# NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION
# NEW DELHI

## REVISION PETITION NO. 1492 OF 2019

(Against the Order dated 28/02/2019 in Appeal No. 371/2010 of the State Commission Kerala)

1. DR. NAYAN THARA & ANR.
GYNECOLOGIST, M/S. KIMS AI-SHIFA HOSPITAL PVT. LTD. PB NO. 26, KAKOOTH OOTY ROAD,
PERINTHALMANNA,
DISTRICT-MALAPPURAM
KERALA-679322

2. M/S. KIMS AI-SHIFA HOSPITAL PVT. LTD.
PB NO. 26, KAKOOTH OOTY ROAD,
PERINTHALMANNA,
MALAPPURAM DISTRICT
KERALA-679322 .....Petitioner(s)

Versus

1. SUBAIDA
W/O. JABBAR, THANKAYATHIL HOUSE, KUNNAPPALLY,
P.O., KUNNAPPALLY, PERINTHALMANNA
DISTRICT-MALAPPURAM
KERALA-679322 .....Respondent(s)

**BEFORE:**

**HON'BLE AVM J. RAJENDRA, AVSM VSM (Retd.),PRESIDING MEMBER**

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| FOR THE PETITIONER : | FOR THE PETITIONER: DR. S. GOPAKUMARAN NAIR, SR. ADVOCATE (THROUGH VC)<br>MS. PRIYA BALAKRISHNAN, ADVOCATE |
| FOR THE RESPONDENT : | FOR RESPONDENT : MR. ZULFIKER ALI, ADVOCATE (THROUGH VC) |

**Dated : 07 November 2024**

## ORDER

1. The present Revision Petition has been filed under Section 21(b) of the Consumer Protection Act, 1986 (the "Act") against Order dated 28.02.2019, passed by the learned State Consumer Disputes Redressal Commission, Kerala ('State Commission') in First Appeal No. 371/2010. In the impugned Order, the State Commission allowed the appeal of the complainant while setting aside the decision of the District Consumer Disputes Redressal, Forum, Civil Station, Palakkad ('District Forum') dated 14.06.2010 in CC No. 282/1999.

2. For the convenience, the parties are referred to as placed in the original Complaint filed before the District Forum.

3. Brief facts of the case, as per the complainant, are that during early stages of her second pregnancy, she sought consultation and treatment from OP-1, a gynaecologist. OP-1 assured her that a normal delivery was expected, with the due date being 26.01.1994. Due to delay beyond the expected delivery date, she was admitted to OP-2 hospital, where OP-1 was practicing. As she did not experience labour pains, OP-1 instructed the use of cervix-prime and Pitocin drip to induce labour. However, the administration of Pitocin caused severe allergic reactions, leading to feeble pulses. OP-1 subsequently performed a forceps assisted delivery. Following the delivery, her condition deteriorated, with sudden drop in BP and massive bleeding, necessitating a hysterectomy. The complainant alleged that during the administration of Pitocin, neither OP-1 nor any medical personnel were present, and that the forceps delivery was conducted recklessly, causing a uterine rupture that led to hysterectomy. The complications arising from her delivery and premature removal of uterus were due to deficiencies in quality, nature, and performance of services provided by OPs, amounting to medical negligence. Additionally, there was a serious contradiction regarding her blood group. Initially, it was stated to be O+, and when complications arose from the Pitocin allergy and forceps delivery, her husband arranged for O+ blood donors. However, it was later revealed that her blood group was AB-. Due to the unavailability of AB- donors, OPs administered both AB- and B- blood to her and she had to undergo the removal of her uterus, which she attributed to the lack of proper care and it also resulted in the infant suffering from asphyxia, neonatal convulsion and birth palsy, requiring immediate treatment at Medical College Hospital, Calicut. The infant was hospitalized for four days and required follow-up visits for three months. She alleged medical negligence against the OPs for complications that arose from forceps delivery and subsequent hysterectomy, filed a complaint seeking compensation of Rs.3,00,250.

4. The OPs filed separate versions but raised identical defences, denying all material allegations made against them. They asserted that, as the complainant did not experience labour pains well beyond the anticipated delivery date, labour induction was recommended to prevent foetal distress due to the delay. Accordingly, after her admission, cerviprime was applied, followed by administration of Pitocin. The OPs further contended that the complainant was found to be allergic to Pitocin, which was promptly discontinued, and an antidote was administered. Despite this, she still did not develop labour pains, and foetal distress was noted, necessitating a forceps-assisted delivery. After about half an hour after the child's delivery, she was reported to be experiencing bleeding, and steps were taken to manage it. In her best interest, and to avoid further life-threatening complications, hysterectomy was performed. The OPs refuted the allegations regarding mismatched blood transfusion, claiming that her husband had initially provided an incorrect blood group. However, they asserted that cross-matching was conducted before any action was taken, and it was discovered that her complainant’s blood group was AB-. Since AB- donors were unavailable, compatible negative blood groups that could be safely transfused were administered. The OPs maintained that there were no lapses in the complainant’s treatment or the transfusion of blood.

5. The learned District Forum vide Order dated 14.06.2010, dismissed the complaint with the following finding:

> ***“It is also contented by complainant that application of forceps caused injury to uterus and resulted in bleeding whereas the expert has categorically deposed that in the sent***

***case it is not traumatic bleeding and is atonic bleeding. Traumatic bleeding can be to injury to vagina, injury to cervix or rupture of uterus. Hysterectomy was done only after attempting to manage the bleeding by blood transfusion. At this juncture it has also be stated that OP contends that the husband of complainant has taken the specimen of uterus which was removed on assurance that he would sent it for histo-pathology report. Complainant does not dispute that he has not taken the sample from the hospital. But the histo-pathology report is not placed before us. Such report if placed would have certainly thrown light to the truth if any of the contentions raised by the complainant. We can draw adverse inference against the complainant for not producing the report. On these grounds we are not able to reach the conclusion that there is negligence application of forceps or, doing the hysterectomy.***

***It is an allegation of the complainant that during ante natal check complainant, the blood group was tested and reported by 1st OP as O+ve. But later it was stated to be AB+ve and at the time of blood transfusion after cross matching it was informed to be AB-ve. AB-ve blood and B-ve blood was given for blood transfusion. That the act of OPs in stating various groups and not properly confirming the blood group prior to delivery is negligence. This allegation is contented by the opposite parties denying that it was never stated by opposite parties that the blood group of the complainant was O+ve. AB+ve group was endorsed as the complainant and her husband stated that it was checked during 1st delivery. But it can be seen that before doing blood transfusion, 1st OP did not rely upon this oral statement but did the blood grouping test and got it confirmed as AB-ve. On perusal of Ext.B1, case sheet, page 3 that the blood group of the complainant is seen recorded as AB+ve. But it is clear that the blood pup was checked and confirmed prior to transfusion as is evident from Ext.B4 & B5. Hence there was no negligence on their part. O+ve seen entered in discharge card (Ext.A1) does not inspire our confidence because it is entered in such a place where there is no specific column for the same.***

***Considering the pleadings, evidence on records and the arguments of respective learned counsels, we are of the view that complainant failed to prove deficiency in service on the part of opposite parties.***

***In the result complaint dismissed."***

6. Being aggrieved by the District Forum Order, the complainant filed Appeal No. 371/2010 and the State Commission vide Order dated 28.02.2019 allowed the Appeal and set aside the Order passed by the District Forum, with the following observations: -

***"There is nothing in evidence to show that the reaction from pitocin to complainant was on account of any negligence in its administration or on account fault attributable to hospital. The infant developed some complications immediately after birth and had to be treated elsewhere, without anything more, is hardly sufficient to hold that there was negligence by the doctor and the hospital. However the case of the***

***complainant imputing negligence against the hospital in identifying her blood group and of informing different groups at different points of time is found to be having some substance on examining the materials produced in the case. There is every reason to hold that her blood group was wrongly identified as AB+ve and accordingly informed to the complaint's husband to arrange blood for transfusion and just before such transfusion when the complainant was in a Critical condition, on matching the blood was identified as AB -ve. Donors of such blood groups not being immediately available other negative blood groups were transfused to complainant. Though we do not have anything to show that transfusion of other negative blood groups when AB-ve blood is not available is detrimental, still, the circumstances presented clearly reveal deficiency of service on the part of the hospital. Entry recorded in the case sheet of complainant on 15-7-93 shows her blood group as AB+ve. The case sheet also contains a note addressed by the lab technician that her blood group is AB-ve and not AB+ve as mentioned in the requisition slip. The explanation offered by the opposite parties that they proceeded with a wrong blood group on the basis of information given by complainant's husband but the matching carried out just before transfusion identified her blood group as AB-ve speaks in volumes the carelessness and negligence shown in identifying the complaint's blood group and in taking precautionary steps in arranging donors of that blood group at least when the complainant had shown severe reaction to pitocin and later profuse bleeding after undergoing a forceps delivery and removal of her uterus.***

***15. We hold both the opposite parties culpable of deficiency in service and medical negligence in the treatment of the complainant, and dismissal of her complaint by the forum is unsustainable. Points are found accordingly.***

***Considering the facts and circumstance presented, we hold that the opposite parties have to pay compensation of Rs. 2 lakhs (Rupees Two lakhs only) for the loss and injuries suffered by the complainant on account of their medical negligence and deficiency in service.***

***In the result in reversal of the dismissal of the complaint by the lower forum allowing the appeal opposite parties jointly and severally directed to pay compensation of Rs. 2 lakhs (Rupees Two lakhs only) with 8% interest p.a. on such sum from the date of filing of the complaint till realization, to the complainant. Opposite parties also shall also pay cost of Rs.50,000 (Rupees Fifty Thousand only) to the complainant.***

***Compensation and cost ordered to the complainant shall be paid by the Opposite parties within one month from the date of receipt of a copy of the judgment.***

***Appeal is allowed."***

7. Dissatisfied by the Order of the State Commission, OPs 1 & 2 filed the present Revision Petition before this Commission praying:

***a) Allow this Revision Petition and to set aside the judgment of the Kerala State Consumer Disputes Redressal Commission dated 28-02-2019 delivered in Appeal No.371 of 2010. And***

***b) Pass such other order or direction deemed fit and proper in the facts and circumstances of the case."***

8. The learned counsels for OPs-1 & 2 reiterated the arguments previously advanced before the learned District Forum and the learned State Commission and asserted that the failure of OP-1 to obtain statutory registration from the State Medical Council did not amount to a "deficiency" under Section 2(1)(g) of the Consumer Protection Act and that this was an incorrect interpretation of law. Since the Travancore Cochin Medical Council subsequently granted statutory registration to OP-1, the State Commission should have found that this act effectively ratified OP-1's prior medical practice in the State, as there were no objections raised regarding her earlier practice or any alleged omissions. Consequently, OP-1's practice, at the time of treating the complainant, was legal and valid. The hospital exercised due care and diligence in correctly identifying the complainant's blood group, as evidenced by the lab technician's accurate entries in the case sheet prior to the blood transfusion. They argued that the State Commission ought to have accepted the explanation that the erroneous entries in the case sheet and requisition slip, which incorrectly recorded her blood group as AB+, were based on misinformation provided by her husband. The correct blood group was confirmed in time and transfused to the complainant, and no injury was caused. Additionally, he asserted that a OP-1's failure to register within the state where the treatment was conducted could not be considered within the legal definitions of "medical negligence" or "deficiency in service." At most, such omission would subject the practitioner to regulatory action by the relevant State Medical Council, which could impose disciplinary measures as per applicable statutory provisions. Therefore, they concluded that the State Commission's finding of medical negligence and deficiency in service was unjustified. They prayed for the complaint to be dismissed.

9. The learned Counsel for the complainant contended that OP-1 was ineligible to practice modern medicine in Kerala as she failed to obtain requisite statutory registration with the State Medical Council at the time of treating and performing surgery on the complainant. Thus, OP-2 hospital, which employed and permitted her to practice as a gynaecologist without such registration, was equally liable. The OPs exhibited gross negligence in accurately identifying the complainant's blood group, providing inconsistent information at different stages, which caused her significant mental anguish. Due to unavailability of her correct blood group, B- blood had to be transfused in the eleventh hour. He supported the findings of the State Commission, asserting that the conclusions were drawn after a thorough examination of the evidence on record. Alleging negligence and deficiency on part of the OPs, he sought upholding of the impugned Order dated 28.02.2019.

10. I have examined the pleading and associated documents placed on record, including the order of the learned District Forum and the learned State Commission and rendered thoughtful consideration to the arguments advanced by learned counsels for both the parties.

11. The primary issue to be determined is whether OP-1 and/or 2 have committed medical any negligence or deficiency in service in treating the complainant? If so, to what extent? In the original complaint before the District Forum, she made several allegations of negligence and deficiency in service. However, based on evidence, all allegations were dismissed by both the District Forum and the State Commission, except for the issue concerning the incorrect blood transfusion. Upon reviewing the evidence on record and considering the limited scope of this Commission's revisional jurisdiction, I find no reason to interfere with the detailed evaluation of evidence and reasoned finding arrived at by the learned District Forum and the learned State Commission, except the conflicting views between the said fora with respect to blood transfusion. Thus, the main question is whether the OPs were negligent or deficient in service with respect to transfusion of wrong blood group to the complainant, as alleged. In this regard the contention of OPs is that the complainant's blood group was incorrectly recorded as AB+ in both the case sheet and requisition slip, based on information provided at the time of admission by the complainant's husband. While the complainant denied this, there is no evidence on record to support her stand. It is undisputed that the OPs have in fact conducted an independent blood matching test prior to the transfusion, which revealed that her actual blood group was AB-ve, making it inappropriate to transfuse AB+ blood. It is further undisputed that B- blood was arranged and administered to the complainant during and after the hysterectomy. According to accepted medical practice, B- blood can be safely transfused to a patient with AB- blood. Regardless of the fact whether her husband provided incorrect input about her blood group, the critical fact remains that the OPs have specifically verified the correct blood group before administering blood, and a medically acceptable blood group was transfused. Therefore, I find no negligence or deficiency in service in this regard.

12. As regards the further issue of OP-1's qualification and registration with the Medical Council, the relevant provisions of the Indian Medical Council, Act, 1956 are reproduced below:

> *21. The Indian Medical Register.—(1) The Council shall cause to be maintained in the prescribed manner a register of medical practitioners to be known as the* ***Indian Medical Register which shall contain the names of all persons who are for the time being enrolled on any State Medical Register and who possess any of the recognised medical qualifications.***
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> *(2) It shall be the duty of the Registrar of the Council to keep the Indian Medical Register in accordance with the provisions of this Act and of any orders made by the Council, and from time to time to revise the register and publish it in the Gazette of India and in such other manner as may be prescribed.*
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> *(3) Such register shall be deemed to be a public document within the meaning of the Indian Evidence Act, 1872, and may be proved by a copy published in the Gazette of India.*

*23. Registration in the Indian Medical Register.* ***-The Registrar of the Council may, on receipt of the report of registration of a person in a State Medical Register*** *or on application made in the prescribed manner by any such person, enter his name in the Indian Medical Register:*

*Provided that the Registrar is satisfied that the person concerned possesses a recognised medical qualification.*

*27. Privileges of persons who are enrolled on the Indian Medical Register.-Subject to the conditions and restrictions laid down in this Act regarding medical practice by persons possessing certain recognised medical qualifications,* ***every person whose name is for the time being; borne on the Indian Medical Register shall be entitled according to his qualifications to practice as a medical practitioner in any part of India*** *and to recover in due course of law in respect of such practice any expenses, charges in respect of medicaments or other appliances, or any fees to which he may be entitled."*

13. Pertinently, the non-registration with the State Medical Council was not originally raised in the complaint. Notwithstanding the same, it is undisputed that OP-1 is a qualified medical doctor (gynaecologist). Her educational and professional qualifications as well as experience are not in question. Her admission to the Indian Medical Register which grants privilege to practice her field of medicine in any part of India is also undisputed. The contention at this stage is, she was not registered with Kerala Medical Council for practice in Kerala as on the date of she administering treatment to the complainant and that it constitutes negligence and deficiency in service. However, it is also undisputed that subsequently the registration of OP-1 was accepted by the Travancore Cochin Medical Council. Mere delay in registration with Travancore Cochin Medical Council, while being adequately qualified and held on the rolls of Indian Medical Register with privilege to practice anywhere in India, does not amount to medical negligence or deficiency in service by OP-1 with respect to the complainant. It is for the Travancore Cochin Medical Council or Kerala State Medical Council to take cognizance of this deviation, if any, as per rules.

14. After due consideration of the entire facts and circumstances of the case, including the above deliberations, no medical negligence or deficiency in service of OPs is established. Therefore, the order of the learned State commission dated 28.02.2019 in FA No. 371 of 2010 is set aside and the complaint is dismissed. Consequently, the Revision Petition No.1492 of 2019 is accordingly allowed.

15. There shall be no order as to costs and all pending Applications, if any, are also disposed of accordingly.

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