

(1999) 05 NCDRC CK 0047

In the National Consumer Disputes Redressal Commission

KANHAIYA KUMAR SINGH

APPELLANT

Vs

PARK MEDICARE AND RESEARCH CENTRE

RESPONDENT

Date of Decision : 27-05-1999

Acts Referred:

Citation : 1999 3 CPJ 9

Hon'ble Judges : C.L.Chaudhry , R.Thamarajakshi , S.P.Bagla , J.K.Mehra J.

Final Decision : Complaint dismissed

Judgement

1. O.P. No. 206/95 has been filed by Mr. Kanhaiya Kumar Singh against the Managing Director and other Directors of M/s. Park Medicare and Research Centre Private Limited, Hooghly, West Bengal alleging professional incompetence and negligence on the part of the latter and the doctors employed by them in treatment rendered by them to his minor son and claiming award of compensation of Rs. 1.00 crore for the same alongwith costs.

2. ACCORDING to the petitioner, his minor son, Ketan Singh (14 years old) was taken to M/s. Park Medicare and Research Centre Private Limited opposite party on 12.8.1995 with pain in the upper abdomen accompanied with vomiting and mild fever and the patient was admitted to the Centre the same day for medical treatment. On 13.8.1995, the petitioner was informed by the opposite party that an emergency operation for acute appendicitis was to be done on the patient for which the petitioner's elder son who was also a minor gave his consent in the absence of the petitioner who had gone to arrange cash and for obtaining a second opinion. In the meantime, the patient was operated upon the same day. That evening, after regaining consciousness, the boy continued to complain of pain in the upper abdomen, and pain, fever and vomiting tendency was ever increasing throughout the next day i.e. 14.8.1995. On 15.8.1995 when the abdominal pain became unbearable and convulsive vomiting also started, opposite party informed the petitioner that his son will have to undergo a second operation as a hole in his alimentary canal or a knot had formed there. Without obtaining the consent of the petitioner, the doctors attached to the opposite party

performed the second operation on 15.8.1995 i.e. within 55 hours from the first one. Even after the second operation, the pain in the upper abdomen did not subside and the patient continued having fever and vomiting through a pipe coming out of his nose and was hovering between life and death till 22.8.1995. On 25.8.1995, the boy was discharged with both incision wounds not completely healed and comparatively lesser pain still in the abdomen. The opposite party's doctors advised the petitioner's son, total rest for three months and to report every one month for check up and ultrasonography. After one month, when the petitioner took his son to the opposite party with intermittent abdominal pain, the doctors after check up referred him to Christian Medical Hospital, (CMC) Vellore for "proper diagnosis and treatment". The petitioner, instead took him on 9.10.1995 to a prominent doctor of Calcutta at Kothari Medical Centre where he was treated as out patient. When on 17.11.1995, the petitioner's son had the same severe upper abdominal pain accompanied with vomiting, he was admitted to the Kothari Medical Centre, where he underwent treatment and became stable, and was discharged on 13.12.1995. The petitioner's allegations in his complaint dated 20.12.1995 are that the first operation was totally uncalled for since it achieved nothing and the boy had to be operated upon second time which was also futile because the condition of the patient deteriorated and this is proved by the doctors of the opposite party Centre referring the boy on 30.9.1995 to CMC, Vellore for "proper diagnosis and treatment". The opposite party charged Rs. 41,000/- for admission, operations, bed-charges, charges for nursing, surgeons and physicians, pathological, radiological and imaging charges, cost of medicines and surgical equipments and other associated miscellaneous charges. The petitioner submitted that the cause for action finally arose on 30.10.1995 when the opposite party did not agree to adequately compensate the petitioner for the irrecoverable damages done to him and his son. The damages listed are : The minor child's psyche was affected so badly that he is terror stricken on hearing the name - "Doctor" which may lead to some disastrous consequences in future. The boy's vital internal organs had been uselessly fiddled and tampered with, making him internally weak and so more prone to future illness and long term post operative complications and drugs. He perhaps lost a lot of blood during the operation and had lost weight. He had to bear unbearable pain at the hands of opposite party and had to suffer and live with tension and stress when his life was uncertain. He has not been able to attend his classes for the last five months and his attending classes in near future is very doubtful which means losing one academic year in this age of tough competition. Before operation, he was a good footballer, an aspiring Karate fighter and all round athlete. Now he can never think of these. The petitioner himself suffered physically and mentally alongwith other members of the family. For these damages and others left out or forgotten damages or for the damages not yet apparent, the petitioner sought direction from the Commission to the opposite party and its Board of Directors to pay him a compensation of Rs : 1.00 crore for the life ruining service rendered to his son and prayed for costs of the case. He requested that the total assets of the opposite party centre and its

Board of Directors be frozen till the final disposal of the case and that the copy of the findings of the Commission be sent to the Indian Medical Council for withdrawal of registration certificate of doctors working for the opposite party and to the Secretary, Ministry of Health and Family Welfare, Government of West Bengal, Calcutta for proper and needful action against the opposite party to check this shameful commercialisation in this honourable life saving profession, and a copy of the case be sent to the Superintendent of Police, Chinapura, Hooghly, West Bengal to ensure safety and well being of the petitioner and his family from the hands of the opposite party.

The reply affidavit to the complaint has been filed by Dr. Pradeep Kumar Agarwal, Director of the opposite party-Centre wherein he has stated that there is no Managing Director for the Centre and that he, a Physician and his wife Dr. (Mrs.) Meera Saraf, a Gynecologist, are the only two Directors of the Centre. He and his wife are practising doctors at the Nursing Home and there are other doctors consisting inter alia of Paediatrician, General Surgeon, Orthopaedician, Eye and ENT specialists. The preliminary objections made in the reply are that the petition is liable to be dismissed in limine, for (a) the petitioner has no locus standi to file the petition as he is neither a consumer nor a complainant within the meaning of the Consumer Protection Act and there is no privity of contract between the Directors and the petitioner as no service is being rendered by them; (b) the alleged cause of action is misconceived and frivolous and the alleged damages have not been suffered by the petitioner and are too remote and not reasonably forceable; (c) the petitioner has suppressed various records and documents particularly the records relating to the treatment at Kothari Medical Centre, Calcutta which would have shown that the treatment at the opposite party- Centre was correct and in the proper direction; and (d) facts of the instant case call for expert opinion and can be decided only in a civil suit and cannot be adjudicated by this Commission.

3. SETTING out the events of the case, Dr. P.K. Agarwal has stated that the petitioner's son was brought on 12.8.1995 at 11.20 a.m. to his outdoor chamber with complaint of pain in abdomen, vomiting and fever for two days. He was advised investigations to find out the cause of such pain. Since he was not tolerating any oral fluid or medicines he was advised admission for I/V fluids and other supportive therapy and the petitioner agreed to the same. The boy was admitted on the same day at 12.15 p.m. and the father was asked to file the papers and the consent form. At that time since the petitioner was taking care of his son, he asked his elder son Mr. Kunal Singh to fill up and sign the admission papers and the consent form which he did in the presence of his father. On 13.8.1995, the condition of the patient was the same and his problem seemed to be of surgical nature. Dr. Subhasis Kole, a general surgeon examined the patient at 8.00 a.m. on that day and found that tenderness which was previously generalised was now more towards the right lower part of the abdomen with muscle guarding. After clinical and investigational assessment, the surgeon diagnosed it as a case of Acute Appendicitis and generalised peritonitis and

accordingly advised operation on emergency basis. The condition of the patient and the decision to operate was discussed with the petitioner and his family members who agreed to the same and were present all the time in the nursing home. The consent form was already filled on 12.8.1995. The operation started at 9.30 a.m. During the operation, straw coloured fluid came out and whole of the mesentery was found to be studded with enlarged lymph nodes, one of which was taken out for biopsy. The appendix was found to be kinked and vascular and appendicectomy was done. Materials collected during operation were sent for biochemical and histopathological testing. Histopathology of the tissue revealed reactive hyperplasia with sinus catarrh which represented mesenteric lymphadenitis which was the most common differential diagnosis. After the operation, the patient's condition did not improve in the normal way and there was persistent fever and pain in the abdomen. These symptoms worried the attending doctors and on 15.8.1995 at 5 p.m., the patient had abdominal distension with increase in temperature and vomiting. Immediately, nasogastric tube suction of stomach was instituted which revealed one litre of bile coloured fluid. The attending surgeon suspected perforation of bowel and second opinion of a Senior Consultant Surgeon, Dr. M.K. Roy was sought who saw the patient at 10.00 p.m. on that day and diagnosed the condition as perforative peritonitis and advised X-Ray of abdomen and Laparotomy. The X-Ray could not be done because of non-availability of the technician on 15th August in the late hours of the night. The overall condition and the necessity of the operation and post-operative problems were discussed with the petitioner by both the doctors, and the petitioner agreed for the operation and the situation was so grave and all the concerned parties were so tense at that hour of night that the thought of taking a further written consent did not arise in the minds of either side. Moreover a written consent had been taken before the first operation at the time of admission. Further the petitioner and other family members orally consented for the second operation. Accordingly, at 11.00 p.m. the anesthetist was called and Laparotomy was done on the petitioner's son; the petitioner and his family members were all waiting in the nursing home. The operation revealed hugely distended intestinal loops and firm to hard pancreatic head which signified pancreatic inflammation. Whole of the mesentery was studded with lymph nodes suggesting it to be a case of pancreatic pathology and mesenteric lymphadenitis. The abdomen was closed after decompression of bowel and thorough lavaging of the intraperitoneal toxic fluids. After the operation, the petitioner was informed about the pancreatic pathology and mesenteric lymphadenitis and the nature of the disease was explained to him.

4. THEREAFTER, the patient recovered slowly and satisfactorily and the fever came down to normal on 20.8.1995. Abdominal pain and distension also slowly lessened. On 18.8.1995, ultrasonography was done which showed diffuse hypoechogenicity in the head of the pancreas confirming the operative findings and there was no peritoneal fluid. From 19.8.1995, no pain killers were advised or administered, as evidenced by chemist's bills. The abdomen softened, bowel

sounds appeared and Ryle's tube suction lessened gradually. On and from 20.8.1995, the patient was fed orally which he tolerated well and Ryle's tube was taken out on 21.8.1995 and liquid diet was allowed. He passed stool satisfactorily twice on 21.8.1995. The drain was taken out, stitches of the first operation was cut and the wound was free from infection. The petitioner's son improved satisfactorily so that he started to walk around. Normal diet was allowed on 24.8.1995 and stitches of the second operation taken out on 25.8.1995 and the wound was found healthy. The other senior surgeon had revisited the patient on 19.8.1995 and was satisfied with the progress of the patient. The patient was well and free from any complaint on 25.8.1995 when the attending surgeon found him fit to be discharged. Accordingly he was discharged on 25.8.1995 at 5 p.m. with advice to take enzyme, antacid and vitamins and was asked to report after one month for check up. Opposite party submitted that the patient reported on 27.9.1995 in a healthy condition without any complaints and underwent one ultrasonological examination which was normal. On 30.9.1995 the petitioner brought his son to the outdoor patient department with complaints of central abdominal pain and nausea for one day; the boy was diagnosed by the attending surgeon as a case of exacerbation of pancreatic pathology and was advised to be hospitalised, if needed. The recurrent nature of the disease was discussed with the petitioner. Since the cause of pancreatic disease was not known, it was suggested that if the cause could be found out, remedial measures could help the patient. In that view, the patient was referred to a better institution like AIIMS, Delhi or CMH, Vellore. The petitioner agreed to this and asked for being referred to CMH, Vellore which was done by the attending doctor. The petitioner, instead took his son to Kothari Medical Centre," Calcutta on 9.10.1995. The patient's condition during 30.9.1995 to 9.10.1995 has not been stated in the petition and as no papers pertaining to investigations, diagnosis and treatment and discharge certificate of the Kothari Medical Centre have been produced by the petitioner, opposite party called upon the petitioner to produce all such records before the Commission. Regarding the allegation that the consent form was signed by his son who was a minor, opposite party stated that the petitioner and his elder son were aware that the consent form could only be signed by a person not less than 18 years of age and if he signed the papers as a minor, he had done so by misrepresentation of facts and opposite party cannot be made liable for such mis-statement by the petitioner. The opposite party also put the petitioner to strict proof on his averment that his elder son's signature was taken when he had gone to arrange cash. Opposite party - Centre filed documents and records maintained by them in the normal course of business in connection with the case. Further in support of the diagnosis, operation and treatment of the patient, opposite party furnished the following extracts from medical literature. (i) From the article published in "Paediatric Surgery" edited by Kenneth J. Welch M.D. on chapter relating to "Pancreas : "Because pancreatitis is seldom suspected in childhood, the usual preoperative diagnosis is acute appendicitis". (ii) From the article published in "Paediatric Surgery" edited by Kenneth J. Welch M.D. on chapter relating to

"Appendicitis" :

"Appendicitis remains the most common condition leading to emergency abdominal operations in children and adolescents. The clinical findings and operative treatment of appendicitis were clearly established over 100 years ago. It is therefore as astounding that appendicitis has remained the surgical emergency condition with the highest percentage of misdiagnosis leading to operation - "the negative appendix" it surely must also be in the first rank among surgical conditions in which the delay of a proper diagnosis is common converting a relatively harmless pathologic condition into a potentially lethal one, since perforation of the appendix has occurred before treatment in more than one-third of all patients with appendicitis. It is equally alarming that, after the offending appendix has been removed, a postoperative complication rate of up to 40% still occurs and is accepted."

"The first symptom of the classic triad of pain, vomiting and fever consists of periumbilical pain. Obstruction of the appendix leads to distention relaying pain via stretch receptors through visceral nerve fibers to the tenth thoracic ganglion, so that pain is perceived in the umbilical dermatome. The periumbilical pain occurs regardless of the location of the appendix, whether intra peritoneal retrocolic or retrocecal. Inflammation follows, with vomiting and fever. The inflammatory exudate causes a localized pain in the immediate area. If the appendix is located in the right lower quadrant, right lower quadrant tenderness develops. Since more than one third of appendices are either retrocolic or retrocecal and/or extend over the pelvic brim, the localization of the inflammation and therefore of the pain may vary. The intensity of the localised pain, however, almost always supersedes the initial periumbilical pain of obstruction."

(iii) From the article on "Appendicitis" published in "Textbook of Surgery : The Biological Basis of Modern Surgical Practice" edited by David C. Sabiston Jr. M.D. : "Acute appendicitis must be considered in any patient who complains of abdominal pain or who presents with minimal symptoms suggestive of peritoneal irritation. Acute appendicitis is the most frequent cause of persisting, progressive abdominal pain in teenagers. It is a common sometimes confusing and often treacherous cause of an acute abdomen at all ages."

(iv) From the article published in "Principles of Internal Medicine" by Harrison's on "Acute Appendicitis" : "a listing of the differential diagnosis of acute appendicitis would produce an encyclopedic compendium of all conditions which cause abdominal pain since appendicitis may simulate any of these diseases. Diagnostic accuracy is about 75 to 80 percent for experienced clinicians and must be based solely on the clinical criteria outlined above. It is probably better to err slightly on the direction of over diagnosis since delay is associated with perforation and increased morbidity and mortality. In unperforated appendicitis the mortality rate is 0.1 percent, little more than that associated with general anesthesia for perforated appendicitis there is an overall mortality of 3 percent a figure which

increases to 15 percent in the elderly. In doubtful cases 4 to 6h of observation is always more beneficial than harmful, however. The most common conditions discovered at operation when acute appendicitis is erroneously diagnosed are in rough, order of frequency, mesenteric lymphadenitis no organic disease, acute pelvic inflammatory disease ruptured graafian follicle or corpus luteum cyst and acute gastroenteritis. In addition, acute cholecystitis perforated ulcer, acute pancreatitis, acute diverticulitis, strangulating intestinal obstruction, ureteral calculus and pyelonephritis frequently present diagnostic difficulties."

"Acute mesenteric lymphadenitis is the appellation usually given when enlarged, slightly reddened lymph nodes at the root of the mesentery and a normal appendix are encountered at operation in a patient who usually has right lower quadrant tenderness and a somewhat higher temperature than most patients with acute appendicitis. Whether this is a single discrete entity is unclear since the causative factor is not known."

"Children seem to be affected more frequently than adults. Operation should be undertaken unless there is rapid resolution of all symptoms and findings."

5. THE following extracts have been filed to show that the decision to go in for the second operation on emergency basis was well founded and was in accordance with medical science : (i) From the article published in "Textbook of Surgery". "THE Biological Basis of Modern Surgical Practice", edited by David C. Sabiston M.D. on "Pancreatitis" : "THE diagnosis of acute pancreatitis is primarily indirect. Aside from direct inspection of the gland, there is no pathognomonic method of diagnosis. Accordingly, it is important to bear in mind that pancreatitis may be exceedingly difficult to separate from other conditions that may require surgical therapy."

"Because many abdominal disorders may closely mimic acute pancreatitis, particularly acute cholecystitis, peptic ulcer perforation, mesenteric, infarction and intestinal obstruction and because indirect diagnosis of pancreatitis is rarely secure, exploratory laparotomy has been recommended in all patients with presumed pancreatitis who show a declining clinical course. Repeated studies have confirmed the observation that simple exploration does not affect mortality rate if the diagnosis of pancreatitis is confirmed. On the contrary, if one of the aforementioned life-threatening conditions is found, exploration may be life-saving." (ii) From the article published in "Principles and Practice of Medicine" by David C. Sabiston on "Acute Pancreatitis" : "THE disease may be recognised for the first time at laparotomy, the patients having been diagnosed as perforated peptic ulcer or acute appendicitis." Laparotomy "This may be performed when a condition requiring surgery such as a perforated duodenal ulcer cannot be excluded. THE diagnosis is then made on the appearance of the pancreas and the absence of any other acute intra abdominal condition." "If the diagnosis of acute pancreatitis is made when laparotomy is undertaken for diagnostic uncertainty no direct surgical intervention should be attempted unless there is cholecystitis." "Once the attack of acute pancreatitis has subsided it is essential to identify

cholelithiasis and obstructive causes of pancreatitis (see Table 10.21p. 480) in order to prevent further attacks."

Regarding the recurrent nature of the symptoms and problems common to many patients who suffer from acute pancreatitis, opposite party have extracted the following from the article "Pancreas" published in "Textbook of Surgery" "THE Biological Basis of Modern Surgical Practice" edited by David C. Sabiston Jr. M.D. : "Table-1 Marseilies Classification of Pancreatitis (1963) I Acute pancreatitis-a single episode of pancreatitis is a previously normal gland. II Acute relapsing pancreatitis-recurrent attacks that do not lead to permanent functional damage, clinical and biologic normalcy in the intervals between attacks. III Chronic relapsing pancreatitis- progressive functional damage persisting between attacks, frequent pain free intervals. IV Chronic pancreatitis-inexorable and irreversible distraction of pancreatic function, constant pain."

6. OPPOSITE party denied the allegation that the petitioner has been charged Rs. 41,000/-, as totally false and incorrect and submitted that only Rs. 14,944.79 was paid for the period 12.8.1995 to 25.8.1995 out of which Rs. 5,505/- was towards the services rendered by the Nursing Home and the balance sum of Rs. 9,439.79 for various other third persons, doctors and medicine shops paid through the Nursing Home authorities. OPPOSITE party submitted that the patient was discharged within 10 days of the second operation and that the subsequent ultrasonography done on 27.9.1995 would evidence that no vital organs have been tampered with or damaged. Since the appendix was inflamed, it was taken out and since the mesentery was found studded with enlarged lymph nodes, one lymph node was taken for biopsy; this does not in any way affect the life of any person. Regarding the alleged loss of blood, opposite party averred that there was the usual loss of blood during the operation and the patient recovered without any blood transfusion. Haemoglobin content of the patient was 12.4 percent on 12.8.1995 and 10.3 percent on 17.8.1995, the fall of 2 gram percent being insignificant. The second attack of abdominal pain on 17.11.1995 was not as a result of the two operations as alleged but due to the relapse of the pancreatic disease and recurrent attacks is common in patients who suffer from the said disease. OPPOSITE party averred that they are in no way responsible for the acute pancreatic disease and that all possible care and treatment had been done. OPPOSITE party put the petitioner to strict proof that the petitioner's son had lost one academic year and that the boy was earlier an all round athlete. OPPOSITE party pleaded that the particulars of alleged damages claimed by the petitioners are vague in nature and devoid of material particulars and in any event have not been suffered by the petitioner and that the petition is misconceived. In his rejoinder, the petitioner referred to the opposite parties admission that they have taken from him Rs. 5,505/- for services rendered by them, and submitted documents pertaining to the treatment at Kothari Medical Centre and the prescription of the renowned homoeopathic physician Dr. Shanti Ranjan Saha under whose treatment his son seems to be recovering. Extracts from medical literature as filed by him are : (i)

From Rob and Smith's Operative Surgery, Edited by H. Dubley, Walter and David Carter on Exploratory Laparotomy (Page 47) : "In no circumstances is exploration a substitute for careful clinical assessment, appropriate laboratory tests, endoscopy, radiology and modern imaging techniques. Laparotomy provides access within the abdomen but to the exterior only of organs while many diseases occur within the hollow viscera ." Laparotomy is now reserved for the assessment of the extent of the disease and currection of mechanical obstruction. Chronic dyspepsia associated with equivocal radiological features was formally a frequent indication for abdominal exploration - the surgeon could easily convince himself of ulcer scaring and patechial haemorrhage. Any sequelae were attributed to the side effects of the operation carried out to "cure the supposed ulcer. It would now be considered unethical to explore the abdomen before performing endoscopy and using the imaging techniques..." Such an exploration is best performed by an experienced and deliberate surgeon."

(ii) From the Chapter "The Appendix" in the book "Principles and Practice of Surgery" by A.P.M. Forest, D.G. Carter, I.R. Macleod (page 516) : "While right iliac fossa pain and tenderness are the most consistent clinical features they can be produced by a large number of conditions including mittleschmerz, acute mesentric adnities, acute terminal ileities and inflammation of a Meckel's diverticulum. Although the presence of these and other conditions may be suspected clinically, all can mimic appendicitis closely, and laparotomy is usually indicated if pain and tenderness persist.... Acute pancreatitis can mimic appendicitis at all stages, but upper abdominal or diffuse pain in pancreatitis is associated mostly with corpious vomiting and retching, back pain and hyperamy lasemia..."

The petitioner pointed out that opposite party was negligent in (a) diagnosis, (b) operation, (c) failure to listen to the patient's complaint, (d) administration of drugs, (e) exposing the patient to the unnecessary risk of infection and (f) post operative care and further advice. He wanted the opposite party to produce Dr. (Mrs.) Maushami Basak, Radiologist, Dr. Gozi, Anaesthetist, Dr. Milan Roy, Surgeon and Dr. Professor Sital Ghosh as an integral part of their expert medical opinion team and witnesses as all of them have received some money directly or indirectly from the petitioner.

On 26.4.1999, the parties were directed to file their written two weeks, which have been complied with. The petitioner has more or less repeated his allegations made in the complaint/ rejoinder : (1) The diagnosis and operation for appendicitis was wrong and but for that operation the need for the second operation on emergency basis would not have arisen. The first operation was done in reckless and negligent manner and the petitioner prayed to the Commission to "presume negligence" in conducting the first operation. (2) In the discharge slip prepared on 25.8.1995 after both operations were done, the diagnosis reads "Acute appendicitis with peritonitis ? Koch's Abdomen" and there is no mention of the "Pancreatic Pathology and Mesentric Lymphadenities

frequently referred to in opposite parties affidavit as being the ailment of the patient. (3) Ultrasonography Report of 13.8.1995 reads as follows : "Pancreas : is mildly enlarged in size however outline and echopattern are homogenous no pancreatic duct dilation is seen". "Evidence of fluid collection is seen in hepatorenal pouch and pelvis. No abnormal mass is seen in either flanks. Gas filled bowel loops are seen". "Imp. - Findings suggest peritonitis". Opposite party overlooked this report and performed appendicectomy when it was noticed that the pancreas was enlarged. Ultrasonography report dated 18.8.1995 after both the operations read, "Pancreatic size is mildly increased, however it is smaller than the previous study done on 13.8.1995" which conclusively proved that opposite party was criminally negligent in performing the operation. (4) According to the 28th edition of Dorland's Medical Dictionary, mesenteric lymphadenitis mimics appendicitis but in fact it is not appendicitis - a condition clinically resembling acute appendicitis, in which there is inflammation of the mesenteric lymph nodes receiving lymph from the intestine. (5) While the diagnosis for the second operation was "perforative peritonitis", the operation notes do not show that there was perforation. The pancreatic pathology could have been ascertained through non-invasive methods. When abdominal Koch's (T-B.) and/or doubtful Pancreas is suspected, it is medically considered unwise to open the abdomen. Dr. Roy the senior surgeon had advised X-ray to demonstrate gas under diaphragm and then laparotomy. But no X-ray was done because of non-availability of technician which itself amounted to negligence. X-ray technician could have been called from a nearby hospital or nursing home. (6) Having diagnosed, opposite party did not take steps to identify the cause of the patient's ailment. Only on 30.9.1995 "acute pancreatitis" is mentioned by opposite party with double question marks. (7) The consent of the petitioner's son who was seventeen years and 26 days old then, was "under influence" and the consent was no consent as it was not "proper consent". While the consent form has been signed by his son, dates have been put by another person. Also the consent form etc. has been signed on 12.8.1995 whereas the need for operation was felt on 13.8.1995 only; as such this portion of consent was not signed by the petitioner's elder son.

7. IN their written arguments, opposite party has mentioned that a case of medical negligence can only be made out when the doctors fail to perform their duties with utmost care and caution. IN the second operation for suspected perforation or leak in the intestine Dr. Kole found after opening the abdomen the pancreas gland to be diseased i.e. pancreatitis and lymph glands were found to be enlarged; no attempt was made to disturb the pancreas gland but after clearing up the fluids inside the abdomen, the abdomen was closed and the operation was finished in an hour's time. On 30.9.1995, when the patient consulted Dr. Kole with pain in the abdomen and nausea, he suspected recurrent pancreatitis i.e. recurrence of the disease of pancreas and advised consultation with a specialised institute. Opposite party have submitted that trust should be reposed in the actions of the doctors, which may involve certain exploratory tests

due to overlapping symptoms and complexities. It has been pointed out that a case of acute pancreatitis is of an extremely complex nature as is borne out from the extracts on medical literature; the symptoms of such a case are first diagnosed as acute appendicitis. The worsening condition of the patient warranted laparotomy and it was only then that acute pancreatitis was discovered. Repeated studies have confirmed that simple exploration may be life saving in case of patients suffering from other fatal abdominal emergencies resembling acute pancreatitis. Thus each operation, treatment and diagnosis of the doctors was in conformity with the principles of medical science and was after application of reasonable caution, care and skill.

8. WE have heard the petitioner in person and the Counsel for the opposite party and carefully perused the records before us. The preliminary objection of the opposite party that the petition is not maintainable as there is no privity of contract between the petitioner and the opposite party Directors has only to be taken note of to be dismissed. Opposite party have admitted that a sum of Rs. 5,505/- was paid by the petitioner to the Nursing Home for bed charges, pathology and X-ray services; further the petitioner had paid Rs. 1,190/- to the opposite party-Director towards physician's charges and for blood sugar and ECG examination and Rs. 1,700/- to his wife for assistance to surgeon and for ultrasonography investigations besides payments to others. In view of payments received and the services rendered, the petitioner is a Consumer qua the Nursing Home and specialists associated in the treatment, under the Consumer Protection Act. In so far as determination of liabilities is concerned, it will depend on the findings on the nature of deficiency in service, if any, and the doctor/ doctors/institution who were responsible for the same. Similarly, the allegation of the petitioner that the consent for the operation signed by his elder son, who was a minor was not a "free consent" has no substance because the consent form indicates that it has to be signed by the guardian in case the patient is below 18 years. It was therefore for the petitioner to ensure that the consent was signed by an adult. As for the consent for second operation, opposite party have explained that under emergent circumstances that developed a specific consent could not be obtained; nevertheless the petitioner and his family members had reportedly given oral consent and were present in the Nursing Home. The question before us is whether there was any negligence on the part of the opposite party and its doctors in handling the instant case. We find that the petitioner had already consulted two doctors before coming to the opposite party Centre i.e. Dr. Kamlesh Chandra Pathak on 11.8.1995 for low grade fever, loss of appetite and pain in abdomen who prescribed medicines and advised sonogram of abdomen and Dr. Sandip Chandra on 12.8.1995 (i.e. on the day of admission to the opposite parties Centre) for fever and pain in the abdomen, who also prescribed some medicines and referred for surgical opinion. The records before us do not show whether this information was shared by the petitioner with the opposite party when he first went to Dr. P.K. Agarwal on 12.8.1995. In any case the petitioner came to the Centre subsequent to obtaining advice for surgical

opinion by Dr. Sandip Chandra.

9. AT the Centre the ultrasonography report on 12.8.1995 recorded "Findings suggest peritonitis". On 13.8.1995 the Consulting Surgeon diagnosed the case as acute appendicitis and generalised peritonitis and appendicectomy was done; according to operation notes, the whole of the mesentery was studded with lymph nodes of different sizes. When the boy did not improve and abdominal pain became severe, a senior surgeon was consulted who suspected it as perforative intestine and X-ray and laparotomy were advised. Opposite party have admitted that X-ray was not possible due to non-availability of the X-ray technician at the midnight hour of 15th August, a holiday. Operation notes pertaining to the second operation given in the Discharge Report showed inter alia that pancreatic head was enlarged and firm to hard, and that mesentery was studded with enlarged lymph nodes. The patient was discharged on 25.8.1995 after he became stable; as such he stayed in the Centre for 14 days. There was admittedly no blood transfusion during the operations. The patient reported for check up on 27.9.1995 i.e. a month after discharge and the ultrasonogram reported normal study but when he went again on 30.9.1995 to Dr. Kole with gnawing pain in central abdomen and nausea, Dr. Kole suspected exacerbation of acute pancreatitis and advised consultation with specialist institutes like AIIMS, New Delhi/CMH, Vellore for proper diagnosis and treatment". The petitioner, however, took his son to Kothari Medical Centre on 9.10.1995; what transpired in the intervening period has not been reported by the petitioner. He has, however, stated that his son was treated at the Kothari Medical Centre first as outdoor patient from 9.10.1995 and was then hospitalised at that Centre from 17.10.1995 till 13.12.1995; the discharge sheet of the Kothari Centre dated 13.12.1995 gave the final diagnosis as "recurrent pancreatitis". The petitioner has stated that his son was later with a homoeopathic physician, Dr. Shanti Ranjan Saha under whose treatment he was improving; from this it seems that the patient did not get relief after treatment from the Kothari Medical Centre, either.

10. WHILE deciding the case, we have kept in view the problems of differential diagnosis in intra abdominal ailments. It is reported in medical literature that differential diagnosis of acute appendicitis is essentially the diagnosis of the "acute abdomen" and essentially identical clinical picture can result from a wide variety of acute processes within or near the peritoneal cavity that produce the same alterations of function as acute appendicitis. (Seymoura : Schwartz : Appendix, Chapter 29 in Principles of Surgery, Vol. Two Ed. Schwartz, Shires and Spencer). Also a listing of differential diagnosis of acute appendicitis would produce an encyclopedic compendium of all conditions which cause abdominal pain since appendicitis may simulate any of these diseases; while diagnostic accuracy is about 75 to 80% for experienced clinicians it is probably better to err slightly to the direction of over diagnosis since delay is associated with perforation and increased mortality rate. Thus once the clinical symptoms point to acute appendicitis, the surgeon cannot afford to delay. It is documented that

appendicitis is the foremost of surgical conditions in which delay of a proper diagnosis is common converting a relatively harmless pathological condition into potentially a lethal one. On finding the petitioner's son's condition of abdominal pain, fever and vomiting as one of acute appendicitis and peritonitis, the surgeon acted promptly and with the normal care of a normally prudent doctor. The second operation was called for in the absence of the expected improvement in the condition of the patient after- the first operation. The Consulting Surgeon took the advice of another senior surgeon who suspected perforative intestines and advised laparotomy. During operation it was found the pancreatic head enlarged and firm to hard and body and tail felt to be normal. Operation notes in both the operations found that mesentery was studded with lymph nodes thereby indicating mesenteric lymphadenitis, which is listed in medical literature as one of the most common conditions discovered at operation when acute appendicitis is erroneously diagnosed. On the question of pancreatitis, it is stated that diagnosis of acute pancreatitis is primarily indirect and since many abdominal disorders may closely mimic acute pancreatitis, exploratory laparotomy is recommended if it is suspected and the disease maybe recognised for the first time at laparotomy, the patient having been diagnosed as perforated peptic ulcer or acute appendicitis. This is corroborated by the medical literature extract (ii) furnished by the petitioner which reads inter alia "Although the presence of these and other conditions may be suspected clinically, all can mimic appendicitis closely, and laparotomy is usually indicated if pain and tenderness persist... Acute pancreatitis can mimic appendicitis at all stages...." We also find that when the patient came to the Consulting Surgeon again on 30.9.1995 with abdominal pain, the latter considered it prudent to refer the case to better equipped medical institutions like AIIMS or CMC, Vellore.

Given that (a) acute appendicitis is a common sometimes confusing cause and often treacherous cause of an acute abdomen at all ages, (b) acute appendicitis may simulate any of the conditions which cause abdominal pain, (c) acute pancreatitis may mimic appendicitis and many abdominal disorders may mimic acute pancreatitis, (d) Diagnostic accuracy in appendicitis is about 75 to 80 per cent for experienced clinicians and must be based solely on the clinical criteria, and (e) delay in operation for suspected appendicitis can be lethal, the actions of the opposite party and its doctors are seen to have been based on their best judgment and as warranted in accordance with medical requirements in the particular situations. It is true that two operations were performed on the minor patient within a period of two days and the same undisputedly would have caused physical pain for him and anxiety for the petitioner and his family. The petitioner has pleaded for "presuming negligence" on the part of the opposite party. Negligence has to be established and cannot be presumed. It is nearly four years since the operations were performed and the petitioner has not produced any evidence to show any damages to the boy attributable to the operations. In the facts and circumstances of the case, we are unable to find any negligence on the part of the opposite party and the doctors associated with the case. The

complaint is, therefore, dismissed. No costs. Complaint dismissed.