NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION
NEW DELHI

ORIGINAL PETITION NO. 269 OF 2001

Dr. Kamal Kishore
S/o Shri Putun Sao
Kumhar Toli, Hazaribag
Jharkhand. … Complainant

Versus

1. Escorts Heart Institute
and Research Center
Okhla Road
New Delhi-110025.

2. Dr. Naresh Trehan
Cardiothorasic Surgeon/Consultant
Escorts Heart Institute &
Research Center
Okhla Road
New Delhi-110025. … Opposite Party(s)

BEFORE :

HON'BLE MR. JUSTICE K.S. GUPTA,
PRESIDING MEMBER
HON'BLE MRS. RAJYALAKSHMI RAO, MEMBER

For the Complainant(s) : In person

For the Opp. Part(ies) : Shri Sanjeev Puri, Sr. Advocate
with Sajand Sultan, Adv. for

OP No. 1.
Ms. Indu Malhotra, Sr. Advocate
with Shri Madhukar Pandey,
Ms.Malika Choudhary, Advocates
for OP No. 2

PRONOUNCED ON:12 February 2010

ORDER

PER MRS. RAJYALAKSHMI RAO, MEMBER

Complainant himself is a doctor, practicing as a pathologist, filed a complaint for medical negligence and deficiency in service while giving treatment to his mother, Smt. Kaushalya Devi against opposite party No.1, Escorts Heart Institute, and opposite party No.2, Dr. Naresh Trehan, Cardio Thoracic Surgeon. He took his mother to Dr. Ashok Seth who was a Cardiac Specialist with opposite party No.1 on 14-12-1999. Dr. Seth suggested coronary angiography and 2-D Color Doppler was suggested to be done in the OPD to ascertain the exact cardiac condition. These tests were done on 15-12-1999 and Dr. Seth told the complainant that his mother had Triple Vessel Disease and suggested him to get Myocardial Vascularisation. It is stated that the complainant requested Dr. Seth that the entire treatment should be done by Dr. Naresh Trehan-opposite party No. 2 who is a well known Cardio Thorasic Surgeon. Smt. Kaushalya Devi was admitted to opposite party No.1-hospital since on 21-12-1999. She was to be operated and was kept fasting till 3.00 P.M. but then they suddenly postponed it to 22-12-1999. On 22.12.1999 also, her operation was undertaken last. They were inconsiderate to her age being 70 years old.

The complainant tried to meet opposite party No.2 on both the days but that request was denied on some practice or other.

On 22-12-1999, she was taken to the operation theatre at around 2.00 P.M. for Coronary Artery Bypass Surgery (CABG) and at 6 O' clock she was shifted to ICU. He was informed that his mother being a high-risk case, CABG was not done instead Beating Heart Surgery was performed and two vessels-LAD-OM2 were bypassed by opposite party No.2. She was in the ICU thereafter.

It is stated that on the very night of 22-12-1999, around 12:30 A.M. he was called and was appraised that his mother had cardiac arrest following Ventricular Fibrillation. She was taken into the operation theatre at around 4.00 A.M. and Dr. Vijay Kohli operated on her. Complainant was informed that two vessels were already/operated by opposite party No.2 and that Dr. Kohli operated/bypassed the remaining one vessel because it was not bypassed by opposite party No.2 in the first operation. The complainant was never told the reasons as to why one vessel was not operated in the first operation. He stated that her condition started deteriorating day by day and she could never recover from the state of unconsciousness till her last breath and that ultimately she died on 31-12-1999 at about 3.00 A.M.

The complainant contended that opposite party No.2 did not graft vessels properly and haemostasis had not been achieved. The blood was oozing from the site of graft which ultimately became the cause of death of his mother. It is because of the excessive bleeding, she had to undergo the second operation and that it is not because of any the cardiac arrest following ventricular fibrillation as suggested by opposite parties. Dr. Vijay Kohli told the complainant that only after doing CT Scan of brain, the exact

degree of brain damage following cardiac arrest can be assessed. During the entire period from 23-12-1999 till the death of the patient i.e. 31-12-199 opposite parties did not perform the CT Scan of brain, Opposite Parties have done 2-D Color Doppler test twice – one on 15th and again on 16th which is surprising because the report dated 15-12-1999 showed defect in the heart whereas report dated 16-12-1999 was showing her almost in normal condition due to which authenticity of this report itself is in doubt.

In death summary given by Dr. Arti Verma on behalf of the opposite party No.1 dated 12-1-2000, it was mentioned that Smt. Kaushalya Devi had bilateral cataract as per pre-operative evaluation done by the eye specialist. The complainant contended that his mother does not have bilateral cataract because she was operated for cataract and IOL was implanted in both of her eyes by Dr. B.K. Nair in the year 1993 itself and opposite parties have wrongly noted in the post mortem report in a casual manner.

Open Heart Surgery is considered to be a very safe surgery and is known to have less mortality rate and yet his mother succumbed to death because of the deficient services of the opposite parties. Alleging medical negligence against the opposite parties the complainant claimed the following:

(i) Rs.2,87,710/- for the cost of treatment (this amount was paid by the employer of the complaint's brother i.e. by NABARD and would be deducted from his salary).

(ii) Rs.13,00,000/- for damages for her sudden death, for deprivation of love and affection of her mother.

(iii) Rs.20,00,000/- for mental agony and sufferings.

REPLY OF OPPOSITE PARTY

Opposite Parties in their reply stated that the complaint is false and frivolous and speculative in nature. Their submissions are as under:-

She was an old case of diabetes mellitus and hypertension. She had sustained inferior wall myocardial infarction (IWMI) on 11th Sept., 1999 and had developed left Ventricular Failure (LVF). During investigation, she was found to have grade II (ulcerated) atheroma in the aorta and minor plaque in left internal carotid artery. She was pre operatively assessed and was taken for surgery as a high-risk case. The high-risk consent form was signed by the patient and the Complainant.

In view of various risk factors, grade II atheroma in the aorta and plaque in the internal carotid artery, it was decided to do OFF PUMP CORONARY BYPASS GRAFTING (OPCAB) to reduce the side effects of ON PUMP Surgery and to minimize the neurocognitive deficits.

On 22.12.1999 the patient was operated upon and surgery was successful and cardiac massage was given. IABP was inserted and DC shock I 50 J, 200J was given. The Complainant was kept apprised of the condition of the patient throughout. But on 31.12.99 at 3.00 AM she had cardiac arrest and could not be revived in spite of all resuscitative measures. When the patient did not respond to any of the resuscitative measures, the patient was shifted to the Operation Theatre at 00.10 AM for re-exploration. Patient was put on cardio pulmonary bypass. As a desperate measure RCA, though it was very small, was also grafted. When the patient was haemodynamically stable and came off bypass, she was shifted to the ICU on intropes at 4.00 AM which was informed to the

Complainant who came & saw the patient. The reason for not grafting the RCA was communicated to the Complainant at the time of the surgery. However, as the patient was in a critical condition and as a desperate attempt to save her, the RCA was also grafted.

The patient was shifted to Intensive Care Unit (ICU). In the post-operative period, she developed ventricular arrythmias for which all resuscitative measures were instituted. It is stated that the highest degree of skill and care was used by Opposite Party No.2 who is a world renowned cardio thoracic surgeon, in the treatment of the patient. It is reiterated that the RCA was very small and had diffuse disease and was therefore not suitable for grafting. It is further submitted that such a decision can only be taken during the course of surgery, which the patient is on the operation table. Therefore, on account of the condition of the patient the RCA was not bypassed. The same is reflected in the operation notes.

It is further submitted that Opposite Party No.2 is always available to meet the patients and their relatives and it is incorrect to say that the Complainant was asked to meet other doctors. It is submitted that the Opposite Party No.2 went out of station on 24/2/99 to attend a conference. His team doctors were available and they took care of the patient, in accordance with the best medical practices. It is denied that the patient was re-explored due to oozing of blood from the site of graft. It is submitted that the Complainant has taken one cause out of list of causes of hospital mortality & major morbidity from the article of journal of Cardio Thoracic Surgery (Annexure G of the complaint) to justify his completely malafide claim. It is submitted that it is amply clear from the evidence on record that there was no excessive oozing of blood from the site of graft and the said allegation has been completely fabricated by the Complainant.

The critical care flow sheet of 22/12/99 documents drainage from two chest tubes are extracted as under:-

	I	II		
7.00 PM	Nil	20	ml	Total 70 ml in 5 hrs.
8.30.PM	Nil	10	ml	which is normal in the
9.00 PM	10	10	ml	postoperative period.
10.00 PM	Nil	Nil		Annexure 'R-4 Critical
11.00 PM	Nil	20	ml	care flow sheet.

The above extract evidences the fact that there was no excessive blood oozing from the site of the graft and the said allegation is indicative of the malafide motives of the Complainant.

It is common medical practice to advice that 2D colour doppler tests be conducted. The first test was done on 15/12/99 at the time of admission and the second was conducted later on after admission on 16/ 12/99. It is submitted that it is common for the results of the echo tests to vary since the results are dependent upon the level of ischemia during the examination time. Therefore, depending on the variables like anxiety, physical or emotional stress and changes of temperature, all or one of these variables can increase heart rate which indirectly induces increased myocardial, demand for oxygen (indirectly blood) leading to wall motion abnormally. However, during other times when heart is beating at a lower rate the blood supply and oxygen demand of the muscle may not have any mismatch there by showing adequate contractility.

OP CAB was done in this case, as she was a high-risk case with grade II atheroma in the aorta. Patient and the Complainant were informed

of this risk and they signed the high risk consent. The patient developed ventricular fibrillation in post OP period for which all resuscitative measures were instituted. Patient was re-explored to find the viability of grafts, which were found patent. RCA, through a very small artery with diffused disease, was also bypassed as a desperate measure. In spite of the best efforts of all the doctors in the Opposite Party Institute, the patient could not be saved on account of the above mentioned risk factors and her extremely unstable condition due to suffering from acute heart disease. Therefore, the claim for damages in the present case is wholly mala fide, unjustified and baseless.

VERSION OF THE COMPLAINANT

Dr. Kamal Kishore filed affidavit by way of evidence and written submissions. He was also cross-examined on 8th & 9th July, 2003. He argued that on the medical negligence and deficiency in service on part of the Opposite Parties on the following grounds :-

1. Opposite Party No. 2-Dr. Naresh Trehan has done Beating Heart Surgery on 22.12.1999 which is a very safe surgery instead of CABG (Coronary Artery Bypass Grafting) which is a risky operation because his mother had ulcerated atheroma grade II in descending thorasic aorta and arch & minor plaque in left internal carotid artery and also because his mother's case is a high risk case. On the same night, the Complainant was called at 12.30 A.M. and Dr. on duty informed that his mother had cardiac arrest following VF. She was shifted to the OT and the same risky operation i.e. Cardio-Pulmonary Bypass which was initially avoided was done. If it were to be done then it should have been

done by same most experienced and competent surgeon –Dr. Naresh Trehan and it could not have been done by his Associate. It is contended that Dr. Trehan did not come on that night but it was Dr. Vijay Kohli who had performed the surgery. Complainant had engaged services of Dr. Trehan for his competence and experience. Hence, it is deficiency in service on the part of Opposite Party No. 2 and is liable to pay damages since his mother died due to default of Opposite Party No. 2 not being present in the said surgery.

2. First operation was done by Dr. Naresh Trehan, Dr. Rajneesh Malhotra and Dr. O.P. Sharma and the Anesthetists were KKS/ SP whereas second operation was done by Dr. Vijay Kohli/ Dr. Rajneesh Malhotra and Dr. O.P. Sharma and Anesthetists were RJ/AD/AC. The same surgical team should have re-operated his mother.

3. On 22.12.1999 at 11.30 P.M., the patient had VT/VF(VT-Ventricular Tachycardia, VF –Ventricular fibrillation). Then DC cardioversion, cardiac massage was done. Trans-femoral IABP (Intra Aortic Balloon Pump) was instituted. She did not respond and then she was shifted to O.T. for the second operation i.e. Cardio-Pulmonary Resuscitation and CPB (Cardio-Pulmonary Bypass. This was necessitated because of oozing of blood from the site of graft and that condition is called ‘Cardiac Tamponade’. The Complainant referred to the Extract of Literature Ventricular Fibrillation by Michael E Zevitz, M.D., Consulting Faculty, Clinical Asstt. Professor, Chicago Medical School and also from Textbook

of Medicine by Davidson, in which is stated that – *as per treatment algorithm if the patient is not responding to DC cardioversion, CPR, IABP, then correct the following if necessary and/ or possible in which there two conditions: Hyperkalemia, Tamponade.*
Due to wrong administration of injection of Kcl (Potassium Chloride) even with normal serum K level there was Hyperkalemia and Tamponade is due to oozing of blood from the site of graft. In her case, the 2nd operation which is Re-exploration, the Opposite Party corrected the Tamponade and then the patient responded. This clearly shows that the Ist surgery was negligent and only when the 2nd operation was, the patient responded.

4. Opposite Parties had taken 40 minutes for shifting the patient to O.T. as per the Progress Notes of Nurses dated 22.12.1999. The patient had VT at 11.30 P.M. but she was taken to O.T. 12.10 P.M. This delay of 40 minutes is significant because as per the e-mail of Dr. James D Fonger, doing CABG after five minutes does not help. The advise and opinion given to the Complainant by Dr. Fonger is a neutral and un-biased whereas the opinion given in response to e-mail of Dr. Trehan by Dr. Fonger is a forced, manufactures & biased to the need of Dr. Trehan.

5. It is submitted that VT which occurred after Beating Heart Surgery on 22.12.1999, which progressed further to VF was due to wrong treatment given by the opposite parties.

6. The patient was given injection Calcium 1 gm which should not have been given because Calcium is contraindicated in the treatment of arrhythmia as it itself causes Cardiac Arrhythmia. He referred to the Text Book of Internal Medicine by Harrison & also

extract of literature of management of VF/VT.

7. In spite of Normal serum K level (Normal range-3.5 to 5.5 meq/L), at 10.00P.M. serum K+=4.8, at 11.00 P.M. serum K+=3.9 meq/L, Inj. Kcl 5 meq was given. At 11.30 P.M. serum K+ level was 12.19 – a dangerously High level, but even then, Inj. Kcl 5 meq was on flow and continued.

Iatrogenic Hyperkalemia may result from overzealous parenteral K+ replacement, which was done in this case. Even the Text Book of Internal Medicine by Harrison clearly states that the most serious effect of Hyperkalemia is Cardiac Toxicity…….. which would result into the VF or Asystole.

8. Due to Iatrogenic treatment leading to cardiac arrest VF was developed and the blood supply to vital organs i.e. brain, kidney, liver got jeopardized and got damaged. This is reflected in her body function that the patient become unconscious because when the brain is deprived of blood i.e. Ischaemia, due to low cardiac output and cardiac arrest, there is lack of supply of oxygen & glucose to brain culminating in CVA (Carebro-vascular accident), damage brain, function of Liver & Kidney get damage i.e. S. Billirubin, SGOT, SGPT, B. Urea, S. Creatinine etc. are all elevated. This was confirmed by the test reports.

9. Gastroenterologist was also consulted on 27.12.1999 after five days and he opined that LFT derangement is most likely secondary to Hepatic Ischaemia following Haemodynamic instability.

10. Neurologist was consulted on 24.12.1999 i.e. after two days and

in his report he mentioned that there is Hypoxic Brain damage i.e. the damage is due to lack of supply of oxygen to brain when there is cardiac arrest following VF which itself is a cause of cerebral ischaemia.

It is argued that Gastroenterologist and Neurologist should have been consulted at earliest within hours and not as late as what the opposite parties have done. This is a careless and negligent attitude on the part of opposite parties.

11. Patient's blood sugar on 22.10.99 at 10.00 P.M. was only 3.25 mg/dl. which is extremely low and remained un-noticed and unattended for one hour and thirty minutes till 11.30 P.M. when Inj. 25% Dextrose 50 ml i.v. was given. This dose of inj. is a gross negligence because Inj. 25% Dextrose 50 ml will deliver 12.5 gms of glucose to the blood and 1 unit of insulin neutralizes 2.5 gms of glucose. This much large dose of insulin s/c will only and only aggravate the Hypoglycaemic shock due to already extremely low blood sugar of 3.25 mg/dl resulting in worst brain damage.

12. On 25.12.1999 fasting blood sugar was only 12 mg/dl (normal range = 70 – 100 mg/dl). Then it started going downwards i.e. than 12 mg/dl for 4 hrs i.e. at 5.00 A.M. when the blood sample was taken, then blood sugar level was 12 mg/dl and it kept on falling (because the brain and other body organs continuously uses glucose as a source of energy) till 9.00 A.M. and then it was only when Dr. Mitesh Sharma at 10.00 A.M. undertook his treatment the blood sugar level came to 148 mg/dl.

On 29.12.1999 the blood sugar- fasting was 28 mg/dl and it further

started going downwards i.e. less than 28 mg/dl for 5 hrs i.e. at 5.00 A.M. when the blood sample was taken, then blood sugar level was 28 mg/dl and it kept on falling till 10.00 A.M. and when on the order for 50% dextrose 100 ml was given, followed by 5% Dextrose 50 ml at 12.00 hrs it again went up.

On 30.12.1999 at 6.00 P.M. the Random blood sugar was only 6 mg/dl. This shows that blood sugar had fallen on 4 occasions much-much below the normal level and remained at that Low level for pretty long time. The patient went to Hypoglycaemic Shock which further aggravated the already damaged brain due to Hypoxia following cardiac arrest on 22.12.1999.

13. As per the Progress Notes, on 24.12.1999 at 8.00 P.M. the patient was not awake not moving limbs, only eye movements seen by Dr. A. Goel. Rt pupil dilated Lt pupil slightly reacting to light and on 27.12.1999 at 2.00 P.M., the patient was unconscious not responding to painfully stimuli, Rt pupil dilated, Lt eye pupil small reacting. It is contended that Medullary Phase was reached and particularly if it persists for a long time and is not corrected immediately and spontaneously then the recovery hits further delay which is what has happened to the patient. It is, further, submitted that large dose of insulin, which produces intense Hypoglycaemia, even of relatively short duration (30 to 60 minutes), is more dangerous than a series of less severe hypoglycaemic episodes from smaller doses of insulin.

14. In her case, the patient remained on low blood sugar level for prolonged time and suddenly intense insulin was given which worsened her system.

15. Opposite parties did not have functional CT scan machine and were utilizing this facility from Holy Family Hospital.

16. Opposite Parties are Super-Specialty Hospital which is a Tertiary Care Center who is charging exorbitantly and that Center cannot claim to be a Super-Specialty Hospital when they do not have CT Scan facility. In her case, CT Scan was not done because she was not in a position to be sent to Holy Family Hospital. Opposite Parties should have made some arrangements for CT Scan at their Hospital so that brain damage could have been assessed earlier and early appropriate intervention either medical or surgical could have saved her life.

17. Opposite Parties had wrongly done the Parsonate scoring which is used for assessment of risk of the patient. The total points (which were encircled) come 11 as per their own record but they had encircled her into the category of High Risk instead of Poor Risk which is once again deficiency in service and negligence. The patient was having fever due to infection since 24.12.1999 but her culture and sensitivity test was done on 26.12.1999 and the report confirmed the infection with a bacteria namely Staph Aureus which is sensitive to Augmentin but resistant to Cloxacillin, Gentamycin, Cefazilin, Ofloxacin.

18. Opposite Party did not give her augmentin instead they gave inj. Genta (Gentamycin), Inj. Omnatax (Cefotaxim), Inj, Cifran (Ciprofloxacin) which are not correct drugs in this case as the bacteria is either resistant to them or bacteria is not responding to the given antibiotics as the temperature of the patient continued.

It was due to negligent act of the opposite parties. The suitable antibiotics were not given which is negligence and deficiency in service on the part of Opposite Parties.

19. The 2-D Colour Doppler was done twice – first on 15.12.1999 and second on 16.12.1999. The Reports of both days vary considerably. It is submitted by the Learned Counsel that variation in the reports of 2-D colour Doppler test proves only negligence on part of the opposite parties.

20. Normally, there is a waiting list of 12 cases everyday for surgery and on 21.12.1999 she was kept pre-operatively prepared and kept fasting on 21.12.1999 to be taken for surgery. But at 3.00 P.M. she was told that she will be operated next day i.e. on 22.12.1999. In the next day's list also her case was listed at No. 12 whereas it should have No. 1. It is not possible that 11 emergency cases came up on 22.12.1999 and they had denied to do the emergency surgery of his mother as No. 1 which again made her to wait.

21. The Complainant in his affidavit stated that he consulted with Dr. James D. Fonger, M.D. through e-mail, who is working in the Division of Cardio Thorasic Surgery, Lenox Hill Hospital, New York, U.S.A. He further stated that Dr. Fonger clearly stated that – "*if refractory VF does not convert, then you have about five (5) minute4s only to get the patient on to full Cardio Pulmonary Bypass support at the bed side and most hospital settings can't do this quickly enough. Doing C.A.B.G. after this won't help, if she has been down for a significant period of time due to ventricular fibrillation."*

22. Pre-operative evaluation of the Eye Specialist pointing out that she

had B/L Cataract shown in the death summary is wrongly written because she had cataract surgery done with Intra Ocular lens at P.D. Hinduja Hospital, Bombay.

In view of the aforesaid arguments, the Complainant urged that the complaint be allowed.

VERSION OF THE OPPOSITE PARTIES

Learned Counsel, Ms. Indu Malhotra alongwith Mr. Sanjeev Puri argued for the Opposite Parties. It is submitted that –

1) No Open Heart Surgery - The Complainant was under wrong apprehension that there was Open Heart Surgery. It is submitted that the patient underwent CABG Off-Pump first time and CABG with Heart Lung Machine (CPB) on second time and both were conducted through the same incision i.e. through the Sternun.

2) No Breach of Contract by OP No. 2- As regards, the procedure, Complainant had made allegations against OP No. 2 as to Dr. Trehan did not conduct the second procedure and alleged deficiency in service accordingly. OP No. 1 has a team of Cardiac Thorasic Surgeons. Since this was an emergency, re-exploration which was needed to be done at that critical stage moment, Sr. Cardiac Surgeon on duty immediately attended on the patient. This re-exploration was conducted by Dr. Vijay Kohli, Dr. Rajneesh Malhotra and Dr. O.P. Sharma. All these Doctors are highly qualified as MBBS, MS, MCH (Cardio Vascular and Thorasic Surgery). There is no deficiency in service on the part of opposite parties because the best services were provided to the patient.

1. No oozing from the sire of Graft- The Complainant has alleged that

due to medical negligence in the surgery by Opposite Parties, his mother suffered from *'cardiac Tamponade'* which is blood oozing from the site of Graft after the surgery. It is further explained that *'Cardiac Tamponade'* is a condition where there is compression of heart due to abnormal accumulation of fluid within the fibrous covering of the Heart (Pericardium/Chest cavity).

In the present case, the cardiac output of the patient was maintained normally and the Pulmonary Artery Pressure was within normal limits. She maintained normal urine output and Arterial Pressure remained within normal limits, till the patient developed Ventricular Tachycardia.

2. The patient did not suffer from Hyperkalemia due to wrong administration of potassium chloride – The allegations made by the Complainant that his mother suffered from Hyperkalemia is an incorrect statement because this is a condition which is characterized by concentration of Potassium in Plasma above the normal range which is 3.5 – 5.5 meq/l. Her blood sample taken at 11 P.M. on 22.12.1999 showed that the patient was having a level of Potassium-3.9 meq/l which was on the lower side of normal limit which is 3.5 – 5.5 meq/l. A small dose of injection Kcl 5 ml was administered. Thereafter, the patient had Ventricular Arrythmia for which CPR and Cardiac Massage was done and her level of Potassium was enhanced. It is incorrect to allege that the Potassium level was increased due to continuous administration of Potassium. The level which increased to 13.1 meq/l was on account of Cardiac Massage.

3. Opinion of Dr. James D. Fonger not based on the medical records of

the patient - The e-mail by Dr. Fonger actually confirms the line of treatment by the Opposite Parties and he clearly stated that Beating Heart Surgery was the right decision and also expressed his inability to give a formal or informal surgical opinion as he was not provided with the medical records of the treatment provided to the patient. Complainant can not support his allegations based on an e-mail which is also not in his favour.

4. Defibrillation done at 11.30 P.M. on 22.12.1999 – The patient was given DC shock which is a standard method of defibrillation and bringing back the patient when she developed Tachycardia followed by Ventricular Fibrillation. She was first given cardiac massage followed by cardioversion. The allegation made by the Complainant that implantation of Implanatable Cardioverter Defibrillators were not put because the patient suffered a sudden attach of acute Ventricular Arrythmias and hence it required DC shock to be done.

5. Allegation of administration of Calcium and Hyperkalcemia – It is stated that patient never suffered from Hyperkalcemia because only one dose of Calcium was administered to increase her Blood Pressure at the time of Ventricular Tachycardia and at that time , her blood pressure was 70/30.

At 11.30 P.M. on 22.12.1999, she suffered from Ventricular Arrythmia and she had Hypertension and fall in blood pressure. She was immediately treated accordingly to bring it into control so that vital organs of the body would not be affected.

6. Allegations of Ventricular Fibrillation in the Post Operation period - Ventricular fibrillation in the post operation period is a known

complication and the patient was pre-disposed to the Arrythmia because of previous heart attacks as is indicated in the Holter Test Report.

7. Allegation of Hypoglacemia unfounded - The Complainant alleged that the patient had blood sugar level of 3.25 mg/dl on 22.12.1999 at 10. P.M. The Critical Care Flow Sheet showed that the patient had an elevated level of blood sugar post operatively and to manage the same injection Actrapid 5 units was administered continuously. At 11.50 P.M. her blood sugar level of 300 mg/dl was diagnosed and only 20 units and not 200 units of injection Actrapid was given. The patient was showing tendency to become acidosis and hence administration of glucose was necessary as her Ph value was 7.28 and base excess of –12.1. The patient had never had Hypoglacemia as alleged by the Complainant. Her blood sugar level was tested 10 times in a day and recorded in a contemporaneous document and an aberrant singular reading cannot be relied upon by the Complainant.

8. Allegation of not doing CT Scan - On 24.12.1999, Dr. Dwivedi, Neurologist advised CT Scan which could not be done because the patient was on life support system consisting of Ionotrope support along with Intra Aortic Balloon Pump (IABP) to support the Heart and Ventilatory support. An alternative arrangement was made by OP No. 1 Hospital to take her to Holy Family Hospital only when she could be freed from the support system. It is submitted that the CT Scan machine was out of order at that point of time and that cannot be construed as deficiency in service or negligence.

9. Parsonate Scoring – The patient had history of previous Heard

Attach/ IWMI, Left Ventricular Failure. Tripe Vessel Disease, present of Atheroma in Arch of Aorta, Hypertension etc. which increased the score to 15-19 and hence the patient was categorized as High Risk Patient.

The Parsonate scoring which is being relied upon by the Complainant, has became antiquated over a period of time as it has modified and used by adding additional factors for scoring risk involved in it. In the present case, the patient was given a Parsonate Score of 15-19 because of co-morbidities.

10. Allegation of Non-Administration of appropriate Antibiotic – The Microbiology report of test done on 26.12.1999 showed that the patient was infected with Staph Aureus and immediately Dr. Ashok Sharma was consulted and Injection Gentamycin was stopped, and Broad Spectrum Gram Positive antibiotic namely Injection Cifran 200 mg BD was started. The patient was also given Broad Spectrum Gram Positive Antibiotic Injection Omnitex 1 g IV every eight hours. Complainant has wrongly alleged that the patient was not administered appropriate antibiotics.

Learned Counsel has relied upon the case of *Sukumari Sahu Vs. Tata Memorial Hospital, 3(2006) CPJ 293 (NC)* and *INS Malhotra Vs. Dr. A. Kriplani, (2009) 4 (SCC) 705.* In the aforesaid cases, Complainant has not produced any expert evidence to prove his case and did not counter or rebut the statements made by the Opposite Parties and hence the complaint was dismissed.

In the present case, there is no expert evidence provided to counter or rebut what is stated.

FINDINGS

Perused the record, affidavits of-Complainant, OP No. 1, Dr. Naresh Trehan & Dr. Vijay Kohlil and written submissions filed by both the parties.

In our considered view, we do not find any deficiency in service or negligence on the part of Opposite Parties for the reasons given below.

Patient had angina for the first time in 1993, for which she continued medical therapy and was a symptomatic for six years till 1999. On 11th September, 1999, the patient suffered a heart attack and subsequently developed a Left Ventricular Failure on 22nd September, 1999.

She underwent angiography on 15th December, 1999, which revealed a Triple Vessel Disease. She was also found to have a grade II (Ulcerated) atheroma (A fatty deposit in the intima (inner lining of an artery) in the aorta and minor plaque in one artery. Given the condition of the patient, she was classified as a high risk case for surgery on account of her age (70 years) and various ailments referred to above. She was therefore advised CABG, which would be performed on a beating heart (i.e. Off pump) since such a surgery has less side effects of a major heart surgery and also minimized the neuro cognitive complications. The complainant, who himself is a qualified doctor after due deliberations and considering the associated complications decided in favour of the Off Pump CABG (OPCABG).

On 22.12.1999, OP No. 2 performed OPCABG on beating heart of the patient. Two vessels of the patient were bypassed. The third artery was not suitable for grafting since it was very small and had diffused disease, and hence it was not operated upon. It was not grafted in the first instance since the benefit of grafting did not outweigh the risk factors in the surgery. Post surgery, the patient was shifted to ICU.

The same night at 11.30 P.M. the patient developed some complications and she was immediately provided resuscitative measures of cardiac massage and DC shock. When the patient did not respond to the same, she was taken to the operation theatre for re-exploration. As a desperate measure to save the life of the patient, the RCA, despite being very small and diffused, it was grafted. When patient became haemodynamically stable, she was shifted back to ICU and put on inotropic support. The complainant was apprised of all the aforesaid events and was himself aware of the high risk condition of his mother. However, the condition of the patient continued to remain unstable and she died on 31.12.1999.

Admittedly, the patient was a 70 years old woman having hypertension and was a known case of diabetes for the previous 12 years who had already suffered a heart attack in September, 1999. Later, she suffered from left ventricular failure. Her angiography report had revealed that she had a triple vessel disease. She was also found to have a grade II (ulcerated) atheroma in the aorta and minor plaque in one artery. Given the condition of the patient, she was classified as a high risk case for surgery on account of her age (70 years) and various ailments referred to as above. She was therefore advised CABG, to perform on a beating heart (i.e. off pump- OPCABG) since such a surgery reduced the probable side effects of a major heart surgery and also minimized the neuro cognitive complications.

The third artery, i.e. RCA was very small and had a diffused disease. Therefore, it was not grafted by the operating Surgeon and this decision was taken during the operation evaluating the options. Although it was

possible to bypass the RCA, but the benefits of the same were outweighed by the risk involved. It is also pertinent to mention here that RCA was supplying blood to an already damaged portion of the heart i.e. the inferior wall. We do not find deficiency in service or medical negligence in doing the said procedures by the Opposite Parties.

In our view, the patient was not sent for re-exploration on account of blood oozing from the site of the graft as alleged but was sent for re-exploration because she had suffered ventricular tachycardia and fibrillation and had not responded to the resuscitation measures of cardiac massage and DC shock. The grafts of the patient were also found to be patent upon re-exploration and no excessive oozing was found.

Allegations of Hypoglacemia and issues of Hyperkalcemia and non-administration of appropriate antibiotics have been nullified with explanation given by the Opposite Parties. Regarding the contention of not getting CT Scan done and the fact that Super-Speciality hospital did not have CT Scan facility have been dealt with by the Opposite Parties stating that- first the Complainant was not in a position to be moved in that critical condition and the CT Scan machine was out of order at that particular time. Opposite Parties cannot be faulted for non-functioning of CT Scan machine at a particular time as machinery does breakdown and for want of parts etc. it could not be used.

Dr. James D. Fonger in his e-mail dated 2.12.2002 has clearly clarified that he did not have the opportunity to review any medical records and was not rendering a formal or informal opinion of any kind and the practice adopted by the Opposite Parties was best under the given circumstances. He stated that – "I did not have the opportunity to review any

medical records and was not rendering a formal or informed surgical opinion of any kind……. My gesture of friendship to him was without adequate medical information and therefore is not a legitimate professional evaluation or opinion and should not be used as such because of the potential for inaccuracy." In view of the aforesaid e-mail of Dr. Fonger, the negligence on the part of the Opposite Parties is not established.

When Complainant himself is a Doctor -Misleading the Commission ! Being a Doctor himself, the Complainant tried to mislead the Commission with a serious allegation of excessive oozing of blood from the grafted site by showing us a thick drainage tube used for bilary discharge etc. which is used for different kind of surgeries. In the present case, it is a very sensitive surgery done with the latest surgical equipments and such thick tube could never be used close to the heart. Complainant-Doctor tried to prove his expertise by showing a thick drainage tube relating to the present case, is not only wrong but also is a misleading action and we condemn such misrepresentation shown in the Commission. We find, on the basis of record, that there was no excessive oozing of blood from the site of graft and the said allegation has been fabricated by complainant because only 70 ml of blood drainage was observed in a span of 5 hours which is normal. Complainant's allegations are purely based on his imagination because there is not even an iota of evidence to prove this false contention/pleading made by the Complainant.

Agreed that Judges/Members of the Commission may not be medical professionals/Doctors but they can easily discern right from the wrong when misleading statements are made.

Every service provider is accountable to explain wherever there is a

complaint, alleging deficiency in service and negligence against them. Nobody is above law. One bad apple in a basket of good apples should be picked up and removed just like removing cancerous part before it affects the rest of the body. Cases are filed for medical malpractices, non-transparency and also for acts of gross negligence. **Ordinary consumer, who is truly affected by them needs to be assisted to get justice especially when medical record is never given within 72 hours after the request for the same by the concerned hospital/Doctor despite the directions of Medical Council of India to consumer who do not have the means or equal bargaining power or those who lack education and those who are unaware of their consumer rights. Consumer need assistance and can avail his right to be heard and get justice and this right cannot be denied under the Consumer Protection Act. Otherwise the objective of the Act will be frustrated.**

Hundreds of medical cases on medical negligence have been decided based on the facts of each case; evidence led by the parties; circumstances of each case; medical record which often speaks volumes than words; situations where principle of 'Res Ipsa Loquitur' (facts speak for themselves) can be applied and many such judgments have been appreciated and upheld by the Apex Court.

We do understand the deep concern and anguish of a son loosing his mother in the present case. But, we cannot appreciate the conduct of the Complainant who in his over enthusiasm tried to mislead us to believe that there was blood oozing from the graft and that no tube has been kept to remove it. We were subjected to believe this by live demonstration with a big tube.

The Complainant argued that Opposite Party No. 2 did not perform

himself the second surgery although he was expected to. The second surgery was necessitated due to change in condition of the patient suddenly in the night. Dr. Vijay Kohli who is a Specialist conducted the second procedure. It is nobody's case that Dr. Kohli is not qualified to do the same or he is negligent in doing it. No case has been established regarding negligence in second procedure by Dr. Kohli. As for OP NO. 2- Dr. Naresh Trehan, it cannot be expected that he should continue to do surgeries round the clock i.e. 24 hrs. in a day like a robot and this allegation by the complainant is unpalatable to us. This contention of the Complainant that Dr. Vijay Kohli is not competent to do the second procedure and Dr. Trehan should come and conduct the second procedure in midnight is totally unjustified, impractical and unacceptable to us. There is no reason to dis-believe the affidavit of Dr. Vijay Kohli who is a Senior Consultant Cardio Vascular Surgeon wherein he stated that – "I bypassed RCA, which was very small and had diffuse disease, as a desperate measure. The patient was gradually weaned off the cardio pulmnonary bypass with the help of IABP and heavy inotropes and was shifted to ICU at 4.00 A.M. I reiterate that on re-exploration no excessive oozing was found and patient was given the benefit of reexploration as she had developed intractable ventricular arrhythmias." The medical record as relied upon by both the parties also supports the aforesaid affidavit of Dr. Vijay Kohli. We do not find any deficiency in service or medical negligence in both the procedures that were done by Dr. Naresh Trehan and Dr. Vijay Kohli as alleged by the complainant.

It has been observed in the case of Jacob Mathew Vs. State of Punjab (2005) 6 SCC 1 at para 26 that *"so long as it can be found that the*

procedure which was in fact adopted was one which was acceptable to medical science as on that date, the medical practitioner cannot be held negligent merely because he chose to follow one procedure and not another and the result was a failure." It was also observed that "At times, the professional is confronted with making a choice between the devil and the deep sea and he has to chose the lesser evil."

We rely on a recent decision of the Apex Court in *Ms. Ins. Malhotra Vs. Dr. A. Kriplani & Ors. 2009 CTJ 472 (Supreme Court)* (CP). "There is a marked tendency to look for a human act to blame for an untoward event, a tendency which is closely linked with the desire to punish. Things have gone wrong and, therefore, somebody must be found to answer for it. An empirical study would reveal that the background to a mishap is frequently far more complex than may generally be assumed. It can be demonstrated that actual blame for the outcome has to be attributed with great caution. For a medical accident or failure, the responsibility may lie with the medical practitioner, and equally it may not. The inadequacies of the system, the specific circumstances of the case, the nature of human psychology itself and sheer chance may have combined to produce a result in which the doctor's contribution is either relatively or completely blameless. The human body and its working is nothing less than a highly complex machine. Coupled with the complexities of medical science, the scope for misimpressions, misgivings and misplaced allegations against the operator, i.e. the doctor, cannot be ruled out. One may have notions of best or ideal practice which are different from the reality of how medical practice is carried on or how the doctor functions in real life."

In *Kusum Sharma & Others Vs. Batra Hospital & Medical Research Centre & Ors., Civil Appeal No. 1385 of 2001 decided on 10.2.2010*, the Apex Court has held that – "It is our bounden duty and obligation of

the civil society to ensure that the medical professionals are not unnecessary harassed or humiliated so that they can perform their professional duties without fear and apprehension.

The medical practitioners at times also have to be saved from such a class of complainants who use criminal process as a tool for pressurizing the medical professionals/ hospitals particularly private hospitals or clinics for extracting uncalled for compensation. Such malicious proceedings deserve to be discarded against the medical practitioners.

The medical professionals are entitled to get protection so long as they perform their duties with reasonable skill and competence and in the interest of the patients. The interest and welfare of the patients have to be paramount for the medical professionals.

……As long as the doctors have performed their duties and exercised an ordinary degree of professional skill and competence, they cannot be held guilty of medical negligence. It is imperative that the doctors must be able to perform their professional duties with free mind".

The medical literature produced by the complainant is vague in nature and has not been corroborated with any act or omission by the Opposite Parties as to establish medical negligence by the Opposite Parties. We find that various grounds taken in the written arguments filed by the Complainant before this Commission are beyond pleadings and the

Complainant is unable to bring out any nexus between the alleged negligence and the death of the patient.

In view of the above discussion, we find there is no merit in this complaint and hence it is dismissed. No order as to cost.

……J.
(K.S. GUPTA)
PRESIDING MEMBER

……
(RAJYALAKSHMI RAO)
MEMBER

Mk/