IN THE NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION AT NEW DELHI

RESERVED ON: 24.12.2024
PRONOUNCED ON: 30.04.2025

CONSUMER COMPLAINT NO. 581 OF 2014
WITH
IA/8684/2016 & IA/8685/2016 (Condonation of delay),
IA/19888/2017 (Early Hearing)

Takam James,
son of Takam Xavier,
residing at Nirjuli, Arunachal Pradesh, … Complainant

Versus

1. Dr. Navanil Barua
Director, Guwahati Neurological Research Centre (GNRC) Complex,
Supermarket, Dispur, Guwahati, Assam,

2. Dr. Bivan Bihari Dey
GNRC Hospital, GNRC Complex, Supermarket,
Dispur, Guwahati, Assam

3. Dr. Monoj Agarwal
All working for gain at GNRC Hospital
GNRC Complex, Supermarket,
Dispur, Guwahati, Assam … Opposite Parties

BEFORE:

HON'BLE MR. SUBHASH CHANDRA, PRESIDING MEMBER
HON'BLE AVM J. RAJENDRA, AVSM VSM (Retd.), MEMBER

For the Complainant : Mr. Bodhisattya Haldar, Advocate(VC)
Mr. Sushant Rao, Advocate

For the Opposite Parties : Mr. K. P. Pathak, Advocate
Mr. Nishant Kumar, Advocate

JUDGMENT

AVM J. RAJENDRA, AVSM VSM (Retd.), MEMBER

1. The present Consumer Complaint has been filed under Section 21 of the Consumer Protection Act, 1986 (for short "the Act") against the Opposite Parties seeking to direct the OPs:

"(i). To pass order directing the opposite parties to jointly and severally pay to the complainant a sum 12,40,19,000 (Rupees Twelve Crore Forty Lakhs Nineteen Thousand only) for gross medical negligence, unfair trade practice and deficiency in service.
(ii). To pass such order further orders as may be fit and proper in the facts of circumstance of the case."

2. Brief facts of the case, as per the complainant, are that at about 6:00 PM on 08.07.2013, Takam James, the complainant, had met with an accident while riding his motorbike in Nirjuli, Arunachal Pradesh. He was rushed to General Hospital in Naharlagun for initial treatment and subsequently referred to GNRC Hospital in Guwahati, where he was admitted on 09.07.2013. Following his recovery, he was discharged on 27.08.2013, with a tracheostomy tube in place. Upon returning home, Takam began to experience severe discomfort, including extreme coughing and expulsion of food particles through the tracheostomy tube. Despite being advised to consult the Neurosurgery outpatient department (OPD) after six weeks, his condition deteriorated due to significant damage to his vocal organs. He was rushed to the nearby hospital in Naharlagun on 11.09.2013 where the attending physician referred him to CMC Vellore for advanced care. He arrived at Vellore on 19.09.2013, with private medical team. Upon arrival, the procedures commenced on 12.09.2013, at CMC Vellore revealing that the surgical intervention performed at GNRC Hospital had resulted in the severing of both the food pipe and the windpipe, leading to permanent damage to Takam's vocal organs. He, therefore, filed the present complaint.

3. The complainant contended that medical negligence, deficiencies in service, and unfair trade practices in his case are conspicuous from the significant lapses in the evaluation and treatment of the patient from 11-15.07.2013, and again from 17-21.07.2013, during which time he was not adequately attended to by specialized medical experts. Multiple instances of inappropriate treatment occurred at GNRC Hospital, and despite the patient's lack of significant improvement, the authorities chose to detain him in the facility from 24.07.2013 to 27.08.2013, leading to an unnecessary escalation of medical expenses. Upon discharge, his CGS was recorded at E4V5M6, indicating a severity score of 15, alongside bilateral pupils graded 2+, yet the condition of his voice box was not clearly addressed. He lost his voice, potentially permanently, prior to his discharge from GNRC Hospital itself. The complainant further contended that he was kept in the super specialty hospital for an excessive duration of one and a half months without receiving any ENT measures to restore his voice, further exacerbating the financial burden. This delay contributed to irreversible damage to his vocal cords. The discharge summary from CMC Vellore, where he was admitted on 08.10.2013 indicated that the re-tracheostomy was a likely cause of the vocal cord damage. He contended that on 11.07.2013, the endotracheal tube was accidentally extubated and successfully reinserted. A CT scan conducted on 12.07.2013 confirmed

that the area surrounding the vocal box was normal. Given this context, Dr. N. Barua, neurosurgeon, should have recognized that a tracheostomy could have been a more appropriate alternative to maintain intubation for over ten days. Consequently, the patient suffered a permanent loss of voice due to the consultant's lack of knowledge and a careless approach to treatment. The complainant contended that, as outlined by Medical Council of India (MCI) guidelines, it is the primary duty of a consultant to ensure that the healthcare professionals to whom they refer patients are competent. He raised questions regarding professional skills of doctors at GNRC performing a critical and potentially life-threatening procedure such as a tracheostomy. He alleged that, historically, this procedure was completed by both general and ENT surgeons, however, with increasing specialization it is now primarily confined to ENT specialists. He contended that as per GNRC discharge summary dated 27.08.2013, the diagnosis included diffuse axonal injury and mandible fracture. However, there was no acknowledgment of post-tracheostomy airway (subglottic) stenosis, a serious condition requiring specialized treatment. The document inaccurately stated that his post-operative recovery was uneventful and failed to mention the airway stenosis, despite its identification by attending physicians on 20.08.2013, through a confirmed CT scan. The summary further advised rest for six weeks

and a re-evaluation in Neurosurgery OPD, with no mention of further consultation with an ENT specialist. Upon returning home to Arunachal Pradesh, he exhibited distress characterized by coughing and the emergence of food particles from the tracheostomy tube. As per the complainant, such symptoms are indicative of a tracheoesophageal fistula, a life-threatening condition that may arise from significant trauma or as a complication of tracheal surgery. The emergence of this condition post-procedure suggests it had developed as a direct result of the last tracheostomy performed by Dr. Agarwal, which was not due to the initial trauma from the accident. The non-availability of Dr. N. Barua needs to be construed as a deficiency in service and an instance of medical negligence. According to the doctor's note dated 11.07.2013, it was recorded that at 1:45 PM, the patient experienced an accidental extubation while under active mechanical ventilation. However, the note does not provide any explanation as to how such a critical incident occurred. Accidental extubation in a mechanically ventilated patient is a serious event that typically results from inadequate monitoring or improper care. Had the patient been adequately attended to by the clinical team, such an incident could likely have been prevented. Thus, the complainant, suffering from a severe brain injury, was subjected to repeated instances of inadequate and improper treatment at GNRC which amounts to a serious deficiency in service. The documentation

reveals significant concerns regarding the medical care at GNRC. From 11.07.2013 to 16.07.2013, no neurosurgical specialist evaluated the patient despite the facility's neurological focus, constituting a serious service deficiency in treating a severe head injury case. The hospital failed to provide appropriate ENT care for the patient's voice box and neglected to refer them to a facility capable of providing such specialized care, instead discharging them with minimal advice and a six-week follow-up recommendation. This represents both service deficiency and unfair practice. The absence of ENT surgeon during the retrachestomy directly resulted in surgical damage to his voice box. Although tracheostomy was planned for 21.07.2013, it was not performed until 23.07.2013, which is a critical delay. Medical standards indicate that prolonged intubation beyond 10 days risks windpipe damage and narrowing, necessitating tracheostomy rather than continued oral intubation. The failure to perform this procedure by 19.07.2013 (after ten days of intubation) constitutes another serious service deficiency. Additionally, standard operation and aesthetic record forms were not utilized for the tracheostomy, and documentation fails to identify the surgeon who performed the initial procedure a fundamental professional responsibility. These facts collectively demonstrate substantial deficiency in care provision and documentation. Examination of medical records reveals numerous issues regarding

patient care practices at the facility. This procedure should have been conducted under expert supervision in the relevant specialty, but the identity of the supervising specialist remains undisclosed to the patient's family, constituting both medical negligence and unfair trade practice. He contended that the documentation deficiencies are particularly concerning wherein the record fails to identify who examined the patient on 10.07.2014, and assessed their Glasgow Coma Scale (GCS) as E2M5VT. Dr. Barua, as the neurosurgeon should have personally evaluated a severe head injury patient under his care. The questions arise regarding his rapid improvement from severe to moderate head injury by 12.07.2014, when the GCS was documented as E3M6VT, raising concerns about the accuracy of these assessments. Critical gaps exist in the evaluation timeline, with documentation suggesting the patient may not have been evaluated on 13.07.2013, despite daily assessment being crucial for severe trauma cases. Evaluations documented between 11-16.07.2013, appear on a single sheet, with only a casual notation of "better" on July 15 without specific clinical parameters or GCS scores. The documentation regarding the tracheostomy is particularly problematic. On July 21, 2013, records indicate a planned tracheostomy without clearly identifying who made this decision. The procedure was performed on 24.07.2013, but without documenting whether an ENT surgeon or neurosurgeon performed this

high-risk invasive procedure. OPs failed to legibly document their names, qualifications, and registration numbers requirements that, when neglected, constitute negligence and unfair practice, particularly when patient harm results from procedural errors. On 22.07.2013, the ITU progress note documented at 10:10 AM indicated "Tracheostomy to be done," signed by an illegible physician signature and by Dr. Barua without a date. A consent form issued that same day in Dr. Barua's name requested an unnamed doctor to perform the tracheostomy. While the form was signed by the patient's guardian and a witness, it failed to specify which physician explained the procedure to the patient violating the ethical obligation of surgeons to personally discuss procedures, risks, and benefits with patients or families before non-emergency operations. This demonstrated that proper informed consent protocols were not followed, representing another significant breach of medical standards. Alleging medical negligence, unfair trade practice and deficiency in service, on part of OPs, he prayed for compensation.

4. Upon notice, the complaint was forcefully resisted by OPs by filing their Written Version. OP-1 to 3 raised preliminary objections, alleging that the complainant had not approached this Commission with clean hands and had deliberately concealed material facts with the intention to harass the OPs. They contended that the complaint was defective due to misjoinder of parties and non-joinder of a necessary party,

namely Christian Medical College, Vellore (CMC Vellore), where he was later treated. It was specifically contended that CMC Vellore had been consulted by the Complainant, and several of the allegations raised in the complaint related to findings or records generated at CMC, which was neither impleaded nor examined. The OPs contended that the Complainant, Takam James, was admitted to GNRC Hospital, Guwahati, on 09.07.2013 after sustaining a severe head injury in a motorbike accident on 08.07.2013. On admission, the patient was unconscious, could not breathe on his own. He required mechanical ventilation and supportive critical care, which was immediately provided. Treatment included broad-spectrum antibiotics, anti-epileptic, anti-edema drugs and analgesics, and other supportive measures were provided. The patient underwent tracheostomy on 23.07.2013 due to prolonged ventilator dependency and, following an unsuccessful attempt at decannulation, was subjected to permanent tracheostomy on 23.08.2013. He also underwent an ORIF with plate and screw for his fractured mandible under general anaesthesia on 27.07.2013. He was discharged on the insistence of his attendants, against medical advice, and was advised to follow up after six weeks. The OPs specifically denied the allegations of medical negligence or deficiency in service. They contended that tracheostomy was not a routine or mechanical procedure but a life-saving intervention performed only when prolonged

ventilation is required. They contended that there is no specific timeframe prescribed in standard medical literature for when to perform a tracheostomy. In this case, the decision was made only when weaning from the ventilator failed. The allegation that the patient was not evaluated by specialists between 17.07.2013 and 27.08.2013 was refuted by OP pointing that the Dept of Neurosurgery comprised three neurosurgeons who took daily rounds. As to the allegation of permanent loss of voice, the OPs contended that the discharge summary from CMC Vellore made no reference to such a diagnosis and, to the contrary, recorded that the vocal cords were "normal" with "normal phonation." The OPs relied upon an independent expert opinion from Dr. Sanjay Sachdeva, a Senior Consultant ENT Surgeon, who examined the Complainant and found that both vocal cords were mobile, symmetrical, and approximating well. Thus, according to the OPs, the contention that the complainant had suffered permanent loss of voice was not only baseless but also medically unfounded. The OPs clarified that Dr. BB Dey (OP-2), an experienced general surgeon who had performed over 1,000 tracheostomies, conducted the procedure on 23.07.2013 in the ICU. The allegation that Dr. Monoj Agarwala (OP-3) conducted the tracheostomy was categorically denied. They explained that since tracheostomy is a bedside procedure, there was no separate operation theatre record and the details were properly documented in

the bed head tickets. It was also stated that similar documentation practice was followed even by institutions such as AIIMS. As regards the choice of tracheostomy tube, the OPs defended the use of a fenestrated silicone tube, stating that such tubes are better tolerated in long-term cases and facilitate speech via speaking valves. They emphasized that the tube used was appropriate and in accordance with the clinical needs of the patient. As for the role of Dr. Nayanil Barua (OP-1), it was contended that as a senior consultant neurosurgeon, he was not required to make every single patient entry personally. The hospital functioned as a team, and it was normal practice for junior doctors to make routine progress notes. Dr. Barua had supervised the treatment plan and signed the discharge summary. He had no role in the tracheostomy procedure and was not the consultant responsible for airway management. The Opposite Parties denied any delay in performing the tracheostomy and asserted that there was no indication at the time of discharge that the patient was suffering from subglottic stenosis or any airway injury. It was argued that if the Complainant's condition had worsened, he should have followed up as advised, and the delay in reporting to CMC Vellore several weeks later could not be attributed to the Opposite Parties. They refuted the allegations of unfair trade practices and contended that the hospital used an online billing system and billed in accordance with standard charges. The assertion

that the patient was detained only to inflate medical bills was denied, and it was reiterated that the patient remained under care due to the severity of his condition and not for any ulterior motive. With regard to the allegation that no proper consent was obtained, the OPs asserted that all procedures were explained to the attendants of the patient and informed consent was duly taken. The claim that consent forms were not signed by the doctors or that risks were not explained was termed as false and misleading. The OPs emphasized that he had in fact improved during the course of his admission at GNRC and that the subsequent complaints arose only after discharge and subsequent treatment at other hospitals. The OP contended that the complaint was entirely baseless and sought for dismissal with exemplary costs

5. The Complainant filed Rejoinder reiterating the facts of the complaint and filed evidence of an expert opinion of Dr. Ranjan Rai Chowdhury.

6. OP-1 and OP-3 have filed there evidence affidavit corroborating the contentions in the written statement.

7. The learned counsel for the complainant reiterated the facts and background of the complaint and vehemently argued in detail, the sequence of events and medical lapses that constitute gross medical negligence and deficiency in service on the part of GNRC and its

doctors, particularly Dr. Navanil Barua and Dr. Manoj Agarwal. He argued that despite the complainant's airway being found normal in a CT scan dated 12.07.2013, an accidental extubation occurred on 11.07.2013, which is a serious lapse suggesting lack of ICU supervision. Although Dr. Barua was the attending consultant, his signature is absent from multiple crucial entries in the patient's clinical notes. Further, the consent forms for tracheostomy procedures lack the necessary doctor's identification, and no formal surgical records exist for either of the two tracheostomy operations conducted at GNRC. He argued that the first tracheostomy was reportedly performed on 23.07.2013, but there is no documentation of the operating surgeon, anaesthetist, method of anaesthesia, or the technique employed. Thereafter, on 09.08.2013, signs of severe airway narrowing were documented, requiring a 5 mm tube indicative of critical stenosis. A CT scan dated 20.08.2013 confirmed a 23 mm subglottic airway stenosis. Despite this, no advanced investigations such as fibreoptic bronchoscopy, laryngoscopy, or barium swallow were undertaken by Dr. Agarwal before recommending a permanent tracheostomy. This procedure too was undocumented, and no reference to the airway stenosis or its implications was made in the discharge summary dated 27.08.2013. he asserted that, upon returning home, the patient's symptoms worsened significantly. He exhibited signs of

tracheoesophageal fistula, a life-threatening condition manifested by food particles emerging from the tracheostomy tube, extreme coughing, and respiratory distress. He was rushed him to CMC Vellore, where, based on advanced diagnostic tests and medical evaluations, it was confirmed that the trachea and oesophagus was surgically compromised during the second tracheostomy performed at GNRC. The complainant had to undergo two major surgeries at CMC Vellore on 03.10.2013 and 28.01.2014. Despite this, the doctors at CMC found the tracheal narrowing to be beyond repair, condemning the complainant to live with a permanent tracheostomy and permanent voice loss. The complainant has also emphasized multiple serious ethical violations and procedural lapses. Most medical records from GNRC lacked names, qualifications, and registration numbers of the doctors. The name of the referring or operating surgeon was never recorded, violating MCI regulations. Expert opinion from renowned ENT surgeon Dr. Ranjan Roy Chowdhury, who evaluated the complainant, strongly supports the contention that the injury was iatrogenic and due to negligent tracheostomy procedures.

8. The counsel for OPs argued that Takam James was admitted to GNRC, Guwahati, on 09.07.2013 in an unconscious, comatose state following a motor accident at Nirjuli, Arunachal Pradesh. He asserted that the Guwahati Neurological Research Centre (GNRC) has not been

impleaded as a party in the complaint despite being the hospital where the treatment occurred, and that the OPs are merely Hospital employees. The specific assertion that OP-1 is a Board member of the hospital is also denied. At admission, the complainant was found to be suffering from diffuse axonal injury a severe and potentially fatal brain injury along with a fractured mandible and other external injuries. The diffuse axonal injury was the most life-threatening and required immediate and expert care. The complainant, unable to breathe independently, was put on ventilator support. OP-1 made a clinical judgment to retain him in an intubated state instead of performing an immediate tracheostomy, believing it was in the patient's best interest to attempt weaning from the ventilator before proceeding with the invasive procedure. He asserted that a doctor cannot be held negligent for a clinical decision made in good faith based on accepted medical standards, citing ***Acutrao Haribhan Khodiva and Ors. v. State of Maharashtra*** *&* ***Ors. Reported in 1996 (2) SCC 634, Para 14);*** *(Ref* : *Landmark Judgment* ***of Bolam's v. Friem Hospital Management Committee, 1957(1) WLR 582, 586).*** When improvement did not occur, OP-1 requested OP-2, Dr. BB Dey, a highly experienced surgeon, to perform a tracheostomy, which was carried out on 24.07.2013 after due informed consent. Later, on 19.08.2013, a silicone tracheostomy tube was inserted by OP-3 at the bedside through the existing stoma without

creating a new incision. The procedure, being routine and bedside in nature, did not warrant an OT record, and the reference to a “permanent tracheostomy” in the internal doctor’s note was merely to avoid confusion among nursing staff. The learned counsel for OPs vehemently denied that a second tracheostomy was ever conducted. Upon the request of his attendants, the complainant was discharged on 27.08.2013 with a stable condition. The discharge summary confirmed that the most serious injuries had healed sufficiently. According to the complainant, complications such as airway stenosis and regurgitation developed only after 15 days post-discharge. These developments occurred at another hospital in Arunachal Pradesh and later at CMC Vellore neither of which have been impleaded in the complaint. The opposite parties argue that they had no opportunity to assess these complications as he never returned for follow-up. Specifically addressing the allegations, the counsel refuted the claim of negligence relating to an accidental extubation on 11.07.2013, explaining that such occurrences are medically recognised and can result from involuntary patient movement. The tube was reinserted without incident. They also state that it is common practice for senior consultants like OP-1 to have junior doctors maintain records under their supervision, especially given the high volume of in-patient evaluations.

9. On the issue of informed consent, he argued that although the consent form listed OP-1, it was OP-2 who performed the procedure after fully explaining the risks to the patient's attendants. The omission of Dr. Dey's name on the form was inadvertent and does not negate that informed consent was obtained. As regards the document referred to by the complainant as a "doctor's note", he clarified that it is described as an internal hospital document not part of the official medical record. The hospital went beyond its obligations by handing over both medical and internal records to the complainant, a gesture of transparency not required under the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002. The OPs argued his allegation that two tracheostomies were performed and asserted that only one surgical tracheostomy was performed, and the subsequent change of tube was a routine procedure conducted through the same incision. They argued that the CT scan dated 20.08.2013 showed only possible tracheal narrowing, which is expected after tube insertion and does not immediately suggest airway stenosis. Since the complainant still had a tracheal tube at discharge, a proper voice assessment was not feasible at the time. The defence notes that the discharge summary from CMC Vellore explicitly recorded the complainant's vocal cords and phonation as "normal," thereby contradicting his claim of permanent voice loss. They invoke the Bolam

Test again to assert that reasonable care was taken at all times during the complainant's stay. The OP further contend that the complainant's failure to implead GNRC Hospital is fatal to the complaint, given that the liability (if any) would lie with the institution and not its individual employees. They also object to the so-called expert opinion filed by the complainant, arguing that it is inadmissible because it is unsigned, not verified by affidavit, and the expert was not made available for cross-examination. They asserted that the complaint is false, exaggerated, and malicious, pointing to the complainant's wild claims such as "cutting off the food and wind pipe," which are refuted by his own discharge papers from CMC Vellore.

10. We have examined the pleadings and associated documents placed on record and rendered thoughtful consideration to the arguments advanced by the learned Counsel for both the Parties.

11. The main issue to be determined is whether OPs were negligent in providing medical care and treatment to the patient, constituting deficiency in service? In this regard, it is undisputed that on 08.07.2013, Takam James, the complainant, had met with an accident while riding his motorbike in Nirjuli, Arunachal Pradesh. He was rushed to General Hospital, Naharlagun for initial treatment and subsequently referred to GNRC Hospital in Guwahati, where he was admitted on 09.07.2013. Following his recovery from the accident, he was discharged on

27.08.2013, with a tracheostomy tube in place. Upon returning home, Takam began to experience severe discomfort, including extreme coughing and expulsion of food particles through the tracheostomy tube and this led to more complexities and serious allegations against the OPs that the sequence of events and medical lapses that constitute gross medical negligence and deficiency in service on the part of GNRC and its doctors, particularly Dr. Navanil Barua and Dr. Manoj Agarwal. Despite the complainant's airway being found normal in a CT scan dated 12.07.2013, an accidental extubation occurred on 11.07.2013, which is a serious lapse suggesting lack of ICU supervision. While Dr. Barua attending consultant treated him, his signature is absent from multiple crucial entries in the patient's clinical notes. Further, the consent forms for tracheostomy procedures lack the necessary doctor's identification, and no formal surgical records exist for either of the two tracheostomy operations conducted at GNRC. The first tracheostomy was reportedly performed on 23.07.2013, but there is no documentation of the operating surgeon, anaesthetist, method of anaesthesia, or the technique employed. Thereafter, on 09.08.2013, signs of severe airway narrowing were documented, requiring a 5 mm tube indicative of critical stenosis. A CT scan dated 20.08.2013 confirmed a 23 mm subglottic airway stenosis. Despite this, no advanced investigations such as fibreoptic bronchoscopy, laryngoscopy, or barium swallow were

undertaken by Dr. Agarwal before recommending a permanent tracheostomy. This procedure too was undocumented, and no reference to the airway stenosis or its implications was made in the discharge summary dated 27.08.2013. The patient's symptoms worsened significantly due to gross negligence of the OPs and the complainant exhibited signs of tracheoesophageal fistula, a life-threatening condition manifested by food particles emerging from the tracheostomy tube, extreme coughing, and respiratory distress. He then had to be rushed was rushed to CMC Vellore, where, based on advanced diagnostic tests and medical evaluations, it was confirmed that the trachea and oesophagus was surgically compromised during the second tracheostomy performed at GNRC. The complainant underwent two major surgeries at CMC Vellore on 03.10.2013 and 28.01.2014. Despite this, the doctors at CMC found the tracheal narrowing to be beyond repair, condemning the complainant to live with a permanent tracheostomy and permanent voice loss. The complainant highlighted multiple serious violations and procedural lapses. Most medical records from GNRC lacked names, qualifications, and registration numbers of the doctors. The name of the referring or operating surgeon was never recorded, violating MCI regulations.

12. On the other hand, OPs asserted that he was admitted to GNRC, Guwahati, on 09.07.2013 in an unconscious, comatose state following a motor accident. He was suffering from diffuse axonal injury a severe and potentially fatal brain injury along with a fractured mandible and other external injuries. The diffuse axonal injury was the most life-threatening and required immediate and expert care. He was unable to breathe independently, was put on ventilator support. OP-1 made a clinical judgment to retain the complainant in an intubated state instead of performing an immediate tracheostomy, believing it was in the patient's best interest to attempt weaning from the ventilator before proceeding with the invasive procedure. He asserted that a doctor cannot be held negligent for a clinical decision made in good faith based on accepted medical standards. When improvement did not occur, OP-1 requested OP-2 a highly experienced surgeon, to perform a tracheostomy, which was carried out on 24.07.2013 after due informed consent. Later, on 19.08.2013, a silicone tracheostomy tube was inserted by OP-3 at the bedside through the existing stoma without creating a new incision. The procedure, being routine and bedside in nature, did not warrant an OT record. OPs vehemently denied that a second tracheostomy was ever conducted and he was discharged on 27.08.2013 with a stable condition. As regards informed consent, OPs asserted that they performed the procedure after fully explaining the

risks to the patient's attendants and that the omission of Dr. Dey's name on the form was inadvertent and does not negate that informed consent was obtained. As regards other records it was reasoned as internal hospital documents not part of the official medical record.

13. On the issue of informed consent, he argued that although the consent form listed OP-1, it was OP-2 who performed the procedure after fully explaining the risks to the patient's attendants. The omission of Dr. Dey's name on the form was inadvertent and does not negate that informed consent was obtained. As regards the document referred to by the complainant as a "doctor's note", he clarified that it is described as an internal hospital document not part of the official medical record. The hospital went beyond its obligations by handing over both medical and internal records to the complainant, a gesture of transparency not required under the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002. The OPs argued his allegation that two tracheostomies were performed and asserted that only one surgical tracheostomy was performed, and the subsequent change of tube was a routine procedure conducted through the same incision. They argued that the CT scan dated 20.08.2013 showed only possible tracheal narrowing, which is expected after tube insertion and does not immediately suggest airway stenosis. Since the complainant still had a tracheal tube at discharge, a proper voice

assessment was not feasible at the time. The defence notes that the discharge summary from CMC Vellore explicitly recorded the complainant's vocal cords and phonation as "normal," thereby contradicting his claim of permanent voice loss.

14. It is undisputed that the first tracheostomy was performed on 23.07.2013. Thereafter, on 09.08.2013, signs of airway narrowing were documented, requiring a 5 mm tube indicative of critical stenosis. Thus a CT scan dated 20.08.2013, which confirmed a 23 mm subglottic airway stenosis. The procedure adopted to address this issue was not explained and recorded. It is also undisputed that, post discharge, stated to be under normal condition, the patient's symptoms worsened and the complainant started exhibiting signs of tracheoesophageal fistula manifested by food particles emerging from the tracheostomy tube, extreme coughing, and respiratory distress. He then had to be rushed to CMC Vellore, where, based on advanced diagnostic tests and medical evaluations, it was confirmed that the trachea and oesophagus was surgically compromised.

15. Now, we would like to discuss with regard to the "Bolam Test", which was articulated in 1957. At that point of time emphasis was not on the principle of autonomy rather on the principle of beneficence. The doctor was considered to be the best person and the patient was

kept in dark with regard to the risks and alternative treatment relating to the illness. Now there is a seismic shift in medical ethics and societal attitude towards the practice of medicine. Also, the Medical Council framed statutory regulations regarding professional conduct, etiquette and ethics. This warrants legal tests to adjudicate the advice aspect of doctor patient relationship. The MCI Regulations as amended up to date clearly stipulate the need to respect the patient's autonomy and doctor's obligation to adequately inform him for self-determination. Nature of the patient doctor relationship has to be examined in the light of education and access to the knowledge of ordinary citizens. In the light of these facts and statutory provisions, the "Bolam Test" can no longer be applied to a doctor's advice to his patient, unless it complies with the statutory provisions. The information given to the patient has to be examined from the patient's perspective. The information disclosed is not limited to risk-related inputs. It should include doctor's diagnosis of the patient's condition, the prognosis of that condition with and without medical treatment, the nature of proposed medical treatment and the risks associated with it, the alternative to the proposed medical treatment, advantages and risks of the said treatment and the proposed treatment. The doctor must ensure that information given is "in terms and at a pace that allows the patient to assimilate it, thereby enabling the patient to make informed decision".

16. Instances, where withholding of information is justified, are:

> "(a) **Waiver situation:** is when the patient expressly indicate that he does not want to receive further information about the proposed treatment or the alternative treatment.
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> (b) **Medical emergency:** when life-saving treatment is required and the patient temporarily lacks decision-making capacity. The "Bolam test" would continue to apply.

(c) **Therapeutic privileges:** when the patient has mental capacity, his decision-making capabilities are impaired to an appreciable degree such that doctor reasonably believes that the very act of giving particular information would cause the patient serious physical or mental harm. For example, the patient with anxiety disorder."

17. As regards recording the consent in ***Samira Kohli Vs. Dr. Prabha Manchanda & Anr***,1 (2008) CPJ 56 (SC), the Hon'ble Supreme Court explained the concept of real and informed consent.

> "Consent in the context of a doctor-patient relationship, means the grant of permission by the patient for an act to be carried out by the doctor, such as a diagnostic, surgical or therapeutic procedure. Consent can be implied in some circumstances from the action of the patient. For example, when a patient enters a Dentist's clinic and sits in the Dental chair, his consent is implied for examination, diagnosis and consultation. Except where consent can be clearly and obviously implied, there should be express consent. There is, however, a significant difference in the nature of express consent of the patient, known as 'real consent' in UK and as 'informed consent' in America. In UK, the elements of consent are defined with reference to the patient and a consent is considered to be valid and 'real' when (i) the patient gives it voluntarily without any coercion; (ii) the patient has the capacity and competence to give consent; and (iii) the patient has the minimum of adequate level of information about the nature of the procedure to which he is consenting to. On the other hand, the concept of 'informed consent' developed by American courts, while retaining the basic requirements consent, shifts the emphasis to the doctor's duty to disclose the necessary information to the patient to secure his consent."

18. The Hon’ble Supreme court further summarize principles relating to consent as follows:

> “(i) A doctor has to seek and secure the consent of the patient before commencing a 'treatment' (the term 'treatment' includes surgery also). The consent so obtained should be real and valid, which means that: the patient should have the capacity and competence to consent; his consent should be voluntary; and his consent should be on the basis of adequate information concerning the nature of the treatment procedure, so that he knows what is consenting to.
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> (ii) The 'adequate information' to be furnished by the doctor (or a member of his team) who treats the patient, should enable the patient to make a balanced judgment as to whether he should submit himself to the particular treatment as to whether he should submit himself to the particular treatment or not. This means that the Doctor should disclose (a) nature and procedure of the treatment and its purpose, benefits and effect; (b) alternatives if any available; (c) an outline of the substantial risks; and (d) adverse consequences of refusing treatment. But there is no need to explain remote or theoretical risks involved, which may frighten or confuse a patient and result in refusal of consent for the necessary treatment. Similarly, there is no need to explain the remote or theoretical risks of refusal to take treatment which may persuade a patient to undergo a fanciful or unnecessary treatment. A balance should be achieved between the need for disclosing necessary and adequate information and at the same time avoid the possibility of the patient being deterred from agreeing to a necessary treatment or offering to undergo an unnecessary treatment.
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> (iii) Consent given only for a diagnostic procedure, cannot be considered as consent for therapeutic treatment. Consent given for a specific treatment procedure will not be valid for conducting some other treatment procedure. The fact that the unauthorized additional surgery is beneficial to the patient, or that it would save considerable time and expense to the patient, or would relieve the patient from pain and suffering in future, are not grounds of defense in an action in tort for negligence or assault and battery. The only exception to this rule is where the additional procedure though unauthorized, is necessary in order to save the life or preserve the health of the patient and it would be unreasonable to delay such unauthorized procedure until patient regains consciousness and takes a decision.

(iv) There can be a common consent for diagnostic and operative procedures where they are contemplated. There can also be a common consent for a particular surgical procedure and an additional or further procedure that may become necessary during the course of surgery.

(v) The nature and extent of information to be furnished by the doctor to the patient to secure the consent need not be of the stringent and high degree mentioned in Canterbury but should be of the extent which is accepted as normal and proper by a body of medical men skilled and experienced in the particular field. It will depend upon the physical and mental condition of the patient, the nature of treatment, and the risk and consequences attached to the treatment."

19. As regards the material issue whether before undergoing surgery, the patient or her parents were informed about the possible risks and complications and their informed consent was taken, it is true that every operation, as small as it may be, carries wide range of risks from the most insignificant to the most serious, may lead to fatal complications. Discussing all complications with patient and attending relatives is a necessity, so that she may make up her mind for surgery. Before commencing a treatment or procedure, an 'Informed Consent' is required to be obtained satisfy the following conditions:

"The consenting party i.e. the patient or his/her family members must be aware of the nature and extent of complications and risks of the surgery. The consenting party must have understood the nature and extent of the complications and risks and the consenting party or his/her family members must have consented to the harm and assumed risk. Comprehensive explanation of the possible complications and risks and the extent of entire procedure and transaction, inclusive of all its consequences, must be explained to the patient or his/her family members."

20. In ***Samira Kohli Vs. Dr. Prabha Manchanda & Anr 1(2008) CPJ 56 (SC)***, the Hon'ble Supreme Court has extensively dealt with the concept of consent to be taken from the patient or his family members. It was held that patient has an inviolable right in regard to his body and he has right to decide whether or not he should undergo the particular treatment or surgery. The Hon'ble Supreme Court held that unless the procedure is necessary in order to save the life or preserve the health of the patient and it would be unreasonable to delay the further procedure until the patient regains consciousness and takes decision, a doctor cannot perform such procedure without the consent of the patient. Identical view was taken by the U.K. Supreme Court in "*Montgomery (Appellant) v.* Lanarkshire Health Board (Respondent) (Scotland)" Hilary Term [2015] UKSC 11 on appeal from: [2013] CSIH 3; [2010] CSIH 104, wherein also the concept of the informed consent has been emphasized.

21. As regards duty of medical care, Hon'ble Supreme Court in **Dr. Laxman Balakrishna Joshi Vs Dr Trimbak Babu Godbole** (2013)15 SCC 481 has held that a person who holds himself out ready to give medical advice and treatment impliedly undertakes that he is possessed of skill and knowledge for that purpose:

1. He owes a duty of care in deciding whether to undertake the case.
2. He owes a duty of care in deciding what treatment to give and,
3. He owes a duty of care in the administration of that treatment.

22. Breach of any of these duties gives right of action for negligence to the patient. This means that when a medical professional, who possesses a certain degree of skill and knowledge, decides to treat a patient, he is duty bound to treat him/her with a reasonable degree of skill, care, and knowledge. Failure to act in accordance with the medical standards in vogue and failure to exercise due care and diligence are generally deemed to constitute medical negligence.

23. As regards tracheostomy performed at GNRC, the document for obtaining 'Consent for Operation, Anaesthesia and Other Medical Services' obtained from the complainant for surgery performed on the complainant on 22.07.2013 is placed on record. This document is undisputed. Perusal of the same reveals that, it is in a printed format wherein the patient is stating the explanation given, understanding he had and associated issues with respect to surgery that is to be performed. This consent form has been signed by the complainant himself, parent/ guardian as well as a witness. It has no reference to actual details of the surgery other than 'tracheostomy' or its implications. It is even more intriguing to note that it does not contain any detail as to who is the doctor who has given the information, explanations, options and cautions to the complainant. It also has no signature of any medical person on the consent form. Therefore, such consent recorded and relied upon by OPs is clearly untenable in law.

24. In **P.B. Desai vs State of Maharashtra & Anr [2013] 11 S.C.R. 863** the 'Duty of Care' towards the patient is explained as below:

> "Once, it is found that there is 'duty to treat' there would be a corresponding 'duty to take care' upon the doctor qua/his patient. In certain context, the duty acquires ethical character and in certain other situations, a legal character. Whenever the principle of 'duty to take care' is founded on a contractual relationship, it acquires a legal character. Contextually speaking, legal 'duty to treat' may arise in a contractual relationship or governmental hospital or hospital located in a public sector undertaking. Ethical 'duty to treat' on the part of doctors is clearly covered by Code of Medical Ethics, 1972. Clause 10 of this Code deals with 'Obligation to the Sick' and Clause 13 cast obligation on the part of the doctors with the captioned "Patient must not be neglected".

25. In **Jacob Mathew vs. State of Punjab**, (2005) 6 SCC 1, decided on 05.08.2005, Hon'ble Supreme Court while laying down the elements of medical negligence observed that:

> "48. (2) Negligence in the context of medical profession necessarily calls for a treatment with a difference. To infer rashness or negligence on the part of a professional, in particular a doctor additional considerations apply. A case of occupational negligence is different from the one of professional negligence. A simple lack of care, an error of judgment or an accident, is not proof of negligence on the part of a medical professional. So long as a doctor follows a practice acceptable to the medical profession of that day, he cannot be held liable for negligence merely because a better alternative course or method of treatment was also available or simply because a more skilled doctor would not have chosen to follow or resort to that practice or procedure which the accused followed. When it comes to the failure of taking precautions, what has to be seen is whether those precautions were taken which the ordinary experience of men has found to be sufficient; a failure to use special or extraordinary precautions which might have prevented the particular happening cannot be the standard for judging the alleged negligence. So also, the standard of care, while assessing the practice as adopted, is judged in the light of the knowledge available at the time of the incident, and not at the date of trial. Similarly, when

the charge of negligence arises out of failure to use some particular equipment, the charge would fail if the equipment was not generally available at that particular time (that is, the time of the incident) at which it is suggested it should have been used."

"At least three weighty considerations can be pointed out which any forum trying the issue of medical negligence in any jurisdiction must keep in mind. These are: (i) that legal and disciplinary procedures should be properly founded on firm, moral and scientific grounds; (ii) that patients will be better served if the real causes of harm are properly identified and appropriately acted upon; and (iii) that many incidents involve a contribution from more than one person, and the tendency is to blame the last identifiable element in the chain of causation with the person holding the 'smoking gun'."

"According to Charlesworth & Percy on Negligence (Tenth Edition, 2001), in current forensic speech, negligence has three meanings. They are: (i) a state of mind, in which it is opposed to intention; (ii) careless conduct; and (iii) the breach of duty to take care that is imposed by either common or statute law. All three meanings are applicable in different circumstances but any one of them does not necessarily exclude the other meanings. (Para 1.01) The essential components of negligence, as recognized, are three: "duty", "breach" and "resulting damage", that is to say:-

1. the existence of a duty to take care, which is owed by the defendant to the complainant;
2. the failure to attain that standard of care, prescribed by the law, thereby committing a breach of such duty; and
3. damage, which is both causally connected with such breach and recognized by the law, has been suffered by the complainant. (Para 1.23) If the claimant satisfies the court on the evidence that these three ingredients are made out, the defendant should be held liable in negligence."

26. Hon'ble Supreme Court in **Neeraj Sud & Anr. v. Jaswinder Singh (Minor) & Anr.** (2024 LiveLaw (SC) 863), decided on 25.10.2024, held that:

"14. It is well recognized that actionable negligence in context of medical profession involves three constituents (i) duty to exercise due care; (ii) breach of duty and (iii) consequential damage. However, a simple lack of care, an error of judgment or an accident

is not sufficient proof of negligence on part of the medical professional so long as the doctor follows the acceptable practice of the medical profession in discharge of his duties. He cannot be held liable for negligence merely because a better alternative treatment or course of treatment was available or that more skilled doctors were there who could have administered better treatment.

15. A medical professional may be held liable for negligence only when he is not possessed with the requisite qualification or skill or when he fails to exercise reasonable skill which he possesses in giving the treatment. None of the above two essential conditions for establishing negligence stand satisfied in the case at hand as no evidence was brought on record to prove that Dr. Neeraj Sud had not exercised due diligence, care or skill which he possessed in operating the patient and giving treatment to him."

27. In **M.A Biviji v. Sunita & Ors.** (2023 LiveLaw (SC) 931, decided on 29.10.2023, Hon'ble Supreme Court observed that:

"38. To hold a medical practitioner liable for negligence, a higher threshold limit must be met. This is to ensure that these doctors are focused on deciding the best course of treatment as per their assessment rather than being concerned about possible persecution or harassment that they may be subjected to in high-risk medical situations. Therefore, to safeguard these medical practitioners and to ensure that they are able to freely discharge their medical duty, a higher proof of burden must be fulfilled by the complainant. The complainant should be able to prove a breach of duty and the subsequent injury being attributable to the aforesaid breach as well, in order to hold a doctor liable for medical negligence. On the other hand, doctors need to establish that they had followed reasonable standards of medical practice."

"54. At this stage, we may benefit by adverting to what the renowned author and surgeon Dr. Atul Gawande had to say on medical treatment. He said "*We look for medicine to be an orderly field of knowledge and procedure. But it is not. It is an imperfect science, an enterprise of constantly changing knowledge, uncertain information, fallible individuals, and at the same time lives on the line. There is science in what we do, yes, but also habit, intuition, and sometimes plain old guessing. The gap between what we know and what we aim for persists. And this gap complicates everything we do*."

55. The above observation by Dr. Atul Gawande aptly describes the situation here. This is a classic case of human fallibility where the doctors tried to do the best for the patient as per their expertise and emerging situations. However, the desired results could not be achieved. Looking at the line of treatment in the present matter, it cannot be said with certainty that it was a case of medical negligence."

28. In **Jacob Mathew vs. State of Punjab**, (2005) 6 SCC 1, decided on 05.08.2005, Hon'ble Supreme Court while laying down the elements of medical negligence also observed that:

"11. Deterioration of the condition of the patient post-surgery is not necessarily indicative or suggestive of the fact that the surgery performed or the treatment given to the patient was not proper or inappropriate or that there was some negligence in administering the same. In case of surgery or such treatment it is not necessary that in every case the condition of the patient would improve and the surgery is successful to the satisfaction of the patient. It is very much possible that in some rare cases complications of such nature arise but that by itself does not establish any actionable negligence on part of the medical expert."

"18. In other words, simply for the reason that the patient has not responded favourably to the surgery or the treatment administered by a doctor or that the surgery has failed, the doctor cannot be held liable for medical negligence straightway by applying the doctrine of Res Ipsa Loquitor unless it is established by evidence that the doctor failed to exercise the due skill possessed by him in discharging of his duties."

29. It is seen from the expert opinion that has been brought on record by the complainant in the form of opinion from Dr Ranjan Rai Chaudhary who filed an Affidavit with specific details as to the scope of surgery that was performed on the complainant, medical aspects and necessary considerations in treating the complainant at acceptable medical standards. He went into significant details of the scope,

condition of the patient in question, actions that were expected of OPs, actions that were taken and how they fell short of medical standards expected. Dr Ranjan Rai Chaudhary in his opinion has brought out that:

> **"Overall it is in my considered medical opinion, that the management of patient's airway at GNRC, Guwahati was negligent. Complications may always follow any operation but not explain the risks at the time of taking consent, to not to recognise and appropriately investigate the complication when it first appeared, to not to discuss all other options for managing the complications, to not thoroughly document the findings at the second tracheostomy procedure and not to give appropriate advice on discharge indicate either ignorance or incompetence or both.**
>
> **He further stated that the patient has been left with a significant disability, in that he cannot speak normally and he has a tube in his neck.**

30. In view of the foregoing the negligence in providing medical treatment to the complainant by both the OPs is manifest in the form of compliance with obtaining informed consent, providing medical treatment of requisite standards, providing necessary information, guidance and support to the complainant. These failures on the part of OPs resulted in adverse impact in the condition of the complainant who has been rendered with significant disability and that he cannot speak normally and has a tube in his neck for time to come.

31. As regards award of compensation, the Hon'ble Supreme Court in **Alfred Benedict & Anr. v. Manipal Hospital, Bangalore & Anr.**, (2015) 11 SCC 423, decided on 11.08.2014, while determining the

quantum of compensation in a case of amputation of arm of a baby, who had developed gangrene due to wrongful administration of IV fluid, the Hon'ble Supreme Court held that:

> ***"10. We have heard the learned counsel for the parties and have gone through the finding recorded by the State Commission as also the National Commission. We do not find any reason to differ with the finding that it was only because of the negligence on the part of the Hospital that the two years' child developed gangrene resulting into amputation of her right arm.***
>
> ***11. However, taking into consideration the sufferings of the girl child, who is now 13 years of age, in our opinion the compensation awarded by the Commission is on a lower side. The learned counsel appearing for the complainant submitted that every year she has to incur battery charges for the artificial limb, which costs Rs 80,000 annually. There cannot be any dispute that the girl will have to suffer throughout her life and has to live with artificial limb. Not only she would have to face difficulty in her education but would have also to face problem in getting herself married. Although the sufferings, agony and pain, which the girl child will carry cannot be compensated in terms of money, but, in our view, a compensation of Rs 20,00,000 (Rupees twenty lakhs only) will be just and reasonable in order to meet the problems being faced by her and also to meet future troubles that will arise in her life.***
> ***12. With the aforesaid reason, we allow the appeal filed by the complainants being civil appeal arising out of SLP (C) No. 35632 of 2013 by enhancing the compensation to Rs 20,00,000 (Rupees twenty lakhs only), which shall carry simple interest of 9% per annum from the date of this order. It may be made clear that out of the total compensation, a sum of Rs 10 lakhs shall be deposited in a long-term fixed deposit in a nationalised bank so that this amount along with interest that may accrue, shall take care of her future needs. The balance Rs 10 lakhs shall be utilised by investing Rs 5 lakhs in a short-term fixed deposit in a nationalised bank so that this amount along with the accrued interest will take care of her needs in near future. The rest Rs 5 lakhs may be spent for her further medical treatment."***

32. In **Shoda Devi v. DDU/Ripon Hospital, Shimla & Ors**., (2019) 14 SCC 357, decided on 07.03.2019, the Hon'ble Supreme Court enhanced the compensation in a case of amputation of arm of the complainant and observed as below:

> ***"15.2. We are constrained to observe that the National Commission, even after appreciating the troubles and trauma as also disablement and disadvantage suffered by the appellant, had been too restrictive in award of compensation. Ordinarily, the general damages towards pain and suffering as also loss of amenities of life deserve to be considered uniformly for the human beings and the award of compensation cannot go restrictive when the victim is coming from a poor and rural background; rather, in a given case like that of the appellant, such a background of the victim may guide the adjudicatory process towards reasonably higher amount of compensation (of course, after having regard to all the attending circumstances).***
>
> ***15.3. Such granting of reasonability higher amount of compensation in the present case appears necessary to serve dual purposes: one, to provide some succour and support to the appellant against the hardship and disadvantage due to amputation of right arm; and second, to send the message to the professionals that their responsiveness and diligence has to be equi-balanced for all their consumers and all the human beings deserve to be treated with equal respect and sensitivity. We are impelled to make these observations in the context of an uncomfortable fact indicated on record that when the appellant was writhing in pain, she was not immediately attended at and was snubbed with the retort that "the people from hilly areas make unnecessary noise". Such remarks, obviously, added insult to the injury and were least expected of the professionals on public duties.***
>
> ***15.4. Apart from the above, when the appellant is shown to be a poor lady from rural background, her contribution in ensuring the family meeting both ends also deserves due consideration. With her disablement and reduced contribution, the amount of compensation ought to be of such level as to provide relief in reasonable monetary terms to the appellant and to her family.***

16. For what has been discussed and observed hereinabove and in the given set of facts any circumstances, we are of the view that the appellant deserves to be allowed further an amount of Rs 10,00,000 towards compensation, over and above the amount awarded by the State Commission and the National Commission. Having regard to the quantum of enhancement being allowed herein, it is also considered proper to grant three months' time to the respondents to make the requisite payment and else, to bear the burden of interest.

17. Accordingly, this appeal is allowed. The appellant is awarded further an amount of Rs 10,00,000 (Rupees ten lakhs) towards compensation, over and above the amount awarded by the State Commission and the National Commission. The respondents shall make the requisite payment within 3 months from today failing which, the enhanced amount of compensation shall carry interest at the rate of 6% per annum from the date of filing of the complaint before the State Commission."

33. In **Charan Singh v. Healing Touch Hospital**, (2000) 7 SCC 668, decided on 20.09.2000, the Hon'ble Supreme Court has held that:

"12. <u>While quantifying damages, Consumer Forums are required to make an attempt to serve the ends of justice so that compensation is awarded, in an established case, which not only serves the purpose of recompensing the individual, but which also at the same time, aims to bring about a qualitative change in the attitude of the service provider. Indeed, calculation of damages depends on the facts and circumstances of each case. No hard and fast rule can be laid down for universal application. While awarding compensation, a Consumer Forum has to take into account all relevant factors and assess compensation on the basis of accepted legal principles, on moderation. It is for the consumer forum to grant compensation to the extent it finds it reasonable, fair and proper in the facts and circumstances of a given case according to the established judicial standards where the claimant is able to establish his charge.</u>

13. <u>It is not merely the alleged harm or mental pain, agony or physical discomfort, loss of salary and emoluments etc. suffered by the appellant which is in issue — it is also the quality of conduct committed by the respondents upon which attention is required to be founded in a case of proven negligence</u>.

34. After due consideration of the entire facts and circumstance of the case, including the trauma and suffering of the complainant, the expenditures that were incurred for his treatment at various hospitals including at VMC, Vellore and the present condition he is in, he needs to be compensated.

35. While the complainant claimed compensation of Rs.12,40,19,000, the same unsupported by evidence necessary and is evidently disproportionate. Clearly, he incurred substantial expenditures towards Treatment, moving from Arunachal to Tamil Nadu for treatment for a long time and also was under constant treatment and medication, in addition to pain and suffering. Therefore, after due consideration of all these, including the sufferings and the condition he needed to cope up in future also, we consider it appropriate to award a lumpsum amount of Rs.20,00,000 as compensation to be to jointly and severely paid by all the three OPs, within one month from the date of this order. In the event of delay, the OPs are liable to pay simple interest @ 12% per annum for such delayed period till final payment.

36. The OPs are also directed to pay Rs.50,000 as costs to the complainant.

37. With the above directions, the CC No. 581 of 2014 is disposed of.

38. All pending Applications, if any, also stand disposed of accordingly.

……
(SUBHASH CHANDRA)
PRESIDING MEMBER

……
(AVM J. RAJENDRA AVSM VSM (Retd.))
MEMBER

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