M. Chinnaiyan vs Sri Gokulam Hospital and Anr.

National Consumer Disputes Redressal Commission

25 September, 2006

Citations: III (2007) CPJ 228 NC

Bench: K G Member, P Shenoy

ORDER

P.D. Shenoy, Member

1. Aggrieved and dissatisfied by the order of the State Consumer Disputes Redressal Commission, Chennai, which had dismissed his complaint, the complainant (husband of the deceased) has filed this appeal before us. Tine dispute in this case falls in narrow compass i.e. whether transfusion of two units of blood to the complainant's wife in the post-operative period in December 1990 could result in full blown AIDS in mid, June, 1994.

Briefly stated facts of the case are as under:

2. Smt. R. Lalitha while taking treatment for abdominal pain at Gokulam Hospital (1st opposite party) before the State Commission was advised to undergo hysterectomy, which was performed by Dr. P. Chellammal, Gynaecologist in December 1990. She was transfused two units of blood in the postoperative period in that hospital which was allegedly procured from Queen Mary's Clinical Laboratory, which is the second opposite party before the State Commission. In mid-1994 the patient developed recurrent loose motion, weight loss, respiratory infection and difficulty in swallowing, for which a blood test was done by the second opposite party which showed that HIV antibodies were present. Therefore she was referred to YRG Centre for AIDS Research and Education, wherein ELISA test was done in June 1994 which confirmed that complainant's wife was infected with HIV. She underwent medical treatment at YRG Centre. In July 1995, complainant's wife developed left sided hemiparesis, oral candidiasis and pulmonary tuberculosis. She was hospitalized at CSI Kalyani General Hospital, Madras in July 1995.

As she became unconscious, a CT Scan was done and where the disease was diagnosed as glioma of the brain, for which she was admitted in Raju Hospital at Madras on 12.8.1995 where she died on 16.8.1995.

Case of the appellant:

3. In late 1990 R. Lalitha the complainant suffered from bleeding of uterus and was admitted to R1 - Sri Gokulam Hospital wherein hysterectomy was performed on 21.2.1990. Subsequent to the operation, two units of blood was transfused to the patient which was brought from R2 - Queen Mary's Clinical Laboratory which did not conduct any test to satisfy itself that it was free from infection like HIV, etc. The hospital authorities (R1) also did not cross check whether there is a certificate in this regard. The treating doctor should satisfy himself that the blood is free from infection which she did not do. In June 1994 when the patient suffered from multiple diseases for which she did not have immunity, blood was tested and found to be HIV+. This gap of 3Vz years is categorized in medical texts as "Aid Symptomatic period". The blood was obtained by the first opposite party from the second opposite party's laboratory. But for the uterine problem the complainant's wife had no other illness. In mid-1994 she developed several problems. The complainant had paid the first and second opposite parties the surgery costs, postoperative care cost as well as the cost of the blood. The second opposite party which supplied the blood had not tested the blood to ensure that the blood was free from the deadly HIV. Any blood bank/laboratory supplying blood is duty-bound to ensure that the blood supplied is free from HIV and other infections. The second opposite party had failed to carry out the test required to ensure that the blood was not infected. The blood supplied by the second opposite party to the first opposite party for transfusion had HIV antibodies. The first opposite party also owed a duty to the patient to ensure that the blood which it was transfusing her was free from HIV/AIDS. There was thus a gross and patent negligence on the part of both the opposite parties while transfusing the blood with the result that the complainant's wife was infected with HIV by the transfusion of HIV contaminated blood. The complainant's wife lost her life on account of this negligence and deficiency in service on the part of the opposite parties.

4. Out of the three modes of transmission of HIV/AIDS the most dangerous one is through the transfusion of blood having the virus. The sole reason for the complainant's wife developing HIV/AIDS was the transfusion of the blood contaminated with the HIV virus done by the opposite parties after the operation in December 1990. The

complainant's wife and the complainant have led clean lives and there was absolutely no other reason for her getting HIV infection which led to her death. The HIV infection developed into full blown AIDS 3% years later. It is well known that persons who are infected with HIV develop complications subsequently after the gestation period/window period. The virus remains dormant in the body and strikes the body's immune system later. The period between the entry of the virus and onset of the disease could be several years depending on several factors.

Submissions by the learned Counselforthe appellant:

5. The learned Counsel for the appellant submitted that blood transfusion was given without obtaining the consent of the patient.

6. The State Commission in its order had noted that complainant's wife and the complainant had led clean lives and there was absolutely no other reasons for her getting HIV infection which led to her death.

7. Under the Drugs and Cosmetics Rules, 1945, an amendment was introduced through which Rule 66A came into effect on 11.7.1989 which shows that every licensee of a blood bank shall get sample of every blood unit tested for freedom from HIV antibodies from such laboratories may be specified for the purpose by the Central Government. The date of performing such test shall be recorded on the label of the container also. As the blood was supplied in December 1990 respondent No. 2 was bound to comply with this legal requirement.

8. In the book under the caption 'HIV (Pathogenesis and Natural History) by Howard Libman, MD and Harvey J Makadon, MD it has mentioned that the acute HIV syndrome has been documented between 6 and 56 days after a known exposure, with an average incubation of approximately 2 weeks. The duration of symptoms has ranged from 5 to 60 days, with reported averages ranging from 2 to 4 weeks (44-46, 51, 57, 64). Symptoms are usually acute in onset, and manifestations include fever, generalized lymphadenopathy, pharyngitis, headache, rash, myalgia and arthralgia. There is considerable variability in the clinical presentation.

9. Progression to Symptomatic HIV Disease - When the high viral levels associated with acute HIV syndrome are suppressed by the initial immunologic response, an infected

person generally moves into an asymptomatic period that may range frori several months to more than 10 years. Although symptoms are not present during this period of clinical latency, viral replication is ongoing, leading to a loss of approximately 10% of CD4 cells per year in most individuals.

10. Unguarded sex, use of same needle for injection, blood transfusion are the known causes of HIV infection, whereas percentage of certainty in the first two causes are low, but in the case of blood transfusion it is more than 99%. Therefore, learned Counsel submitted that it is necessary that the patient or the guardian be told about the risk of blood transfusion.

In Chhatterton v. Gerson and Anr. (1981) 1 ALL ER 257, it is held that-

The duty of a doctor was to explain to the patient what he intended to do and the implications of that action in a way that a careful and responsible doctor would do in similar circumstances; that where a patient had been given some explanation of the action proposed to be taken so that there was a real consent to the operation, an action would lie in negligence if there was a failure to inform the patient of the nature of the operation and its implications and the patient proved that, if a proper explanation had been given, she would not have consented to the operation; and that since the plaintiff had failed to prove that she had not been given details of the operation and its implications, her action both in trespass and negligence failed (post, pp. 442 H-443B, 445B)

In Reibl v. Hughes (1997) 78 DLR (3d) 35 it stated that-

Action for damages for trespass to person and negligence. Plaintiff suffered severe headaches. Medical examination revealed plaintiff suffering from major occlusion of artery which should be surgically removed. During operation plaintiff suffered massive stroke. Held : Duty of surgeon to explain problems caused by such a complaint and to explain specific risks of surgen/of this kind. Duty also to explain risks of continuing without surgery. Defendant had only told plaintiff of mechanics of operation. Failed to communicate purpose or gravity of operation or risks involved. Defendant negligent in failing to carry out this duty. Liable also in battery. Plaintiff suffered permanent paralysis of right side of body, leaving him impotent, unfit for work and with no hope of working again. Was 44 years old at time of injury. Good work record. In expectation of substantial

accident disability and retirement benefits if he had been able to remain with his employer for ten years. General damages of $ 225,000.00 ACWS.

Submissions of the learned Counsel for respondent No. 1:

11. Learned Advocate for the respondent submitted that consent for the surgery was taken before operation was performed-

I am hereby giving my consent for doing operation in my wife for removal of her uterus after giving anesthesia.

This consent note can be interpreted to include blood transfusion as the patient was suffering from anemia, it urgently require blood transfusion.

12. It is mentioned in the clinical note of the Gokulam Hospital on 29.12.1990 'reserve one bottle of blood' which was in the knowledge of the complainant. It is also mentioned in the nurses note dated 29.12.1990, 'Queen Mary's reserved one bottle of blood.' Hence, blood was obtained from Queen Mary's Clinical Laboratory and it was their responsibility to supply pure blood as it was a recognized laboratory. Dr. Chellammal has stated that as the laboratory was well established and Government approved blood bank and since the blood was certified to be free from infection it was administrated without any further second test. Complainant's wife perfectly recovered from the ailment and the wounds also had healed well. Further, Dr. Suniti Solomon has stated that it is medically impossible for her to say that the complainant's wife had acquired HIV through blood transfusion.

13. The complaint is time-barred as it was filed on 30.4.1996. Though she was operated in December 1990.

Submissions by the learned Counsel for the respondent No. 2 and his written arguments:

14. Learned Advocate for respondent No. 2 submitted that there are two issues which are involved in this case; one is whether R1 had obtained the consent of the complainant or his wife for conducting the surgery. R2 is not concerned with this. The second issue is whether R2 had supplied blood and if so whether it was impure. It is contended by R2 that no blood was supplied by R1 or R2. There is no proof and no receipt has been obtained. R1 has stated that she did not obtain the blood from R2 only the patient's

attendant brought it from R2. The complainant has not produced the receipt for having made payment to R2 for obtaining the blood. The learned Counsel stated that he will submit the attested copy of the affidavit produced before the State Commission wherein it has been stated that this blood was not supplied by R2. Exh. A18 is a bogus and forged document. This is not issued by Queen Mary's Clinical Laboratory.

15. In his written arguments the learned Counsel for the respondent has submitted that the following facts will emerge from the stand taken by the parties:

(a) The complainant admittedly never procured two units of blood on his own, but says on oath that it was independently procured by the respondent No. 1

(b) The respondent No. 1 admittedly never procured the blood from the respondent No. 2 but states on oath that the complainant has independently procured the blood from respondent No. 2.

(c) The respondent No. 2 says that it has never supplied blood either to the complainant, or to the respondent No. 1 ever since its inception in the year 1987.

16. He further submitted that the complainant has not produced any receipt relating to the alleged purchase of any blood from any person, leave alone the respondent No. 2. The respondent No. 2 has filed documents/affidavits which are fabricated. A perusal of the same shows that it does not by any stretch of imagination shows the evidence of purchase of blood from respondent No. 2. No such ground has been taken by the appellant before this Commission, therefore, the complainant cannot make this as an oral submission at this stage of final arguments not having pleaded so. He also submitted that his institution strictly follows the procedure for the sale of blood as laid down in the Drugs and Cosmetics Act, 1940 and the Rules framed thereunder.

Analysis of evidence:

17. Dr. P. Chellammal, Gynaecologist who performed the operation at Gokulam Hospital in her counter affidavit had stated that it is not factually correct that the patient was administered with two units of blood during post-operative period, that too, without the consent of the patient. It is also false to say that the blood was obtained by the 1st opposite party from the 2nd opposite party. The doctor has further stated that none of the relatives, including the complainant could donate blood and they themselves have

secured the blood from the 2nd opposite party which is a Government recognized approved blood bank and allegation is that the blood was secured from the 2nd opposite party by the 1st opposite party is false. Further it is stated that the 2nd opposite party is a recognized and Government approved blood bank and since it was certified that the blood supplied was free from any infection of communicable or transmittable disease the blood was not tested before transfusion. It is true that the blood banks are duty bound to supply blood which are free from any infections or communicable viruses.

18. As against this affidavit of the Gynaecologist who performed the surgery on the complainant's wife, the complainant has given his affidavit. The relevant extract is given below:

The complainant's wife was transfused two units of blood in the surgery. The blood was obtained by the first opposite party from the 2nd opposite party's laboratory. At the relevant time Thiru M Somasundaram was the Assistant in the 2nd opposite party's laboratory and he had delivered the blood to the first opposite party.

19. In the proof affidavit, Dr. P. Chellammal has stated that the 2nd opposite party is a renowned blood bank in Salem. It is a Government recognized blood bank. The 2nd opposite party has got a laboratory also and since the blood was certified that it was free from infection of any communicable or contagious diseases, there was no necessity to counter test the blood, nor was there any reason to suspect the correctness of the certificate. Hence, the 1st opposite party did not test the blood and she respectfully submits that it was not an act of negligence on her part.

Further it is pertinent to mention a vital fact that during the year 1990's HIV cases were not reported in Salem or for that matter in Tamil Nadu itself and therefore there was no occasion for the first opposite party to have any suspicion of infection of blood by HIV and in this case, the 3rd opposite party is a well established Government approved blood bank and since the blood was certified to be free from any infections, it was administrated without any further second test. Therefore, there was no negligence on the part of the first opposite party in administering blood.

It is more pertinent to mention another vital fact that if blood was taken from a person who was infected with HIV/AIDS virus immediately after infusion, the infection will not be able to be detected in testing by any method and the period during which such

detection is not possible is popularly called as 'window period'. Medical Science has established that due to various reasons HIV some times will take even 4-10 years time to get fully grown up in the human bodies. Therefore, any donor or blood bank cannot detect the presence of any HIV virus during this period due to several scientific reasons.

Findings:

20. In the complaint before the State Commission, it is submitted as follows:

21. One of the modes of transmission of HIV/AIDS is through the transfusion of blood having the virus. The sole reason for the complainant's wife developing HIV/AIDS was the transfusion of the blood contaminated with the HIV virus done by the opposite parties after the operation in December 1990. The complainant's wife and the complainant have led clean lives and there was absolutely no other reason for her getting HIV infection which led to her death. The HIV infection development into full blown AIDS later. It is well known fact that persons who are infected with HIV develop complications subsequently. The virus remains dormant in the body and strikes the body's immune system later. The period between the entry of the virus and onset of the disease could be several years depending on several factors.

22. The second blood test was done in June 1994 which revealed that the patient was suffering from HIV. Hence, the complaint filed on 30.4.1996 is not time-barred. Blood transfusion is one of the methods through which a person can be infected with HIV.

23. No affidavit from the respondent No. 2 (laboratory) regarding non-supply of blood has been produced. The complainant had pointed out that the relevant document quoted below indicates that blood was obtained by the first opposite party from the second opposite party.

---------- Patient's name: Mrs Lalitha Dated:28.12.1990 W/o Age 48 years Chinnaiyam

Address : SP No. 14448 Blood Group : O

Rh. Factor : Positive

Sd/-

Ref. by Queen Mary's Clinical Dr. Sri Gokulam Laboratory & Blood Bank Hospital 19-c Sarada College Road Salem - 636 007 Phone: 62626,

65282

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24. R. Lalitha, as seen from medical records was transfused two units of blood in December 1990. She acquired HIV through blood transfusion. In persons who acquire HIV through blood transfusions the disease manifests from two years to ten years of the transfusion. In Lalitha's case HIV manifested itself in mid-1994. Although HIV manifests two years or later, the antibodies to HIV can be detected in the blood from a few weeks of exposure to the virus. Any blood test done thereafter would have shown the presence of HIV.

25. Dr. Suniti Solomon who holds a Master's Degree in Medicines and the Director of Y R Gaitonde Medical Educational and Research Foundation Centre for AIDS Research and Education in her supporting affidavit has stated as follows:

R. Lalitha, as seen from medical records was transfused two units of blood in December 1990. She acquired HIV through blood transfusion. In persons who acquire HIV through blood transfusion the disease manifests from two years of the transfusion. In Lalitha's case HIV manifested itself in mid-1994. Although HIV manifests two years or later, the antibodies to HIV can be detected in the blood from 3-12 weeks to exposure to the virus. Any blood test done thereafter would have shown the presence of HIV.

This statement of Dr. Suniti Solomon has gone unrebutted.

26. The undisputed facts are that Smt. R. Lalitha had uterus problem and she was operated by Dr. P. Chellammal at Sri Gokulam Hospital on 29.12.1990. She was administered two units of blood. In the clinical notes of the hospital dated 29.12.1990 'reserve one bottle of blood' is mentioned. This is supplemented by nurse's report of the same date 'Queen Mary reserved one bottle of blood'. Consent of the patient is required for transfusion of blood. In this case, it is clear from the records that the complainant has given his consent only for hysterectomy operation to be performed under general anesthesia and not for transfusion of blood. Surgery involves risk and blood transfusion involves additional risk.

27. The Advocate for the R1 has brought to our notice the judgment rendered by this Commission I (1999) CPJ 13 (NC) : 1986-99 Consumer 3628 (NS) The Calcutta Medical Research Institute v. Bimalesh Chatterjee and Ors.:

Further the complainant has filed documents which are completely lacking in the essential technical details. We also find that the said patient ultimately died on 23.7.1997 which means he survived for four years after the treatment complained of. No evidence has been brought on record to link the blood transfusion with any of the resultant complications in the case. Nor has any evidence been led which would go to show the Hospital/appellant or any of its doctors had been negligent. In the absence of such evidence it cannot be held that the appellant or its doctors were guilty of any negligence or deficiency in service. The onus of proving negligence and resultant deficiency in service was clearly on the complainant which onus had not been discharged. In that view of the matter, the impugned order qua this appellant cannot be sustained and is hereby set aside. The result is that the appeal is accepted to the extent of the finding and the relief granted in the impugned order against the appellant and the impugned order to that extent is set aside. Rest of the order which is against the Insurance Company is upheld.

28. Though this case relates to blood transfusion, it does not pertain to HIV infection. In this case the allegation is of negligence of deficiency in service by transfusing wrong group of blood to the complainant/petitioner. In the aforesaid case National Commission has also stated as under:

We have heard at length arguments on both sides with regard to the amount of compensation of Rs. 2.00 lakh to be paid by the Calcutta Medical Institute, the appellant in the present case. The amount appears to have been awarded for negligence and deficiency in service in transfusing blood of wrong group to the complainant - respondent No. 1 before us. We find that reliance has been placed by the State Commission on a certificate issued by Dr. Sukumar Mukherjea who is neither the haemotologist nor a pathologist. His opinion lacks in all requisite technical details and is absolutely vague. He does not mention the blood group of either the donee or the donor. This doctor who is only an MB (Calcutta) and ex-Senior House Surgeon, Calcutta Medical College Hospital, has no specialist qualification. He has talked of the blood picture without mentioning any detail thereof nor does he talk of having had a look at any blood picture. A patient is considered fit for kidney transplantation only when he has reached a critical stage and

that stage is confirmed by the certificate issued by Woodlands Nursing Home which apart from giving estimate of the cost of the treatment and surgery also states the following:

This is to certify that Mr. Bimalesh Chatterjee, 33 years, 132-A Charu Chandra, Place East, Calcutta - 33 is suffering from End Stage Renal Disease and is undergoing Maintenance Haemodialysis in this centre. He has been advised to undergo a Renal Transplantation as a definitive form of treatment. This form of treatment is of a rather prolonged nature, and entails considerable expenses. An approximate estimate of the anticipated expenditure is given herewith....

(Emphasis supplied)

Thus it is clear from this certificate that the patient was already suffering from End Stage Renal Disease and was undergoing Maintenance Haemodialysis which means he was already critical even in June 1993.

29. The above extracts indicate that patient was already suffering from End Stage renal disease at the time of admission for surgery for which blood transfusion took place. Secondly, whether transfused blood belonged to wrong grouping was based on a certificate by Dr. Sukumar Mukherjea who is neither a haemotologist nor a pathologist. His opinion lacks in technical details and is absolutely vague. He does not mention the blood group of either the donee or the donor. Hence the above judgment has no relevance in the case under consideration.

Learned Counsel for the appellant brought to our notice the folloiving judgment:

30. In Malette v. Shulman 72 OR (2d) 417 in Ontario Court of Appeal - Robins, Catzman and Carthy JJ. A the Court has ordered;

ROBINS J.A : The question to be decided in this appeal is whether a doctor is liable in law for administering blood transfusions to an unconscious patient in a potentially life-threatening situation when the patient is carrying a card stating that she is a Jehovah's witness and, as a matter of religious belief, rejects blood transfusions under any circumstances.

In the early afternoon of June 30, 1979, Mrs. Georgette Malette, then age 57, was rushed, unconscious, by ambulance to the Kirkland District Hospital in Kirkland Lake, Ontaria.

She had been in an accident. The car in which she was a passenger, driven by her husband, had collided head on with a truck. Her husband had been killed. She suffered serious injuries.

At about this time, a nurse discovered a card in Mrs. Malette's purse which identified her as a Jehovah's witness and in which she requested, on the basis of her religious convictions, that she be given no blood transfusions under any circumstances. The card, which was not dated or witnessed, was printed in French and signed by Mrs. Malette. Translated into English, it read:

No Blood Transfusion:

As one of Jehovah's witnesses with firm religious conviction, request that no blood or blood products be administered to me under any circumstances. I fully realize the implications of this position, but I have resolutely decided to obey the Bible command : "keep abstaining.... From blood." (Acts 15:28, 29). However, I have no religious objection to use the non-blood alternatives, such as Dextran, Haemacee, PVP, Ringer's Lactate or saline solution.

As when the condition deteriorated and would have been revertible blood transfusion was given. It is held in this case:

The doctrine of informed consent has developed in the law as the primary means of protecting a patient's right to control his or her medical treatment. Under the doctrine, no medical procedure may be undertaken without the patient's consent obtained after the patient has been provided with sufficient information to evaluate the risks and benefits of the proposed treatment and other available options. The doctrine presupposes the patient's capacity to make a subjective treatment decision based on her understanding of the necessary medical facts provided by the doctor and on her assessment of her own personal circumstances. A doctor who performs a medical procedure without having first furnished the patient with the information needed to obtain an informed consent will have infringed the patient's right to control the course of her medical care, and will be liable in battery even though the procedure was performed with a high degree of skill and actually benefited the patient.

I am of the view that the card had the effect of validly restricting the treatment that could be provided to Mrs. Malette and constituted the doctor's administration of the transfusions a battery,

Finally, the appellant appeals the quantum of damages awarded by the trial Judge. In his submission, given the findings as to the competence of the treatment, the favourable results, the doctor's overall exemplary conduct and his good faith in the matter, the battery toas technical and the general damages should be no more than nominal While the submission is not tuithout force, damages of$ 20,000 cannot be said to be beyond the range of damages appropriate to a tortuous interference of this nature. The trial Judge found that Mrs. Malette suffered mentally and emotionally by reason of the battery.

31. There is a strong force in the argument that the consent should have been taken or there should have been explained to the complainant of the risk of blood transfusion by the attending surgeon.

32. Whether the blood was obtained from R 2? The nurse's clinical note clearly indicates that one bottle of blood was reserved at Queen Mary's Clinical Laboratory. The Exhibit A18 which clearly mentions name of the patient, the IP No., referred by Sri Gokulam Hospital, date and the printed name of the clinic and the address and telephone number. It is difficult to disbelieve this document. Further Shri M Chinnaiyan in his proof affidavit has stated that the complainant's wife was transfused two units of blood after the surgery. The blood was obtained by the first opposite party from the 2nd opposite party's laboratory. At the relevant time Thiru M. Somasundaram was the Assistant in the 2nd opposite party's laboratory and he had delivered the blood to the first opposite party. This has not been controverted by any affidavit of R2.

33. In a counter affidavit filed by Dr. P Chellammal has stated that:

Further it is pertinent to mention a vital fact that during the year 1990's HIV cases were not reported in Salem or for that matter in Tamil Nadu itself and therefore there was no occasion for the first opposite party to have any suspicion of infection of blood b HIV and in this case, the 3rd opposite party is a well established Government approved blood bank and since the blood was certified to be free from any infections, it was administered without any further second test. Therefore, there was no negligence on the part of the first opposite party in administering blood.

34. This statement is not supported by any document and literature. The laboratory was duty-bound as per the Drugs and Cosmeties Rules duly amended on 11.7.1989. Rule 66(A) which clearly stipulates a mandatory condition of conducting HIV antibody test before certifying the purity of blood. This was not complied with by the blood bank and clinical laboratory. Dr. Chellammal merely stated that she relied on the clinical report, blood bank who conducted the test but she did not insist for the blood test certificate. There is no mention about the clinical record maintained by the doctor that the blood was found to be free from infection. This is a clear-cut case of negligence on the part of R1 and R 2.

35. The next issue is to be decided whether, if the blood was transfused in December 1990, whether it can result in full blown HIV AID'S after 3Vi years. In the State Commission's order, dates have been wrongly mentioned that operation was performed in December, 1992 and after VA years of operation the patient was found to be suffering from AIDS. Actually there was a gap of 3Vi years. The medical literature produced by the learned Counsel for the appellant is very clearly mentioned in 'HIV (Pathogenesis and Natural History) by Howard Libman, MD and Harvey J Makadon, MD which reads as under:

Progression to symptomatic HIV Disease-

When the high viral levels associated ivith acute HIV syndrome are suppressed by the initial immunologic response, an infected person generally moves into an asymptomatic period that may range from several months to more than 10 years. Although symptoms are not present during this period of clinical latency, viral replication is ongoing, leading to a loss of approximately 10% of CD 4 cells per year in most individuals.

36. Apart from the duty of the clinical laboratory and the blood bank to ensure that the blood is free from infection and it is the duty of attending physician to ensure that the blood is free from infection. The decision to transfuse blood or blood products must be based on a careful assessment which indicates that they are necessary for saving life or for preventing major morbidity. Responsibility for the decision to transfuse must rest ultimately with the attending physician, although this will often be made in consultation when a specialist transfusion advice is available.

37. Considering the age and profession of the complainant and the report that they have been leading a clean life, it is clear from the records that the blood transfused resulted in contracting HIV infection which ultimately after gestation period became full blown AIDS and the patient succumbed to her terminal illness.

Now the issue to be decided is the quantum of compensation to be awarded:

38. Complainant has stated that his wife was 51 years old at the time of her death and her last basic pay drawn was Rs. 1,850 per month with six years service left. She had incurred more than Rs. 1.5 lakh for her medical treatment, travel cost to and fro Salem and Chennai. She would have drawn Rs. 3.00 lakh salary for six years. Further the agony suffered by her and the family is untold and a conservative amount of Rs. 2.00 lakh is claimed as damages for mental agony and anguish. Hence the complainant is entitled for Rs. 6.5 lakh. Complainant has also stated that she had two unmarried daughters and a son who is unemployed. It is quite likely that daughters may not be able to get married due to the stigma attached by society to the infection.

39. Considering the trauma caused to the family and untimely death of the wife of the complainant due to AIDS we award a consolidated sum of Rs. 4.00 lakh as compensation with interest @ 6% p.a. from the date of filing the complaint which is to be paid jointly and severally by the respondents. The respondents are also directed to pay Rs. 10,000 as cost.

40. Accordingly, the impugned order of the State Commission is set aside, the complaint is allowed and the appeal is disposed of with the above directions.