife her passing away has resulted in loss of consortium to the Appellant which deserves to be indemnified. Learned Counsel has advanced the submissions contending that the compensation awarded by the State Commission is considerably low and hence the same deserves to be enhanced and awarded as claimed in the complaint. The Appellant has been awarded only a sum of Rs.8,00,000/- as against the respondent doctor and Rs.4,00,000/- against the hospital. The contention is that this gross negligence has not been adequately compensated and therefore keeping in view the law and the legal principles applicable, a sum of Rs.99,00,000/- and odds together with interest as just compensation should be awarded.

18. Having perused the impugned order of the State Commission dated 28.12.2018 and the findings recorded therein and having heard learned Counsel for the Complainant as well as the learned Counsel for the Opposite Parties Doctor and Hospital, the deceased patient was recommended hysterectomy through laparoscopy by Dr. Nilaabha Bhaduri. This recommendation was made on 17.04.2010 when the patient visited for examination but on 21.04.2010 on her second visit, certain medicines were prescribed and she was advised admission at Uma Medical Related Institute Private Limited, with which Dr. Bhaduri stated that he was attached to. The Complainant also alleges that the Doctor advised certain arrangements for blood which would be necessary for transfusion to the patient and the same would be arranged by his assistant. On 22.04.2010, the patient was admitted in the said Nursing Home and on 23.04.2010, hysterectomy (removal of the uterus through surgery) was performed. The patient was not showing any improvements of recovery after the operation and as such Dr. Jayanta Datta was called who is said to have examined the patient.

19. It is also evident that 5 bottles of blood had been arranged, out of which two bottles of blood had been transfused prior to the operation and 2 bottles during and thereafter. One bottle of blood was transfused in the morning on 25.04.2010. It is from this point of time that the patient became senseless and was reportedly having breathing trouble and looking to this serious condition, Dr. Bhaduri himself arranged for shifting of the patient to Apollo Glen Eagle Hospital. The Complainant alleges that after getting her admitted in the second hospital, Dr. Bhaduri did not turn up and at 9:20 a.m. on 26.04.2010, the patient died. A Death Certificate was issued by the Apollo Glen Eagle Hospital reporting the death on 26.04.2010 at 10 am. due to distributive shock and Disseminated Intravascular Coagulation (blood clotting). The Death Certificate is on record.

20. The Complainant appears to have undertaken a threefold action, one by lodging an FIR alleging criminal liability, second by moving a complaint before the West Bengal Medical Council against the alleged negligent conduct of Dr. Bhaduri and a complaint before the State Government against the Doctor and Hospital and the third step was filing of Complaint No.94 of 2011 before the State Commission that has given rise to these Appeals.

21. The first ground taken by the Complainant was that the surgery was planned unnecessarily in a hasty manner. The second ground taken is that there were preoperative lapses and the patient was not managed postoperative according to the medical norms. The 3rd ground taken is that the ultimate death was caused on account of transfusion of contaminated blood for which the Complainant's Counsel invited attention of the Bench to various documents and evidence on record. This has been responded to by Mr.Majumder on behalf of the Doctor and the Hospital contending that the enquiry, which was conducted on 28.09.2011 by four Doctors of the District Hospital, did not indicate any negligence nor was there any conclusive report of negligence by the expert team of the Medical College of Kolkata consisting of three Doctors. Thirdly, he contends that the West Bengal Medical Council came to the conclusion that the Doctor only deserved to be warned and therefore, there was no gross negligence as found by the State Commission. He submits that the 5th bottle of blood, which was stored in the refrigerator of the Hospital, was kept under the permissible temperature conditions for storing blood and hence, there was no error in maintaining the protocol. It appears that the other bottles of blood had also been kept in the same refrigerator from where they were transfused time and again from 23.04.2010 to 25.04.2010. Consequently, on none of the grounds the findings recorded by the State Commission are sustainable and the Complaint ought to have been dismissed.

22. On the issue of quantum learned Counsel for the Complainant submits that the State Commission has failed to award just compensation for which reliance is placed on the judgments of the Apex Court in the case of **"Malay Kumar Ganguly vs. Dr. Sukumar Mukherjee And Others, (2009) 9 SCC 221"** (paragraphs 170- 172 and the judgment in the case of **"Balram Prasad vs. Kunal Saha And Others, (2014) 1 SCC 384"** (paragraph 104). Learned Counsel for the Doctor and the Hospital contends that the award of compensation was itself not based on valid grounds and even otherwise the same is disproportionate and untenable.

23. On the first count, as to whether the decision to undertake a surgery was appropriate or hasty, it would be appropriate to refer to the statement of the experts, particularly the opinion

of Dr. S. Bose that was deposed vide a letter dated 18.08.2011 and has been filed on record. This deposition was made before the Ethics Committee of the West Bengal Medical Council. In the said report, the expert clearly opined that the patient had not been managed according to medical norms and there was nothing to indicate that the patient was having bleeding at the time of admission so as to assume an urgent need for surgery. The medical norms were not followed by not waiting for 24 hours after blood transfusion to ascertain the oxygen carrying capacity of the blood. The patient should have been evaluated by a Cardiologist and Anesthetist at the preoperative stage. The statement categorically records that there were no evidences of fibroid uterus or other pathology requiring urgent hysterectomy. To avoid any incorrect description of the said opinion, the same is extracted hereinunder in its entirety:

"Expert Opinions

Expert Opinion of Dr. S.Bose sent vide letter dated 18.08.2011, relevant portion of which is reproduced below: -

"……..my observation is as follows:-

On the 1st visit- c/o not noted, B.P. 140/100 mm of Hg, no note of Cervix & Fornix vide page 1.

- Vide Pg-3-Hb%- 6 gm%

- Vide Pg-12-x-ray chest PA view - Cardiomegally.

From the above, the Impression is that the clinical examination was substandard and considering that the patient's B.P. was 140/100 mm of Hg, H0% 6 gm% & Cardiomegally - a cardiologist's opinion was mandatory and a full work up from the Haematological point of view should have been done Including PT/APTT, all of which were not done.

- 2 units of blood were transfused, one after another on 22.4.10 at 6 p.m. and 8 p.m. respectively. There is no note in the records when the 2nd unit was completed & whether there was any adverse reaction or not. The operation was performed on 23.4.10 at approx. 8 a.m. There is no record to show that the patient was having

bleeding P/V at the time of admission. Ideally, one should wait for 24 hours after blood transfusion so that the oxygen carrying capacity of the blood becomes optimal. Here it was not done and there does not appear to be any scientific justification for not doing so. After the blood transfusion and before operation, Hb% was not repeated.

• On the page after Pg-26, the husband's queries are fully justified.

• In conclusion, my opinion is that the management of the above mentioned patient, has not been correct, for the following reasons:

The patient should have been evaluated by a Cardiologist & Anaesthetist pre-operatively. After 2 units of blood transfusion the Hb% should have been repeated and blood transfusion given accordingly. D&C, being a minor operation could have been done & the patient put on medical treatment, if at all required, thereafter and proper preparation hysterectomy could have been done, if required. Pre-operative USG report showed a bulky uterus (102 x 63 x 43) mm with no evidence of Fibroid Uterus & HPE report also did not find any evidence of Fibroid Uterus or other pathology, requiring urgent hysterectomy. The operation was hurriedly done without adequate preparation. Furthermore, on 23.4.2010 (day of operation) the patient was transfused with 2 units of blood again no note of any adverse reaction & the time of completion of transfusion. On 24.4.2010 the Hb% is noted as 9 gm% therefore, there does not appear to be any justification for blood transfusion and the sequlae of unfortunate events followed the 5th unit of blood transfusion. It is observed that the packets of blood transfusion were brought from the blood bank (Life Care) on 22.4.10 and stored in the Nursing Home. This is not correct blood should not be stored other than in the blood bank.

Thus the treatment rendered is substandard and the flaws in the management have been documented above.

Sd/- Dr. S.Bose dated 18.08.2011

24. From the above opinion of the expert, it is evident that the patient was subjected to surgery without ascertaining the other options and also not following the appropriate protocol of preoperative stage and the process of blood transfusion.

25. The aforesaid factors were also assessed by the State Commission after taking into account the deposition of Mr. Subrata Mukherjee, Adminsitrator of the Hospital, Dr. Amitava Basu, Dr. Surendra N.M. and Dr. Sarmila Chandra. Apart from this, the expert opinions of Dr. S. Bose, Dr. Utpal Chaudhuri, Institute of Hematology and the report of the Ethics Committee as well as the West Bengal Medical Council, the State Commission came to the conclusion that there were preoperative lapses as well as hasty decision to take surgery without proper management of the patient.

26. In this regard, it would be relevant to mention that at the initial stage, a team of four Doctors of District Hospital of District 24 Paragana submitted a preliminary report on 28.09.2011 stating that since there were no complete documents available, therefore, it was not possible to give any firm opinion and the matter should be referred for enquiry by a more experienced team of Gynecologists and Hematologists from any teaching institute of Kolkata. The said report is extracted hereunder:

> "To
>
> The Chief Medical Officer of health
>
> North 24-Parganas
>
> Ref: Enquiry into the matter of death of Smt. Sima Paul. W/O-Sri Provat Kumar Paul, vide Baguiati PS Case no 174/10 dated 28.04.2010 u/s 304(A) IPC.
>
> Respected Sir.
>
> We, the members of enquiry team, visited UMA Medical Related Institute Pvt. Ltd. on 10.03 2011 and talked with the surgeon Dr. Nilabha Bhaduri, Asstt. Surgeon Dr. Jaydeep Basu & Anesthetist Dr. Saurendranath Mitra & checked OT registers & ward registers.
>
> Patient Sima Paul admitted in UMA Medical Related Institute Pvt. Ltd. on 22.04.2010 at 9.15 am for laparoscopic Hysterectomy operation in a case of DUB with Hemoglobin - 6 gm %(As per statement of the surgeon) no papers in this regard available. This is negligence on the part of the Nursing Home.
>
> She was transfused with two units of packed cell (B+) on 22.04.2010 and she was operated on 23.04.2010, a little more blood lose than average occurred in per

operative period as per statement of Asstt. Surgeon Dr. Jaydeep Basu, but bleeding through the abdominal drain was within normal limit.

The patient was ok till 25.04.2010 when patient developed severe rigor, respiratory distress and rise of temperature with subsequent oliguria following starting of blood transfusion with was immediately stopped and patient was examined and managed by Anastheatist Dr. Saurendranath Mitra & patient was shifted to ICCU of the Nursing Home. But as the condition of the patient further deteriorated patient was referred to the Apollo Gleneagles Hospital on 25.04.2010 at night.

No treatment details and death certificate from Apollo Gleneagles Hospital could be found.

So, the cause of death of the patient could not be confirmed by the members as the total papers are not available but it may be a case of blood transfusion reaction.

The members unanimously decide that the enquiry should be conducted by more experienced team including laparoscopic gynecologist surgeon, Hematologist from any teaching institution of Kolkata to ascertain the cause of death of the said patient.

Dr.Anupam Mondal	Dr.Asraf Ali	Dr.Jagadish Burman	Dr.AsimHaldar
Physician,	M.O (G&O)	Anesthetist	Z.L.O
District Hospitals	District Hospitals	District Hospitals	
North 24 Parganas	North 24 Parganas	North 24 Parganas	North 24 Parganas

27. In between, the Doctor approached the High Court for praying of quashing of the criminal proceedings through a Petition under Section 482 of CrPC which was allowed on 30.11.2011. This order was, however, subsequently set aside on 22.07.2015 in a criminal appeal filed by the Complainant and it is stated that the criminal case is still pending.

28. In terms of the above report dated 28.09.2011, an Enquiry Committee of three Doctors of the Medical College Kolkata was constituted and they submitted a report on 20.10.2014.

The same is extracted hereinunder:

Report of enquiry committee---of the following members

1. Prof. Tapan Kumar Lahiri -Principal

2. Prof. Rathindra Nath Sarkar -HOD, Medicine

3. Prof. Partha Mukhopadhyay -HOD, G&O

Regarding complaint of Sri Pravat Kumar Pal for death of his wife Sima Pal after Total Laparoscopic Hysterectomy done by Dr. Nilava Bhaduri at Uma Medical Related Institute (P) Ltd.

1. Deceased Sima Pal attended chamber of Dr. Nilava Bhaduri on 17/04/2010 and advised to be admitted on 22/04/2014 for TLH & Total Laparoscopic Hysterectomy and bilateral salpingo oophorectomy

2. Investigation report showed Hb 6 gm%, Platelet count normal on 19/04/2010, X-Ray Chest- Cardiomegaly. No other Investigation report is available as per records.

3. According to transfer note TLH was done on 23/04/2010.

4. No other documents including (a) Pre-operative investigations (b) Pre-operative anesthetic check up report (c) Pre-operative preparation of blood transfusion etc. (d) Type of anaesthesia (e) per operative management (f) post operative check up (g) post operative management, are available.

So bed head ticket is required for verification of these records.

5. It is not clear why Laparoscopic hysterectomy was done on an emergency basis inspite of patient's Hb level was of 6 gm% and cardiomegaly was detected before operation.

6. Sima Pal was transferred to Appollo Gleneagles Hospital on 25/04/2014. On that day morning hemoglobin was 11 gm%. However at the time of referral Hb level was 6.6 gm%, PCV 22% (according to transfer note).

Why 5th unit blood was transfused with Hb 11 gm% is not clear.

7. No treatment sheet and death certificate of Appollo Gleneagles Hospital is available.

8. No post mortem report is available.

9. No comment can be made regarding cause of death.

10. So no opinion can be given regarding negligence in the treatment of victim Sima Pal as no paper is available like detected investigation reports and bed head ticket from both Uma Medical Related Institute (P) Ltd. And Apollo Glean Eagles Hospital."

29. The said report even though did not give a final opinion but recorded its doubts with regard to the blood transfusion and the surgery being conducted at low levels of hemoglobin and symptoms of cardiomegaly.

30. After the said report was submitted, the Ethics Committee tendered its report to the Medical Council which is extracted hereinunder:

"Opinion of PE Committee

The members of the PE Committee have gone through the relevant documents lying with the file and taken expert opinions and came to the following opinion:

The aforesaid patient had died of acute haemolytic transfusion reaction resulting in DIC and Multiorgan failure.

As per record the blood transfused, which was stored in the UMA Medical Institute for more than 24 hours, prior to transfusion.

No Nursing Home is permitted by the Government of West Bengal to store blood (vide copy of verification from the Directorate of Drugs Control Memo No. DCWB/2016/RTI/136 dated 1-7-2016).

Dr. Debasis Bhattacharyya, Principal NRSMC&H and Professor of Gynae & Obstetric in addition to Dr. S Bose, Professor & HOD Gynae & Obst, NRSMC&H, and Prof. Dr. Subrata Lall Seal, Deptt of Gynae & Obst. R G KMC & H was consulted as a third expert by this Committee in this case. As two earlier experts were not concordant about their respective opinions

In the opinion of two of three G & O experts decision of LA H was not absolutely indicated in this case although detailed previous management was not fully available in the records.

Although pre-operatively blood transfusion was given but keeping three more units in nursing home Freeze for more than 24 hrs was not prudent as per opinion of the Director of Drugs Control and Experts.

Considering all these the PE Committee is in the opinion, that **Dr. Nilabha Bhaduri acted irresponsible in two manners.**

i. Enough or conservative treatment had not been tried for sake of surgery (LAH) in haste. Decision of surgery was hasty without enough or prior conservative treatment

ii) Transfusion of overnight stored blood (in a Private Nursing Home), which is the prima-facie cause of death of this patient deviated from all existing Government norms."

31. Perusing the said report, the West Bengal Medical Council proceeded to analyse the same and passed a detailed order finding deficiencies to be such that the professional conduct of the Doctor was infamous. The said report is extracted hereinunder:

West Bengal Medical Council

IB-196, sector-III, Salt Lake, kolkata-700 106

Dated, Kolkata the 2018

ORDER

Subject: Complaint lodged by Shri Provat Kumar Pal against Dr.Nilabha Bhaduri, Registration No. 50957 of WBMC

The complainant alleged that on 17.04.2010, he took his wife Soema Pal in the Chamber of Dr. Nilabha Bhaduri at Lake Town for a complaint of her excessive bleeding during menstruation (monthly period). Dr. Bhaduri, after seeing the patient opined it as an operation case und advised for operation as soon as possible, even before the next cycle of menstruation. Dr. Bhaduri recommended "Uma Medical Related Institute (P) Ltd at Tegharia having various facilities including ICCU, where he is attached. He also told that there is un Air-conditioned Cabin beside his chamber at the said Institute and if patient stays there, it would be easier for him to take care. He described it as a minor operation and he will do laporoscopy und within three days the patient would be discharged. He also fixed a date of operation on 23.04.2010, as a good Anaesthetist would be available on that date and told the patient party not to be worried. He prescribed some medicines and investigations and advised to see him at his chamber again on 21.4.2010 after administration of medicines and also advised for admission at the said Institute on 22.4.2010.

On 21.4.2010 the Complainant took his wife again at the chamber of Dr. Bhaduri with all investigation reports. After seeing those he commented about less percentage of Hb and advised to give Rs.4500/- to his assistant for bringing 4(four) bottles of blood, which will be required 2 bottles each before and after operation.

With full faith on the doctor, the Complainant got her wife admitted at Uma Medical on 22.4.2010 and on 23.4.2010 Dr. Bhaduri performed hysterectomy operation on the patient and after 2 hours told the Complainant about successful operation but the Complainant did not notice any improvement. After that Dr. Bhaduri told the patient party every time, as and when asked, that condition of the patient was being improved.

On 24.4.2010, at the time of bill payment, the Complainant noticed that one Dr. Jayanta Datta, Cardiologist visited his wife, which Dr. Bhaduri did not disclose to them.

On 25.4.2010 at about 11.00 am. the Complainant reached at Uma Medical, blood transfusion started before that; he noticed a 'blood packet in half-fill condition' was hanging, the channel of which was opened; patient told him with feeble voice about vomiting at the time of blood transfusion and complained of chest pain; her body was shivering with fever, did not hotice any trained Nurse there ever, some "Ayas' were looking after the patient and on being asked they could not say anything; after sometimes pulse rate was checked with a machine as 112.

Complainant phoned the doctor then and there and after one hour Dr. Bhaduri came, when pulse rate was 150. He discussed with another doctor and transferred the patient at ICCU and told the Complainant that after 2 hours patient would be stable, nothing to be worried. After that every time it was told that patient was improving, as and when asked. At visiting hours Complainant saw his wife in a senseless condition with very much breathing trouble. Dr. Bhaduri also turned down the proposal of the Complainant for calling any other outside doctor for better management.

Suddenly at about 9 p.m. on 25.4.2010 Dr. Bhaduri told them about shifting the patient at Apollo Gleneagles Hospitals and advised for arrangement of Ambulance with Ventilation facility. Ambulance arranged; patient was brought to Apollo Gleneagles Hospitals and Dr. Bhaduri accompanied the patient party. But after that, seeing the deteriorating condition of the patient, Dr. Bhaduri fled away. Doctors of Apollo Gieneagles Hospitals also wanted Dr. Bhaduri for detailed case history and also told the patient party that condition of the patient was grave and chances of her survival is rare and ultimately the patient breathed her last at 9.20 a.m. on 26.4.2010 at Apollo Gleneagles Hospital.

The Complainant firmly believes that Dr. Bhaduri and Uma Medical Institute are fully responsible for the death of his wife as it was well known to Dr. Bhaduri about lack of various facilities like Ventilation, 24 Hours Scanning, USG System, Dialysis System, etc. at Uma Medical, which are absolutely essential in such type of operation. He had also doubt about the quality and preservation of 5 Units blood, which Dr. Bhaduri arranged from some private institutions.

The Complainant also alleged that Dr. Bhaduri had taken decision of operation without seeing any report and every time falsely assured them about condition of the patient. He also alleged that his wife was deprived of better treatment only for Dr. Bhaduri.

The complaint was investigated by one of the Penal & Ethical Cases Committees of the Council by obtaining scrutinizing all relevant papers, taking depositions of all concerned & also obtaining Opinion of the Experts. The Committee submitted their report to the Council for consideration & decision.

The Council, at their meeting dated 13.04.2017, considered the Report of the above P&E Committee and decided that charges be framed against Dr. Nilabha Bhaduri for hearing in one of its forthcoming meetings.

Accordingly, charge sheet was framed against Dr. Nilabha Bhaduri as under :-

1." You had not tried conservative treatment upon the patient, Smt. Seema Pal, since deceased, in Uma Medical Related Institute Pvt. Ltd., for saks of surgery (LAH) in haste. Decision of surgery of the said patient was hasty without enough or prior conservative treatment.

2. You had transfused over night stored blood (in a private Nursing Home) leading to transfusion reaction and Sepsis causing death of the said patient, which is beyond of all Government norms and rules, (vide letter No. DCWB/2015/RTI/078 dated 28-04-2016 of State Public Information Officer, Government of West Bengal, Department of Health & Family Welfare, Directorate of Drugs Control)" and that in relation thereto you have been found prima-facie guilty of infamous conduct in a professional respect.

The Council, at their meeting dated 03.01.2018, noted that both the complainant as well as the charged medical practitioner was present and they were called in.

The Registrar, WBMC then read to the Council the notice of the enquiry addressed to the charged medical practitioner and the complainant was then invited to state his case, which he did. He was very specific on the issue that it was Dr. Bhaduri's convincing assurance about the positive outcome of the operation, solely based on which he and his wife decided to go in for the surgery. He and his wife were neither in a hurry nor in proper mental preparedness for the surgery. He further said that Dr. Bhaduri suggested no alternative like conservative treatment and it was made to feel that surgery was the only way out.

The members of the Council then put the following questions to the complainant through the Chairman of the Meeting, which he replied as under: -

Q1. Narrate the incident in brief.

Ans. I have already stated the incident in my complaint letters dated 20.09.2010, 22.02.2011, 06.09.2013 and 28.04.2016.

Q2. Did you go for any treatment prior to consulting Dr. Bhaduri?

Ans. No.

Q3. Was the patient hypertensive?

Ans. No, But first we came to know her high BP by seeing Dr. Bhaduri's Prescription on 17.04.2010.

Ans. Yes.

Q4. Did you notice any anomaly in the patient's report prior to operation?

Q5. Did you ask for any PM ? If not, why?

Ans. No. Because we could not understand the situation and Doctors of Apollo Hospital didn't advice. Moreover I personally very much fell ill after hearing the death news of my wife on that day.

Ans. No.

Q6. Was she suffering from any other ailments?

did. The charged medical practitioner was then invited to state his case, which he

The members of the Council then put the following questions to the charged medical practitioner through the Chairman of the Meeting, which he replied as under: -

Q1. Narrate the incident.

Ans. As per my deposition dated 14.12.17.

case? Q2. What was the emergency indication in this case to go for laparoscopy in the

Ans. Consultation and surgery interval was of almost a week. PAL was done by Dr. SN MITRA, MD at my clinic. Two units of pre operation PRBC was Transfused. Pre operation AMCODIPINE given; ECG ECHO-CONL. No other COMORBIDITIES; BP on 23.04.2010 8 AM 160/90 hg.

Q3. Why did not you think for conservative management in the case?

Ans. 43 yrs Lady; Complicated Family, Heavy Menstrual Bleeding for 9-10 yrs.

Q4. What would have been the implication of the patient had faced another menstrual cycle?

Ans. Further loss of HB.

Q5. What were the parameters you thought of about the safety of the patient pre-operatively?

Ans. Anaemia. Except Hb%, she was medically uncomplicated. Regards HTN I would like the honorable committee to talk today anaesthetist Dr. SN MITRA, MD well known without whose anaesthesia I could not have operated on late Mrs Sima Pal.

Q6. Did you yourself monitor the cardiac aspect of the case pre-operatively or

depended on the Anaesthetist? Ans. Depended on Dr. SN Mitra, as he is a Cardiac Anaesthetist. Also please see his Deposition on 14.03.11.

Q7. Why did you make requisition for 5 bottles at a time? Were you aware of the

storage parameter of blood in the Nursing Home? Ans. Nursing Home authority to be answered please.

Q8. Why did not you check the endometrium in this case where the patient had history of bleeding for long?

Ans. No high risk factors for ENDOCA apparently Mobile, unfortunately Globular uterus, without any H/O weight loss, anorexia etc.

The Council then offered both the complainant as well as the charged medical practitioner to cross-examine each other, which they did not feel necessary.

The Council then advised both the parties to leave the meeting.

The Council then deliberated in private and observed as follows:-

[1] The patient had a complaint of excessive bleeding during menstruation. While the Complainant claimed that the problem was not so old, Dr. Bhaduri claimed that the patient had been suffering from such complication for 9-10 years.

[2] The patient was having a pre-operative Hb% of 6 gm, i. she was anaemic.

[3] There was evidence of pre-operative cardio-megaly and she was also diagnosed as hypertensive.

[4] While the decision of procuring blood preoperatively was not against norms but it was not prudent to keep the blood in a routine hospital freeze for more than 24 hours as per the Director of Drugs Control as well as Experts. In fact, poor preservation of blood had led to all the troubles and mortality.

[5] Even if it was accepted that Dr. Bhaduri's claim about the prolonged suffering of the patient (though the same was not documented) as correct, it was not at all rational on his part to go in for a surgery after only one visit and within a week of such a visit. The surgery being a planned one, there could not have been such a haste to perform it, particularly keeping in mind that the same was not a life-saving one.

[6] It was not clear as to what had prompted Dr. Bhaduri to go in for a surgery in a 43-year old subject without trying for any conservative treatment, whatsoever. It can be concluded as a case of unnecessary haste.

[7] Though 2 Units of blood was transfused preoperatively, it was not scientifically corroborated whether the Hb% was adequate enough for a surgery.

[8] Adequate preoperative precautions like consultation with cardiologist (due to presence of cardiomegaly) was not done.

At the conclusion of the deliberations, the Chairman called upon to vote on the question whether the charged medical practitioner was guilty of infamous conduct in a professional respect. The Council unanimously found the charged medical practitioner guilty of infamous conduct in a professional respect. As regards quantum of punishment, the Council unanimously decided that the charged medical practitioner is WARNED."

(Manas Chakraborti)

Registrar, WBMC

32. Learned Counsel for the Complainant, however, submitted that after having found deficiencies, it is strange that the Medical Council only issued a note of warning instead of taking a severe action for the negligence of the Doctor.

33. It is, thus, evident from the aforesaid facts that apart from professional conduct, there were lapses clearly indicated therein which are sufficient to conclude that the Doctor was negligent.

34. Coming to the issue of contamination of blood, it is evident that the bottles of blood were arranged by the Hospital itself and were brought to the Hospital probably on 23.04.2010 on the date when the operation was conducted and the blood was transfused after admission before the surgery. The transfusion continued even thereafter and the complications arose on the morning of 25.04.2010 when the patient became senseless and breathing trouble enhanced whereafter she was shifted to Apollo Glen Eagle Hospital. It is here that deposition of Dr. Nilaabha Bhaduri becomes relevant and the other material on record in this regard. The Doctor in his deposition before the Ethics Committee categorically admitted that the patient’s condition worsened and in the answer to the last question on 28.02.2011 he stated as follows:

"Q: The patient was young, anaemic, borderline hypertensive and it was a case of DUB. Why emergency hysterectomy was done before stabilizing the patient? The committee feels that death of the patient could possibly be prevented if adequate preoperative measures we and after operation the committee strongly feels that one second expert opinion should have taken to prevent this untoward incident. Your comment.

A:<u>I strongly feel that my patient Mrs. Sima Pal was probably a victim of transfusion related acute lung injury which is characterized by sudden onset of fever with chills tachycardia, breathlessness and rapidly progressing hypoxaemia and DIC usually starting 1 to 6 Hrs following transfusion and is one of the leading causes of posttransfusion mortality.</u> As the condition of the patient was deteriorating very fast and after contacting Dr. Tapan Mukherjee who was unable to come and we were preoccupied transferring the patient, it did not come to my mind at that moment to call another surgeon.

Dtd: 28/02/2011

Dr.Nilabha Bhaduri

Consultant Gynaecologist"

35. It is, thus, evident that the blood was contaminated. In his explanation which was sent to the Registrar West Bengal Medical Council, he has admitted therein which is dated 11.11.2010 that 5 units of blood were brought from Life Care Blood Bank, Linton Street Kolkata and it was stored in the ward refrigerator. It is also stated therein that so far as arrangement of blood is concerned, the patient's husband and the Complainant Mr. Provat Kumar Pal requested that it would be better if somebody from the nursing home can arrange the blood on his behalf as he was unable to do so. The Doctor has also stated that he introduced Mr. Pal to Mr.Vidyanand Mishra, staff of the nursing home who had been working for the past 10 years and it was specifically mentioned to Mr. Pal to have a talk with him because the Doctor will have nothing to the do the same and he would be free to take a receipt of the Blood Bank to gather from where the blood was brought. The aforesaid explanation given by the Doctor, therefore, confirms the allegation of the Complainant that all the 5 bottles of blood were arranged through Hospital staff and was then kept in a ward refrigerator. It is, thus, clear that this arrangement of the 5 bottles of blood had been arranged by the Hospital itself and for the same reason, it also appears that after the patient was transferred to Apollo Glen Eagle Hospital on 25.04.2010, the Nursing home also took care to seek a report of the Blood Bag which contained the blood that was transfused and which led to the complications. This report of the Blood Bag was sought from the Pathology Centre of the Hospital itself and is Annexure P-33. The said report dated 29.04.2010 is extracted hereinunder:

"UMA Medial Related Institute Pvt. Ltd.V.I.P. Road, Teghoria, Kolkata-700157 Phone 2570-1956-59, Helpline:2570-6111

Ref.No. : IND/45/107/2010191

Patient : MS. SIMA PAL, 43 YRS.

Refd. By : DR. N. BHADURI

SPECIFMEN : BLOOD COLLECTED FROM **BLOOD BAG**

(BAG NO.10/D 31-67)

ROUTINE CULTURE : Aerobic

Growth of enterococcus faecalis after 72 hours of incubation

Date of collection : 25/04/2010

Date of report : 29/04/2010

Enterococcus Faecalis – 72 Hrs. of incubation"

36. This microbiology report confirms the manner in which the blood was contaminated and were the highly probable causes of symptoms that were developed by the patient that have been confirmed in the experts' depositions and the evidence as discussed hereinabove.

37. There is yet another aspect which needs examination and that is the opinion given under the Right to Information Act by the concerned Department of Government of West Bengal dated 28.04.2016. The same is extracted hereinunder:

"GOVERNMENT OF WEST BENGAL

DEPARTMENT OF HEALTH & FAMILY WELFARE

DIRECTORATE OF DRUGS CONTROL

K.I.T. BUILDING-5TH FLOOR

P-16, INDIA EXCHANGE PLACE EXTENSION

KOLKATA-700 073

No.DCWB/2015/RT1/078 Dated-28-04-2016

To

Provat Kumar Pal

Flat No.-B, 408, R.K.Puram

156/1, M.N.K.Road

Kolkata-700 036

Ref:- His RTI application dated 22-04-2016 seeking information

Regarding Storage Permission for Blood by a Nursing Home

With reference his RTI application as above, the undersigned is to state that **Nursing Homes are prohibited from the permission of setting up of Blood Storage Unit for storing of blood.**

STATE PUBLIC INFORMATION OFFICER"

38. It categorically states that all Nursing Homes are prohibited from setting up any blood storage unit for storing blood. It is, thus, evident that the blood which was kept for 3 days in the ward refrigerator of the Hospital was apparently in violation of the aforesaid Government instructions.

39. The expert opinion of Dr. Utpal Chaudhury dated 22.04.2013 before the Ethics Committee also confirms the same position which is extracted hereinunder:

"Expert opinion of Prof. (Dr.) Utpal Chaudhuri, Director Institute of Haematology & Transfusion Medicine, Medical College, Kolkata.

Patient was admitted on 22-4-2010 at 9-15 a.m. for TLH with Hb of 6 Gm% 5 units were transfused on the day and the remaining 3 units were kept in the ward refrigerator.

Operation was done on 23-4-2010 and operation was uneventful.

Two of the remaining three units of blood were transfused on 24-04- 2010 and Hb on 24-4-2010 was 9Gm%. As per records of UMRI patient was stable throughout 24-4-2010.

On 25-4-2010 morning Dr. Bhaduri (consultant in charge) found the patient breathless and was looking pale. He advised the 5th unit of blood kept in the ward refrigerator to be transfused and the transfusion was started at the morning. Within few minutes patient developed signs and symptoms suggestive of Acute haemolytic transfusion reaction.

From the next chain of events it appears that patent developed severe acute (possibly haemolytic) transfusion reaction leading to DIC and shock.

The culture report from the blood bag shows growth of Streptococcus fecalis which can cause sepsis leading to shock and DIC.

From the above facts it is clear that 5 units of blood were collected on 22-4-2010. Two units were transfused on that day and the remaining 3 units were kept in ward refrigerator. But it is not clear how much time had lapsed since the blood bags were issued from the blood bank and they were kept in the refrigerator. It is also not mentioned whether temperature-monitoring device is Installed in the refrigerator. It is well known that ward refrigerators are opened frequently for removal of medicines and blood product resulting in wide variation in temperature.

It is well documented that blood should be stored between 2-6 degree C. Once the blood bags are taken out of blood bank they should either be transfused within 30 minutes or should be stored at 2-6 degreeC. Blood stored at temperature beyond this range carries a high chance of bacterial contamination and hemolysis leading to severe transfusion reaction and sepsis. In the case under consideration, both of which remains a possibility. However, a definite and conclusive opinion is not possible since it is not clear whether the system was followed properly.

I have attached few relevant portions of some articles regarding ideal

storage of blood.

Sd/-

Prof. (Dr.) Utpal Chaudhuri,

Director Institute of Haematology & Transfusion,

Medical College, Kolkata"

40. Apart from this a World Health Organization Article has been brought on record which also supports the said opinion given by the expert that is extracted from the Manual on the Management, Maintenance and Use of Blood Cold Chain Equipment.

41. It is, thus, evident from all the aforesaid facts on record that there was gross negligence having accumulative effect right from the stage of the planning of the surgery till the culminating of entire episode with the allegations arising out of the contaminated blood transfusion resulting in the death of the patient.

42. Coming to the issue of quantum of compensation, the State Commission has awarded ₹8 Lakhs against the Doctor and ₹4 Lakhs against the Hospital with direction to pay the same within the period directed therein or else interest @ 9% p.a. for the entire period of default shall be levied. The payment was directed to be made within 45 days from the date of the order.

43. The patient died on 26.04.2010. The Complaint has been lodged on 28.12.2018, 8 years after the death of the patient. The first issue is as to what should be just compensation in such matters. In the case of **Kunal Saha** (supra) which was also the case of death of the spouse of the Complainant, guidelines were indicated but for the purpose of non-documentary damages paragraphs 172 to 174 in the case of **Malay Kumar Ganguly** (supra) are instructive. Apart from this, it is to be noted that the deceased was 43 years of age when she died and her expected life span, if assessed on a probable basis, would be 70 years. If that is so, then the principles laid down in two cases referred to above will have to be viewed from the judgment in another case decided by the Apex Court in **"Arun Kumar Agrawal And Another vs. National Insurance Company Limited,** (2010) 9 SCC 218". This was a case where the income of the housewife had been assessed and pecuniary estimation in relation to a housewife was computed even though in a case arising out of Motor Vehicle Act 1988 against the Insurance Company. Paragraphs 22 and 35 to 43 of the said judgment are instructive which are extracted hereinunder:

> "22. We may now deal with the question formulated in the opening paragraph of this judgment. In Kemp and Kemp on Quantum of Damages, (Special Edition - 1986), the authors have identified various heads under which the husband can claim compensation on the death of his wife. These include loss of the wife's contribution to the household from her earnings, the additional expenses incurred or likely to be incurred by having the household run by a house-keeper or servant, instead of the wife, the expenses incurred in buying clothes for the children instead of having them made by the wife, and similarly having his own clothes mended or stitched elsewhere than by his wife, and the loss of that element of security

provided to the husband where his employment was insecure or his health was bad and where the wife could go out and work for a living.

35. In our view, it is highly unfair, unjust and inappropriate to compute the compensation payable to the dependents of a deceased wife/mother, who does not have regular income, by comparing her services with that of a housekeeper or a servant or an employee, who works for a fixed period. The gratuitous services rendered by wife/mother to the husband and children cannot be equated with the services of an employee and no evidence or data can possibly be produced for estimating the value of such services. It is virtually impossible to measure in terms of money the loss of personal care and attention suffered by the husband and children on the demise of the housewife. In its wisdom, the legislature had, as early as in 1994, fixed the notional income of a non-earning person at Rs.15,000/- per annum and in case of a spouse, 1/3rd income of the earning/surviving spouse for the purpose of computing the compensation.

36. Though, Section 163A does not, in terms apply to the cases in which claim for compensation is filed under Section 166 of the Act, in the absence of any other definite criteria for determination of compensation payable to the dependents of a non-earning housewife/mother, it would be reasonable to rely upon the criteria specified in clause (6) of the Second Schedule and then apply appropriate multiplier keeping in view the judgments of this Court in General Manager Kerala State Road Transport Corporation v. Susamma Thomas (Mrs.) and others (supra), U.P. S.R.T.C. vs. Trilok Chandra (supra), Sarla Verma (Smt.) and others v. Delhi Transport Corporation and another (supra) and also take guidance from the judgment in Lata Wadhwa's case. The approach adopted by different Benches of Delhi High Court to compute the compensation by relying upon the minimum wages payable to a skilled worker does not commend our approval because it is most unrealistic to compare the gratuitous services of the housewife/mother with work of a skilled worker.

37. Reverting to the facts of this case, we find that while in his deposition, appellant No.1 had categorically stated that the deceased was earning Rs.50,000/- per annum by paintings and handicrafts, the respondents did not lead any evidence to controvert the same. Notwithstanding this, the Tribunal and the High Court altogether ignored the income of the deceased. The Tribunal did advert to the Second Schedule of the Act and observed that the income of the deceased could be assessed at Rs.5,000/- per month (Rs.60,000/- per annum) because the income of her spouse was Rs.15,416/- per month and then held that after making deduction, the total loss of dependency could be Rs.6 lakhs. However without any tangible reason, the Tribunal decided to reduce the amount of compensation by observing that the deceased was actually non-earning member and the amount of compensation would be too much. The High Court went a step further and dismissed the appeal by erroneously presuming that neither of the claimants was dependent upon the deceased and the services rendered by her could be estimated as Rs.1250/- per month.

38. In our view, the reasons assigned by the Tribunal for reducing the amount of compensation are wholly untenable and the approach adopted by the High Court in dealing with the issue of payment of compensation to the appellants was ex facie erroneous and unjustified.

39. In the result, the appeal is allowed. The impugned judgment as also the award of the Tribunal are set aside and it is held that the appellants are entitled to compensation of Rs.6 lacs. Respondent No.1 is directed to pay the said amount of compensation along with interest at the rate of 6% per annum from the date of filing application under Section 166 of the Act till the date of payment. The needful shall be done within the period of 3 months from the date of receipt/production of copy of this order. The appellant shall get cost of Rs.50,000/-.

A. K. GANGULY, J. (concurring) - While agreeing with the judgment delivered by my learned brother Singhvi, J., I wish to add my perception of the problem which has been raised in this case.

41. Despite the clear constitutional mandate to eschew discrimination on grounds of sex in Article 15(1) of the Constitution, in its implementation there is a distinct gender bias against women and various social welfare legislations and also in judicial pronouncements.

42. In the Motor Vehicles Act, 1988 (hereinafter, `the said Act'), Section 163A provides for special provision for payment of compensation on structured formula basis. The said Section has been quoted in the earlier part of the judgment by brother Singhvi, J. Therefore, I refrain from quoting the same. The Second Schedule which is referred to in the said Section has several clauses. Clause 6 of the said Schedule provides for notional income of those who had no income prior to accident. Clause 6 has been divided into two classes of persons, (a) non-earning persons, and (b) spouse. Insofar as the spouse is concerned, the income of the injured in fatal and non-fatal accident has been categorized as 1/3rd of the income of the earning and surviving spouse. It is, therefore, assumed if the spouse who does not earn, which is normally the woman in the house and the homemaker, such a person cannot have an income more than 1/3rd of the income of the person who is earning. This categorization has been made without properly appreciating the value of the services rendered by the homemaker. To value the income of the home-maker as one- third of the income of the earning spouse is not based on any apparently rational basis."

44. In the instant case, the deceased was a post graduate in commerce and was also in possession of a Certificate from the Institute of Cost Work Accounts. This aspect does not seem to have been appropriately addressed by the State Commission and it has been decided on the ground that the said assertions were not supported by any cogent documentary evidence. The said facts relating to the qualification and the age of the deceased had not

been seriously disputed nor anything has been shown to contradict the same. In such a situation, the guidelines provide for assessment to be made on reasonable and probable basis and in my considered opinion, award of ₹8 Lakhs against the Doctor and ₹4 Lakhs against the Hospital seems to be on the lower side. The deceased was an educationally well qualified homemaker. Her untimely death occurred at a premature age of 43 years. She could have ordinarily survived in normal conditions as per life expectancy standards at least for another 25 years if not more. Her contributions towards her family have been snapped even though she was not having regular income. A non-earning spouse can also be assessed to have a notional income. There is an unfortunate loss of consortium and company. However, to calculate this in exact tangible terms may not be possible, yet taking guidance from the judgments referred to above and the possible life span of the deceased, the compensation deserves to be enhanced suitably.

45. The facts and the manner in which the patient was handled clearly indicate gross medical negligence on the part of the Doctor as well as on the part of the Hospital administration in the manner in which the events and incident of blood transfusion compounded the worsening situation of the patient. Thus, a sum of ₹15 Lakhs against the Doctor and ₹10 Lakhs against the Hospital deserve to be imposed in the background above which would be just compensation.

46. Over and above this the State Commission erred by providing no interest on the awarded amount which obviously would be due till the date of actual payment.

47. Nevertheless what has been found above, the interest would be payable on the said amount from the date of institution of the Complaint i.e. 15.09.2011. The interest of 9% on the said amount would, therefore, be payable accordingly till the date of actual payment. First Appeal No.183 of 2019 filed by Provat Kumar Pal is, therefore, partly allowed to the aforesaid extent.

48. There is no merit in First Appeal No.394 of 2019 filed by the Doctor and the Hospital which is hereby dismissed.

49. The impugned order dated 28.12.2018 of the State Consumer Disputes Redressal Commission, West Bengal is modified to the extent above and confirmed accordingly. The amount payable under this order shall be paid together with the interest within three months. Any amount deposited by the appellants either before the State Commission or before this Commission or paid over to the complainant pursuant to the order and decree of the State Commission shall be adjusted accordingly.

.........................J

A. P. SAHI

PRESIDENT