NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION

NEW DELHI

CONSUMER COMPLAINT NO. NC/CC/740/2017

WITH

NC/IA/18750/2019 (DIRECTIONS)

PUTCHA GURUDEV DATTA & 2 ORS.
PRESENT ADDRESS - S/o Putcha Srinivasulu R/o 12-11-1254/A, Warasiguda, Bouddha Nagar, Secunderabad, 500061Telangana ,
Putcha Srinivasulu
PRESENT ADDRESS - S/o Lt. Krishna Murthy Sri Kanaka Durga Temple, R/o 12-11-1254/A, warasiguda, Bouddha Nagar, Secunderabad, 500061Telangana ,
Smt. Putcha Annapurna
PRESENT ADDRESS - w/o Sri Putcha Srinivasulu R/o 12-11-1254/A, warasiguda, Bouddha Nagar, Secunderabad, 500061Telanagana ,

.....Complainant(s)

Versus

M/S. APOLLO HOSPITALS ENTERPRISE LTD. & 3 ORS.
PRESENT ADDRESS - Regd. off. 19, Bishop Garden, Raja Annamalaipuram, Chennai, 600028Tamil Nadu ,
Apollo Hospitals
PRESENT ADDRESS - Secunderabad Branch of M/s Apollo Hospitals Enterprise Ltd., St. John's Road, Secunderabad 500003Telangana ,
Dr. Naveen P. Reddy
PRESENT ADDRESS - Secunderabad Branch of M/s Apollo Hospitals Enterprise Ltd., St. John's Road, Secunderabad 500003Telangana ,
Dr. H. Rahul , Consultant Neurologist
PRESENT ADDRESS - Secunderabad Branch of M/s Apollo Hospitals Enterprise Ltd., St. John's Road, Secunderabad 500003Telangana ,

.....Opposite Party(s)

BEFORE:

HON'BLE DR. INDER JIT SINGH , PRESIDING MEMBER
HONBLE JUSTICE DR. SUDHIR KUMAR JAIN , MEMBER

FOR THE COMPLAINANT:

FOR THE COMPLAINANT MR. P. BHASKAR MOHAN, ADVOCATE MR. D. BHARAT KUMAR, ADVOCATE MR. AMAN SHUKLA, ADVOCATE

FOR THE OPPOSITE PARTY:

FOR THE OPPOSITE PARTIES MRS. K. RADHA, ADVOCATE MR. K. MARUTHI RAO, ADVOCATE ALONG WITH DR. P. NAVEEN REDDY

DATED: 18/02/2026

ORDER

DR. SUDHIR KUMAR JAIN, J

1. The complainant no. 1 is the eldest son of the complainants no 2 & 3. The complainant no 1 was pursuing the Chartered Accountancy and the B. Com. The complainant no 1 had fallen down from a two wheeler being driven by the complainant no 2 due to skid on 03.08.2016 at about 8.15 am. The complainant no 1 complained severe pain in the right knee and was removed to the opposite party no 2 at about 8.30 am by the complainant no 2. The complainant no 1 was attended by the staff of the opposite party no 2 at about 9.45 am. The complainant no 1 was conscious and received abrasions on the hands, elbow and right knee and the investigation revealed that the complainant no 1 received RTA-soft tissue injury. The complainant no 1 was attended by the opposite party no 3, an orthopaedic surgeon who gave a finding on the Out Patient Assessment Form that there was swelling of right knee, painful and tender with abrasion on right foot and hand. The complainant no 1 was diagnosed with Tibial Condyle fracture of right leg and was admitted in the opposite party no 2 as in-patient. The right leg of the complainant no 1 was operated on 04.08.2016 and a medical condyle locking plate was inserted to his right knee with screws. The complainant no 1 after regaining the consciousness informed the opposite party no 3 that he before surgery was able to move his right foot and fingers but after surgery he was not having any sensation and movement in his right foot and the fingers. The opposite party no 3 told the complainant no 1that he would gain sensation after removal of bandages. The complainant no 1 lost sensation of the entire right leg up to knee. The complainants got panicked over this and again approached the opposite party no 3 and apprised him about the condition of the complainant no 1. The opposite party no 3 reassured the complainants that sensation would be regained after removal of the bandage and the complainant no 1 would be discharged on 05.08.2016. The complainant no 1 was recommended to be discharged on 05.08.2016 with medical prescription.

1.1 The complainant no 1 continued to loss sensation from 05.08.2016 to 09.08.2016. The complainant no1 was rushed to the opposite party no 2 where he was attended by the opposite party no 3 who referred the complainant no 1 to the opposite party no 4, a consultant neurologist. The opposite party no 4 prescribed

medicines for a week and asked the complainant no 1 to come again after one week for review and further conveyed that the complainant no 1 after one week might require physiotherapy. The opposite party no 4 also mentioned right foot drop-post trauma on out-patient assessment form and also conveyed that the complainant no 1 would gain sensation in a week after using medicines. The complainant no 2 after two days conveyed the opposite party no 3 that there was no improvement in the condition of the complainant no 1. The opposite party no 3 asked that he may be contacted after completing seven days course of medicines. The condition of the complainant on 13.08.2016 got worse and felt heaviness on the right foot besides unable to move his right leg.

1.2 The complainant no 2 on 13.08.2016 took the complainant no. 1 to Yashoda Hospital, Hyderabad where the complainant no 1 was admitted as in-patient. The complainant no 1 after conduction of several clinical and other examinations was diagnosed with **Right Lower Limb Irreversible Ischemia; Right Popliteal Artery occulusion; Foot Drop; Vitamin D Deficiency and Hyperthyroidism**. The condition of the complainant no 1 as per various clinical reports was deteriorated after surgery of right knee at the opposite party no 2 which reflected medical negligence in performing surgery and total mismanagement of post-surgical complications. The complainant no 1 was discharged on very next day of surgery and was not kept under observation as per practice. The complainants no 2 & 3 were never informed about complications of surgery. CT Angiography of the right lower limb depicted that there was complete loss of normal attenuation of muscles of leg with faint peripheral contrast enhancement and ischemic myonecrosis. The doctors of the opposite party no 2 should have referred the complainant no 1 to a vascular surgeon. Two surgeries were conducted on 16.08.2016 and 17.08.2016 on right leg of the complainant no 1 above knee and the right leg of the complainant no 1 above knee was amputated. The complainant no 1 was first subjected to right leg fasciotomy under epidural anaesthesia and subsequently right leg up to knee was amputated and debridement was done under general anaesthesia. The complainant no 1 was discharged from hospital on 24.08.2016. The discharge summary of Yashoda Hospital reflected about deteriorated health condition of the complainant

no 1 after he was operated at the opposite party no. 2 and all muscles in the leg of the complainant no 1 were dead. The complainant no 1 suffered due to negligence of the opposite parties no. 2 to 4. The opposite party no 1 is also vicarious liable for the acts and omissions of the opposite parties no. 2 to 4.

1.3 The opposite parties no 3 & 4 even after realizing their mistake only advised the complainant no 1 only to take medicines for one week. The opposite party no. 3 & 4 did not take proper care despite being told that after knee plating blood circulation stopped and the complainant no. 1 developed numbness. The opposite parties no. 3 & 4 should have keep the complainant no. 1 under observation as and when the complainant no 1 complained about loss of sensation. The opposite parties no. 3 & 4 should have taken remedial measures as the injury to popliteal artery is possible during operation. The amputation of the complainant no. 1 could have been avoided. The complainant no 1 after being discharged from hospital was treated for more than three months post operation and also underwent physiotherapy with crutches and also assisted by medical attendant.

1.4 The complainant no 2 spent huge amount on the treatment of the complainant no 1 and post operation care. The complainants no 2 & 3 being parents of the complainant no. 1 and younger brother of the complainant no 1 suffered inexpressible mental agony and physical strain. The complainant no 1, a promising young boy faced tremendous trauma and also needs continuous nursing and physical help in attending the college. The leg of the complainant was amputated due to negligence of opposite parties 2 to 4 while the complainant suffered only a simple and normal fracture. The artificial leg/prosthetic leg of good quality may cost around 5 lacs to 95 lacs as per quotations from different vendors and this may also require replacement. The study of the complainant no 1 bound to suffer and his future dreams have shattered completely. There was deficiency in service on the part of the opposite parties. The opposite parties are jointly and severally liable to pay suitable compensation besides costs to the complainants.

1.5 The complainants claimed compensation towards expenditure incurred at the opposite parties no 1 & 2 and at Yasoda Hospital; arranging medical assistance;

purchasing artificial knee; miscellaneous expenses besides loss of earnings of the complainant no 2 which the opposite parties are liable to pay jointly and severally due to gross medical negligence and breach of duties towards the complainant no 1. The complainants also served a legal notice upon the opposite parties no 1 to 4 calling them to pay compensation amounting to Rs. 22,23,25,000/- for loss of foot of the complainant no 1 due to negligence of the opposite parties, mental agony, harassment and damages. The complainants claimed compensation amounting to Rs. 20,00,00,000/- (Rs. twenty crores) for the complainant no 1; Rs. 1,23,25,000/- as compensation for the complainant no 2 which included loss of earnings, transport expenses to be incurred for providing vehicle to the complainant no 1, compensation on account of mental pain and agony and legal expenses; and Rs. 1,00,00,000/- for the complainant no 3 for mental pain and agony being mother of the complainant no 1. The complainants as such claimed total compensation of Rs. 23,23,25,000/-. The complainants being aggrieved filed the present complaint under section 21(a) (i) of the Consumer Protection Act, 1986 (hereinafter referred to as **"the Act"**) titled as **Putcha Gurudev Datt & others V M/s Apollo Hospitals Enterprise Limited & others** bearing no 74 of 2017 for recovery of compensation and made the following prayers for directing the opposite parties to pay:-

(a) to the Complainant No.1 an amount of Rs.20,00,00,000/- (Rupees Twenty Crores only) as compensation towards punitive damages for gross negligence resulting in amputation of the right leg, deficiency of service, harassment and mental agony;
b) to the Complainant No.2 an amount of Rs.1,23,25,000/- as compensation and damages as stated afore;
c) to the Complainant No.3 an amount of
Rs.1,00,00,000/- and thus totaling Rs.22,23,25,000/- together
with interest there on @ 24% per annum from the
date of the complaint to the date of final payment;
(d) Award cost of the proceedings;
(e) to pass such further order(s) as deem fit and proper in the facts and circumstances of the case

2. The opposite parties filed written version to the complaint wherein denied

allegations of medical negligence and deficiency in service. The opposite parties in **preliminary objections** stated that the present complaint is not maintainable against the opposite party no 1 as the opposite party no 1 did not treat the complainant no 1 and the complainants only stated that the opposite party no 1 is also vicariously liable for the negligence on the part of the opposite parties no 2 to 4. There is no allegation against the opposite party no 1 in the entire complaint and as such the complaint against the opposite party no 1 is liable to be dismissed being abuse of process.

2.1 This Commission does not have pecuniary and territorial jurisdictions under the Act and no cause of action has ever accrued against the opposite parties. There was no negligence on the part of opposite party no.2 to 4 in attending and treating the complainant no 1. The complainant no 1 was brought to the opposite party no 2 on 03.08.2016 at about 8.30 am and was examined thoroughly by the doctors on duty in emergency ward. The complainant no 1 was found to be conscious and coherent. The complainant no 1 on initial examination was noticed to be having abrasions over dorsum of right hand and elbow and abrasion over right great toe. The complainant no 1 was also noticed to be having painful right knee range of movement, tenderness, swelling and creptius. The chest and cardio-vascular system were normal. The distal pulses were felt and pulse oximetry showed 100% reading. The complainant no 1was advised for X-Ray of the right knee (antero-posterior and lateral view). The complainant no 1 was given primary medication for pain relief and the right knee was immobilized with splint to reduce pain. The opposite party no 3 after investigation was informed to attend the complainant no 1 and examined the complainant no 1 thoroughly. The X-Ray of right knee showed fracture medial tibial condyle with no distal vascular injury and right knee range of movement was noticed to be painful. The distal pulses were felt and pulse oximetry showed 100% reading which ruled out any vascular injury to the right lower limb.

2.2 The opposite party no 2 thoroughly consulted the complainant no 2 being father of the complainant no 1 who was a minor about fracture, treatment (conservative management and surgical management), the advantages and disadvantages of the treatment and the complications of the fracture were examined in detail. The

complainants no 2 & 3 after mutual discussion about further course of action at about 1.40 pm decided to admit the complainant no 1 for surgery i.e. open reduction & internal fixation operation. The opposite party no 3 after admission again checked the complainant no 1 at about 5 pm. The right lower limb was warm and distal pulses were felt. The pulse oximetry showed 100% reading, chest was normal, CVS (cardio vascular system) was normal, no paraesthesia, no swelling of foot was noticed. The opposite party no 3 as such ruled out any vascular distal injury and accordingly the complainant no 1 was posted for surgery on 04.08.2016.

2.3 The surgery after explaining necessary details and obtaining consent was performed on 04.08.2016 with right medial tibial condyle plating under spinal anaesthesia and the surgery was concluded at 4 pm. The complainant no 1 under the effect of spinal anaesthesia recovered well but lower limbs remained paralysed for 4-5 hours due to effect of spinal anaesthesia. The distal pulses were felt and pulse oximetry showed 100% reading post-surgery in post- operative room. The complainant no 1 in evening was shifted to the room with post-operative orders as written in case sheet. The complainant no 1 on next day i.e. 05.08.2016 was examined by the opposite party no 3 and at that time partial foot drop right side was noticed and the complainants no 2 & 3 were explained about the recovery. The foot drop of the injured leg is commonly noticed in high velocity injuries around the knee joints due to swelling pressure on the nerve. The discharge procedure was initiated on the same day on request of the complainant no 2 and the complainant no 1 left hospital on 06.08.2016 with hemodynamically stable condition. The complainant no 1 was prescribed medicines as per discharge summary and advised non-weight bearing walking for eight weeks and strict foot and elevation. The complainant no 1 was asked to report after a week for review. The complainant no 1 was brought to the opposite party no 2 for dressing of operated site and at that time vascular insufficiency was ruled out as right lower limb was normal in colour, warm and without swelling. The complainant no 1 was also referred to the opposite party no 4 who was consultant neuro-physician for right foot drop. The complainants no 2 & 3 being attendants of the complainant no 1 were explained about neurological recovery which might take 6 weeks to 8 months besides prescribing additional

medication. The complainant no 1, thereafter, did not contact to the opposite parties no 3 & 4 for follow up action as per medical advice. The opposite party no 3 already indicated that recovery of foot drop might take 6 weeks to 8 months for recovery of foot drop. The complainants have not given any reason for skipping follow up action as advised by the opposite parties no 2 to 4.

2.4 The diagnosis could be delayed because the arterial deficit may progress slowly being cause of limb amputation and 70% injured extremities should neither hard signs of arterial insufficiency nor evidence of compartment syndrome. The popliteal artery occlusion is a delay complication of the tibial condyle fractures or any high velocity injuries around the knee joint which is also described in various journal articles and text books. There was no sign of vascular injury. There was no negligence on the part of the opposite parties. The bone fixation does not cause damage but helps to stabilize the fracture fragments which in turn help to prevent vascular injury. The right lower limb irreversible ischemia and right popliteal artery occlusion are complications of high velocity injuries. The pulse oximeter test reports showed 100% reading which indicated that there was no vascular injury and distal pulses were felt on clinical examination. There was no negligence on the part of the opposite parties no 2 to 4 and the complainant no 1 was treated as per medical standard. The opposite parties also denied other allegations as stated in the complaint. The complainants are not entitled for compensation. The complaint is liable to be dismissed.

3. The complainants have filed rejoinder to the written version filed by the opposite parties wherein the complainants reiterated facts narrated in the complaint and denied allegations and averments stated in the written version being false, ill-conceived and motivated. The complainants stated that the opposite party 2 to 4 are being administered and governed by the opposite party no 1 and as such the opposite party no 1 is vicariously liable for the acts and omissions of the opposite parties no 2 to 4. The complainant no 1 was having sensation in right knee before the surgery but lost sensation after surgery. The complainant no 1 was removed to Yashoda Hospital due to deteriorating condition. The opposite parties are jointly and severally liable to pay compensation as claimed by the complainants.

4. The complainants as CW1 to CW3 have tendered their respective affidavit in evidence. The complainants in their respective affidavit besides referring factual position deposed that the complainant no 1 was admitted in Yashoda Hospital on 13.08.2016 as in-patient and after several clinical and other examinations diagnosed with Right Lower Limb Irreversible Ischemia, Right Popliteal Artery Occlusion, Foot Drop, Vitamin-D deficiency and hypothyroidism. The condition of the complainant no 1 get deteriorated post-surgery conducted at the opposite party no 2.The complainant no 1 was victim of medical negligence in conduction of surgery and post-surgical management and the complainant no 1 should have referred to thorasic-vascular surgeon. The complainant no 1 was subjected to first surgery called Right Leg Fasciotomy before surgery conducted for amputation. The complainants are entitled for compensation as claimed.

4.1 The opposite parties in evidence have tendered respective affidavit of Dr. A. Ravindrababu, Superintendent, Apollo Hospital as RW1, Dr. Naveen. P. Reddy (the opposite party no 2) as RW2 and Dr. H. Rahul (the opposite party no 3) as RW3.

5. The complainants also served interrogatories dated 14.02.2019 to Dr. A. Ravindra Babu, Dr. Naveen Reddy i.e. the opposite party no 3 and Dr. H. Rahul i.e. the opposite party no 4. Dr. A. Ravindra Babu in response to interrogatories stated that he was not present in the opposite party no 2/ the hospital when the complainant no 1 was treated and when the opposite party no 3 found foot drop right side on 05.08.2016 i.e. post-operative day one. He further stated that as per statement of the opposite party no 3, partial foot drop right side was noticed and the complainants no 2 & 3 were explained that recovery might take 6 weeks to 6 months as per medical literature. He further stated foot drop of injured leg is commonly noticed in high velocity injuries around the knee joints due to swelling pressure on the nerve. He further stated that foot drop was persistent from first day of post-surgery and the complainant no 1 was referred to the opposite party no 4 who examined the complainant no 1 thoroughly and found that the complainant no 1 was not having pain and no change in colour of the limb. The opposite party no 4 also noticed right foot drop and no tenderness or colour changes in the extremity and the pulses of the complainant no 1 was normal. The opposite party no 4 was of opinion

that it was a post traumatic common peroneal neuropathy (neuropraxia). The opposite party no 4 after clinical evaluation started short course of steroids and physiotherapy and the complainant no 1 was asked to come after one week for review. Dr. A. Ravindra Babu further stated that the complainant no 1 would have investigated if foot drop persisted after a week but the complainant no 1 did not turn up. He also stated that the opposite party no 3 was mindful of the vascular injury and the opposite party no 3 got pulse oximeter test done on the date of admission and post-operative day which was showing 100% reading indicating that there was no vascular injury and distal pulses were felt on clinical examination. The opposite party no 3 ruled out vascular injury. Had there been any block in vessels, the leg colour would have turned to blue and became cold and clammy and pulse rate at foot could not be felt and these indication were not present during stay of the complainant no 1 in the opposite party no 2.

5.1 The opposite party no 3 in response to interrogatories stated that the complainant no 1 was operated under spinal anaesthesia on 04.08.2016 which wares out after 4-5 hours and during this period whole of lower limbs/both sides remained numb and paralyse and any neurological deficit cannot be elicited during post spinal anaesthesia time. The opposite party no 3 noticed foot drop on 05.08.2016 i.e. on first post-operative day. The complainant no 1 was discharged on 06.08.2016. Foot drop post traumatic is quite common in high velocity injuries around the knee joint especially in tibial condyle fractures which can be managed by orthopaedic surgeon and the complainant no 1 was given the treatment and due to this reason, the complainant no 1 was not refer to neuro physician. He also stated that the complainants no 2 & 3 being parents of the complainant no 1 were explained about injury and recovery might take 6 weeks to 6 months. The opposite party no 3 explained the foot drop and stated that it is a condition where there is partial or permanent damage to the peroneal nerve caused by trauma/compression or in diabetic patients. It is a condition where upward movement of the foot is absent due to damage to the nerve which is main source for the electrical stimulation of the muscles fibres. The opposite party no 3 admitted that no consultant was involved during surgery as it was a pure case of fracture tibial condyle without any sign of

neurovascular injury. He referred the complainant no 1 to neuro surgeon i.e. the opposite party no 4 on 09.06.2016 for second opinion. However the foot drop was clinically diagnosed and due to this requisite tests could have been done after waiting period of minimum six weeks to ascertain cause of foot drop. The cross consultation to vascular surgeon was not needed as there was no sign of vascular deficit in the right lower limb at the time of admission or during stay in the opposite party no 2 or at time of discharge.

5.3 The opposite party no 4 in response to interrogatories stated that he did not examine the complainant no 1 from 03.08.2016 to 08.08.2016 and examined the complainant no 1 on 09.08.2016 thoroughly on being referred by the opposite party no 3 for foot drop and perused the discharge summary. The complainant no 1 had no pain or any colour change in the limb. The opposite party no 4 noticed right foot drop and there was no tenderness or colour changes in the extremity and pulse rate was normal. The opposite party opined that it was a post traumatic common peronal neuropathy (neuropraxia). The opposite no 4 prescribed short course of steroids and physiotherapy. The opposite party no 4 would have investigated if foot drop persisted after a week but the complainant no 1 did not turn up for follow-up after 09.08.2016. He also stated that pulses were normal and as such it was not necessary to refer the complainant no 1 to vascular surgeon.

6. We have heard the arguments for the counsels of the complainants and the counsels for the opposite parties. We have also considered the relevant records including the evidence and written submissions submitted on behalf of the complainants and opposite parties.

7. The counsels for the complainants besides referring the factual background of the case argued that the complainant no. 1had fallen from a two wheeler scooter due to skid on 03.08.2016 around 8.15 am and was removed to the opposite party no 2. The opposite party no 3 operated the complainant no 1 on 04.08.2016. The complainant no 1 was able to move his right foot before the surgery but the complainant no 1 after surgery lost sensation. The complainant no 1 was told that he

would regain sensation after removal of bandage. The opposite party no 3 on 05.08.2016 in Doctor's Diary Progress Report mentioned about noticing foot drop. The complainant no 1 was recommended to be discharged on 05.08.2016 but without taking any care for the foot drop which established negligence of the opposite party no 3 besides negligence on part of the opposite parties no 1 and 2. It was further argued that as per medical literature, diagnosis of injury to popliteal artery resulting into ischemia is important and initial assessment plays an important role and diagnostic error might have severe consequences resulting in amputation or possible death. The counsels for the complainants after referring written version filed by the opposite parties submitted that the opposite parties were mindful of vascular injury and due to this reason pulse oximeter test was done by the opposite party no 3 on the day of admission and post-operative day but additional tests such as ultrasound Doppler & CT argiogram were not conducted either to confirm or ruled out vascular injury particularly when the complainant complained about loss of sensation. The counsels for the complainant further referred another internal document i.e. In-Patient Progress Sheet wherein it was mentioned that the Department of Physiotherapy noted about inability of the complainant no 1 to do ankle toe movements. The opposite parties no 1 to 3 were aware at time of discharge of the complainant no 1 that there was no sensation in the operated right leg but the complainant no 1 was discharged without seeking opinion of the vascular surgeon. It was also additionally argued that fact of foot drop was not mentioned in the discharge summary but it was mentioned in the discharge summary that the complainant no 1/patient was advised to walk for eight weeks but non-weight bearing.

7.1 It was further argued that the complainant no 1 continued to suffer loss of sensation on his right leg and due to this reason on 09.08.2016 was taken to the opposite party no 2 and was referred to the opposite party no 4 who recorded right foot drop. The opposite party no 4 without taking opinion of thoracic vascular surgeon prescribed only some medicines and advised review after one week. The complainants contacted opposite parties no 2 and 3 over telephone as the condition of the complainant no 1 was not improved. The opposite parties adopted a

consistent stand that neurological recovery could take 6 weeks to 6 months. The complainant no. 1 due to further worsening of the condition was admitted to Yashoda Hospital on 13.08.2016. The counsels for the complainants referred scan reports to establish that there was a cut/disconnection of vein/nerve injury to right popliteal artery which ultimately resulted into amputation of right leg up to knee level. The opposite parties no 2 to 4 were negligent in proper handling of the problem of the complainant no 1.

7.2 The counsels for the complainants in additional written arguments also referred Discharge Summary prepared at Yashoda Hospital which clearly depicted condition of the complainant no 1. It was mentioned in the Discharge Summary that foot drop was noticed on 13.08.2016 and with regard to lower limb angiography it was mentioned that there was non-opacification of popliteal artery over a length of approximate 4 cm at the level of joint space and below-s/o occlusion. It was also mentioned that complete loss of normal attenuation of muscles of leg with faint peripheral contrast enhancement may represent ischemic myonecrosis. The counsels for the complainants empathetically argued that the complainant no 1 was planned for A K amputation due to right popliteal artery occlusion. It was also mentioned that all the muscles in the legs are dead. The counsels further argued that the opposite parties in the interrogatories clearly mentioned that no action was taken on the complaint of foot drop and had the opposite party no 3 on 05.08.2016 or 06.08.2016 and the opposite party no 4 taken appropriate remedial steps then the right leg of the complainant no 1 could have been saved.

7.3 The counsels for the complainants also justified compensation as claimed in the complaint and referred various decisions delivered by the superior courts besides referring medical literature which shall be discussed herein below. It was argued that the opposite parties be held liable jointly and severally and compensation along with interest and costs as prayed for be awarded.

8. The counsels for the opposite parties stated that the complainants primarily alleged that the opposite party no 3 did not take proper post-operative care towards the complainant no 1 despite he complained regarding loss of sensation in the right

foot and for this vascular surgeon was not consulted. The counsels for the opposite parties countered said contention of the complainants by arguing that the complainant no 1 was examined by the opposite party no 4 who was a neurologist and thereafter the opposite party no 4 prescribed the suitable medicines. It was further argued that the surgery was conducted after explaining the procedure and line of treatment, risk involved and chances of recovery. The complainants no 2 and 3 being parents of the complainant no 1 were also suitably counselled. The complainant no 1 was recovered well post- surgery but the lower limb of the complainant no 1 had paralyzed in his feet for 4/5 hours due to effect of spinal anaesthesia. The counsels further mentioned that distal pulses were felt post-operative surgery and pulses Oximeter showed 100% reading. The complainant no 1 was recommended to be discharged on 05.08.2016 with instructions to visit to the opposite party no 2/hospital for review after two days. The complainant no 2 called over telephone regarding physical condition of the complainant no1which was stated to be not improved and the opposite party no 3 has prescribed the necessary medicines besides the complainant no 1 was asked to visit the opposite party no 2/hospital.

8.1 The counsels for the opposite parties further argued that the complainant no 1 was brought to hospital on 09.08.2016 for dressing and at that time right lower limb was normal in colour, warm and swelling was also noticed by the opposite party no 3 who on this ruled out any vascular insufficiency. The complainant no 1 as a precautionary measure was referred to the opposite party no 4 who was consultant neuro physician for right foot drop who on examination did not find any symptom of vascular injury. The complainants no 2 and 3 being parents of the complainant no 1 were explained about neurology recovery which might have taken six weeks to six months and the complainant no 1 was also prescribed additional medicines. The counsels for the opposite parties emphatically argued that there was no medical/professional negligence on the part of opposite parties as alleged by the complainants.

8.2 It was also argued that the complainant no 1 did not come for follow up treatment after 09.08.2016 and due to this the opposite parties were not aware

about development in the treatment. The opposite parties came to know that the complainant no 1 had visited Yashoda Hospital, Hyderabad where right leg was amputated on 17.08.2016. The Yashoda Hospital in the discharge summary did not explain reasons for amputation of leg and doctors did not observe that treatment given by the opposite parties was not correct or there was negligence on the part of the opposite parties. The counsels for the opposite parties also countered the allegations that the opposite parties did not inform complications in the treatment of the complainant no1 and argued that the complainants no 2 and 3 were counselled and were explained about treatment. The counsels for the opposite parties also countered the allegations of the complainant that the opposite parties ought to have taken remedial measures as the injury to the popliteal artery might have caused during operation and the complainant no 1 should have been referred to thoracic vascular surgeon and argued that there was no sign of vascular injury and as such no negligence can be attributed to the opposite parties no 3 and 4. The counsels vehemently argued that the complaint is not maintainable and the complainants are not entitled for compensation. There was no negligence in the treatment of the complainant no 1 and opposite parties have taken appropriate care during pre and post-surgery as well post-operative care. The counsels also referred case law and medical literature which shall be discussed herein below.

9. The negligence can be normally explained as a breach of duty caused by omission to do something which a reasonable man guided by those considerations which ordinarily regulate the conduct of human affairs would do, or doing something which a prudent and reasonable man would not do. The actionable negligence consists in the neglect of the use of ordinary care or skill towards a person to whom the defendant owes the duty of observing ordinary care and skill, by which neglect the plaintiff has suffered injury to his person or property. The definition involves three constituents of negligence which are i) a legal duty to exercise due care, ii) breach of the duty and iii) consequential damages. The medical negligence may be explained as a want of reasonable degree of care or skill or willful negligence on the part of the medical practitioner in the treatment of a patient with whom a relationship of professional attendant is established, so as to lead to bodily injury or to loss of

life. The absence or lack of care that a reasonable person should have taken in the circumstance of the case is held to be negligent. The three ingredients of negligence are i) the defendant owes a duty of care to the plaintiff, ii) the defendant has breached a duty of care and iii) the plaintiff has suffered an injury due to breach. The basic principle relating to negligence by professionals is called as the **Bolam Rule** which was laid down in **Bolam V Friern Hospital Management Committee, (1957) 1 WLR 582** as under:-

> **(W)here you get a situation which involves the use of some special skill or competence, then the test as to whether there has been negligence or not is not the test of the man on the top of a Clapham omnibus, because he as not got this special skill. The test is the standard of the ordinary skilled man exercising and profession to have that special skill. A man need not possess the highest expert skill…..It is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art**

9.1 The Supreme Court in **Indian Medical Association V V. P. Shantha,** (1995) 6 SCC 651 has brought the medical profession within the ambit of the Act. The Supreme Court after referring **Lucknow Development Authority V M.K. Gupta,** 1994 (1) SCC observed that keeping in view the wide amplitude of the definition of service in the main part of Section 2(1) (o) of the Act, there is no plausible reason to exclude the services rendered by a medical practitioner from the ambit of the main part of Section 2(1) (o). The Supreme Court in an action for negligence in tort against a surgeon in Laxman Balakrishna Joshi V Trimbak Bapu Godbole & another, 1969 (1) SCR 206 held that the duties which a doctor owes to his patient are clear and a person who holds himself out ready to give medical advice and treatment impliedly undertakes that he is possessed of skill and knowledge for the purpose. It was further held that such a person when consulted by a patient owes him certain duties which are a duty of care in deciding whether to undertake the case, a duty of care in deciding what treatment to give or a duty of care in the administration of that treatment and a breach of any of those duties gives a right of action for negligence to the patient. It was also held that the practitioner must bring to his task a reasonable degree of skill and knowledge and must exercise a reasonable degree of

care. The relationship between a medical practitioner and a patient carries within it certain degree of mutual confidence and trust. The Supreme Court also observed that section 14 of the Act indicates that the reliefs that can be granted on a complaint filed under the Act in respect of deficiency in service and the compensation can be awarded for loss or injury suffered by the consumer due to the negligence of the opposite party including medical negligence. The Supreme Court in **Dr. C. P. Sreekumar V S. Ramanujam,** II (2009) CPJ 48 (SC) which is also referred by the counsels for the opposite parties held that onus to prove medical negligence lies on the claimant and this onus can be discharged by leading cogent evidence. This Commission in **Nalini V Manipur Hospital & others,** IV (2011) CPJ 280 (NC) observed that appellant's case of alleged medical negligence cannot be accepted only on basis of affidavit without support of any expert opinion.

10. The Supreme Court in **Achutrao Haribhau Khodwa V State of Maharashtra and others,** (1996) 2 SCC 634 held as under:-

> **The skill of medical practitioners differs from doctor to doctor. The very nature of the profession is such that there may be more than one course of treatment which may be advisable for treating a patient. Courts would indeed be slow in attributing negligence on the part of a doctor if he has performed his duties to the best of his ability and with due care and caution. Medical opinion may differ with regard to the course of action to be taken by a doctor treating a patient, but as long as a doctor acts in a manner which is acceptable to the medical profession, and the Court finds that he has attended on the patient with due care skill and diligence and if the patient still does not survive or suffers a permanent ailment, it would be difficult to hold the doctor to be guilty of negligence.**

11. The Supreme Court in **Jacob Mathew V State of Punjab** which was also referred by the counsels for the opposite parties extensively discussed negligence by professionals including doctors. The Supreme Court observed as under:-

> **In the law of negligence, professionals such as lawyers, doctors, architects and others are included in the category of persons professing some special skill or skilled persons generally. Any task which is required to be performed with a special skill would generally be admitted or undertaken to be performed only if the person possesses the requisite**

skill for performing that task. Any reasonable man entering into a profession which requires a particular level of learning to be called a professional of that branch, impliedly assures the person dealing with him that the skill which he professes to possess shall be exercised and exercised with reasonable degree of care and caution. He does not assure his client of the result. A lawyer does not tell his client that the client shall win the case in all circumstances. A physician would not assure the patient of full recovery in every case. A surgeon cannot and does not guarantee that the result of surgery would invariably be beneficial, much less to the extent of 100% for the person operated on. The only assurance which such a professional can give or can be understood to have given by implication is that he is possessed of the requisite skill in that branch of profession which he is practising and while undertaking the performance of the task entrusted to him he would be exercising his skill with reasonable competence. This is all what the person approaching the professional can expect. Judged by this standard, a professional may be held liable for negligence on one of two findings: either he was not possessed of the requisite skill which he professed to have possessed, or, he did not exercise, with reasonable competence in the given case, the skill which he did possess. The standard to be applied for judging, whether the person charged has been negligent or not, would be that of an ordinary competent person exercising ordinary skill in that profession. It is not necessary for every professional to possess the highest level of expertise in that branch which he practices.

11.1 The Supreme Court also referred **Bolam case** and stated that it is cited and dealt with in several judicial pronouncements. It was observed that the classical statement of law in **Bolam's** case has been widely accepted as decisive of the standard of care required both of professional men generally and medical practitioners in particular. It has been applied to as touchstone to test the pleas of medical negligence. It is enough for the defendant to show that the standard of care and the skill attained was that of the ordinary competent medical practitioner exercising an ordinary degree of professional skill. The fact that a defendant charged with negligence acted in accord with the general and approved practice is enough to clear him of the charge. The Supreme Court further observed that a mere deviation from normal professional practice is not necessarily evidence of

negligence. An error of judgment on the part of a professional is not negligence per se. The medical professional is often called upon to adopt a procedure which involves higher element of risk, but which he honestly believes as providing greater chances of success for the patient rather than a procedure involving lesser risk but higher chances of failure. It was also observed that no sensible professional would intentionally commit an act or omission which would result in loss or injury to the patient as the professional reputation of the person is at stake. A single failure may cost him dear in his career.

11.2 The Supreme Court also discussed rule of ***res ipsa loquitur*** and stated that it is not of universal application and has to be applied with extreme care and caution to the cases of professional negligence and in particular that of the doctors otherwise it would be counter-productive. The doctor cannot be held liable by applying doctrine of ***res ipsa loquitur*** because a patient has not favourably responded to a treatment given by a physician or a surgery has failed. The Supreme Court has summed up the conclusions as under:-

> **(1) Negligence is the breach of a duty caused by omission to do something which a reasonable man guided by those considerations which ordinarily regulate the conduct of human affairs would do, or doing something which a prudent and reasonable man would not do……Negligence becomes actionable on account of injury resulting from the act or omission amounting to negligence attributable to the person sued. The essential components of negligence are three: 'duty', 'breach' and 'resulting damage'.**
>
> **(2) Negligence in the context of medical profession necessarily calls for a treatment with a difference. To infer rashness or negligence on the part of a professional, in particular a doctor, additional considerations apply. A case of occupational negligence is different from one of professional negligence. A simple lack of care, an error of judgment or an accident, is not proof of negligence on the part of a medical professional. So long as a doctor follows a practice acceptable to the medical profession of that day, he cannot be held liable for negligence merely because a better alternative course or method of treatment was also available or simply because a more skilled doctor would not have chosen to follow or resort to that practice or procedure which the accused followed. When it comes**

to the failure of taking precautions what has to be seen is whether those precautions were taken which the ordinary experience of men has found to be sufficient; a failure to use special or extraordinary precautions which might have prevented the particular happening cannot be the standard for judging the alleged negligence. So also, the standard of care, while assessing the practice as adopted, is judged in the light of knowledge available at the time of the incident, and not at the date of trial. Similarly, when the charge of negligence arises out of failure to use some particular equipment, the charge would fail if the equipment was not generally available at that particular time (that is, the time of the incident) at which it is suggested it should have been used.

(3) A professional may be held liable for negligence on one of the two findings: either he was not possessed of the requisite skill which he professed to have possessed, or, he did not exercise, with reasonable competence in the given case, the skill which he did possess. The standard to be applied for judging, whether the person charged has been negligent or not, would be that of an ordinary competent person exercising ordinary skill in that profession. It is not possible for every professional to possess the highest level of expertise or skills in that branch which he practices. A highly skilled professional may be possessed of better qualities, but that cannot be made the basis or the yardstick for judging the performance of the professional proceeded against on indictment of negligence.

(4) The test for determining medical negligence as laid down in Bolam's case [1957] 1 W.L.R. 582, 586 holds good in its applicability in India.

12. The Supreme Court in **Neeraj Sud & another V Jaswinder Singh (minor) & another,** Civil Appeal No 272 of 2012 decided on 25.01.2024 after referring **Bolam case** and **Jacob Mathews V State of Punjab** in context to medical negligence held as under:-

11. Deterioration of the condition of the patient post-surgery is not necessarily indicative or suggestive of the fact that the surgery performed or the treatment given to the patient was not proper or inappropriate or that there was some negligence in administering the same. In case of surgery or such treatment it is not necessary that in every case the condition of the patient would improve and the surgery is successful to the satisfaction of the patient. It is very much possible that

in some rare cases complications of such nature arise but that by itself does not establish any actionable negligence on part of the medical expert.

14. It is well recognized that actionable negligence in context of medical profession involves three constituents (i) duty to exercise due care; (ii) breach of duty and (iii) consequential damage. However, a simple lack of care, an error of judgment or an accident is not sufficient proof of negligence on part of the medical professional so long as the doctor follows the acceptable practice of the medical profession in discharge of his duties. He cannot be held liable for negligence merely because a better alternative treatment or course of treatment was available or that more skilled doctors were there who could have administered better treatment.

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

16. When reasonable care, expected of the medical professional, is extended or rendered to the patient unless contrary is proved, it would not be a case for actionable negligence. In a celebrated and very often cited decision in Bolam v. Friern Hospital Management Committee (Queen's Bench Division)3, it was observed that a doctor is not negligent if he is acting in accordance with the acceptable norms of practice unless there is evidence of a medical body of skilled persons in the field opining that the accepted principles/procedure were not followed. The test so laid down popularly came to be known as Bolam's test and stands approved by the Supreme Court in Jacob Mathews v. State of Punjab and Another.

17. In **Jacob Mathews** (supra) this Court held that a professional may be held liable for negligence if he is not possessed of the requisite skill which he supposes to have or has failed to exercise the same with reasonable competence.

18. In other words, simply for the reason that the patient has not responded favourably to the surgery or the treatment administered by a doctor or that the surgery has failed, the doctor cannot be held liable for medical negligence straightway by applying the doctrine of *Res Ipsa*

Loquitor **unless it is established by evidence that the doctor failed to exercise the due skill possessed by him in discharging of his duties.**

13. This Commission in **Sir Dorabji Tata Trust Aided Hospital Chottanikkara V Dr. S. Krishna Iyer & others,** 2014 2 CPJ (NC) 644 observed that the patient might be suffering from rat fever and the hospital did not have proper facilities to treat the patient suffering from rat fever. The petitioners were held to be liable for medical negligence. The Supreme Court in **P. N. Gupta V Rajinder Singh Dogra,** 2024 SCC OnLine SC 2927 observed that the appellant i.e. the doctor did not offer any convincing reason for delaying the referral to a liver-specialist despite being aware of the medical condition and the conduct of the appellant did not meet the required standard of reasonable care and he being negligent cannot be ruled out.

14. The Supreme Court in **Kusum Sharma V Batra Hospital,** (2010) CPJ 29 (SC) which was also referred by the counsels for the opposite parties observed that m edical science has conferred great benefits on mankind but these benefits are attended by considerable risks. Every surgical operation is attended by risks. It was further observed that the professional should be held liable for his act or omission, if negligent, is to make life safer and to eliminate the possibility of recurrence of negligence in future but at the same time courts have to be extremely careful to ensure that unnecessarily professionals are not harassed and they will not be able to carry out their professional duties without fear. The Supreme Court in **Martin F D'Souza V Mohd Ishfaq,** (2009) 3 SCC 1 observed that simply because a patient has not favourably responded to a treatment given by a doctor or a surgery has failed, the doctor cannot be held straightway liable for medical negligence by applying the doctrine of *res ipsa loquitur*. No sensible professional would intentionally commit an act or omission which would result in harm or injury to the patient since the professional reputation of the professional would be at stake. A single failure may cost him dear in his lapse. It was also observed in this case that a medical practitioner is not liable to be held negligent simply because things went wrong from mischance or misadventure or through an error of judgment in choosing one reasonable course of treatment in preference to another. He would be liable only where his conduct fell below that of the standards of a reasonably competent

practitioner in his field.

15. The Supreme Court in **Deep Nursing Home and another V Manmeet Singh Mattewal and others,** 2025 SCC OnLine SC1934 after referring **Jacob Mathew V State of Punjab** and **Martin F. D'Souza V Mohd. Ishfaq** observed as under:-

> 23. As pointed out in **Jacob Mathew vs. State of Punjab** and another6, simply because a patient did not favourably respond to the treatment given by a physician or if a surgery failed, the doctor cannot be held liable per se by applying the doctrine of res ipsa loquitur. This edict was reiterated in **Martin F. D'Souza vs. Mohd. Ishfaq7** wherein, it was pointed out that no sensible professional would intentionally commit an act or omission which would result in harm or injury to a patient as the reputation of that professional would be at stake and a single failure may cost him or her dear in that lapse. It was also pointed out that sometimes, despite best efforts, the treatment by a doctor may fail but that does not mean that the doctor or surgeon must be held guilty of medical negligence, unless there is some strong evidence to suggest that he or she is. It was also pointed out that Courts and Consumer Fora are not experts in medical science and must not substitute their own views over that of specialists. While acknowledging that the medical profession had been commercialised to some extent and there were doctors who depart from their Hippocratic Oath for their selfish ends of making money, this Court held that the entire medical fraternity cannot be blamed or branded as lacking in integrity or competence just because of some bad apples.
>
> **24. On the same lines, in Devarakonda Surya Sesha Mani and others vs. Care Hospital, Institute of Medical Sciences and others , 2022 SCC OnLine SC 1608 it was held that unless a complainant is able to establish a specific course of conduct, suggesting a lack of due medical attention and care, it would not be possible for the Court to second-guess the medical judgment of the doctor on the line of treatment which was administered and, in the absence of such material disclosing medical negligence, the Court cannot form a view at variance, as every death in the institutionalised environment of a hospital does not necessarily amount to medical negligence on a hypothetical assumption of lack of due medical care.**

15.1 The counsels for the complainants also referred **Jyoti Devi V Suket Hospital,**

(2024) 8 SCC 655 wherein the Supreme Court observed as under:-

The Law on Medical Negligence

13. Three factors required to prove medical negligence, as recently observed by this Court in M.A Biviji v. Sunita, (2024) 2 SCC 242 following the landmark pronouncement in Jacob Matthew v. State of Punjab9 are:

37. As can be culled out from above, the three essential ingredients in determining an act of medical negligence are:

(1) a duty of care extended to the complainant,

(2) breach of that duty of care, and

(3) resulting damage, injury or harm caused to the complainant attributable to the said breach of duty.

However, a medical practitioner will be held liable for negligence only in circumstances when their conduct falls below the standards of a reasonably competent practitioner."

14. To hold a doctor liable, this Court in Dr. Mrs. Chanda Rani Akhouri v. Dr. M.A. Methusethupathi observed:

"31…. a medical practitioner is not to be held liable simply because things went wrong from mischance or misadventure or through an error of judgment in choosing one reasonable course of treatment in preference to another. In the practice of medicine, there could be varying approaches of treatment. There could be a genuine difference of opinion. However, while adopting a course of treatment, the duty cast upon the medical practitioner is that he must ensure that the medical protocol being followed by him is to the best of his skill and with competence at his command. At the given time, medical practitioner would be liable only where his conduct fell below that of the standards of a reasonably competent practitioner in his field."

(Emphasis supplied)

15. Observations in Harish Kumar Khurana v. Joginder Singh, (2011)10SCC291 are also instructive. Bopanna J., writing for the Court held:

11. "…It is necessary that the hospital and the doctors are required to exercise sufficient care in treating the patient in all circumstances. However, in unfortunate cases, though death may occur and if it is alleged to be due to medical negligence and a claim in that regard is made, it is necessary that sufficient material or medical evidence should be available before the adjudicating authority to arrive at a conclusion."

(emphasis supplied)

16. We shall now refer the relevant facts appearing from the record. The complainant no 1 was removed to the opposite party no 2 on 03.08.2016 at about 8.15 am with complained of pain in the right knee. The complainant no 1 as per investigation received RTA-soft tissue injury and was attended by orthopaedic surgeon/ the opposite party no 3 who noticed swelling on the right knee, pain and tender with abrasion on right foot and hand. The opposite party no 3 noticed distal pulses were felt and pulse oximetry showed 100% reading. The complainant no 1 was ultimately diagnosed with Tibial Condyle fracture of right leg and his right leg was operated on 04.08.2016 with insertion of medical condyle locking plate in right knee with screws. The opposite party no 3 before operation again noticed that the right lower limb was warm and distal pulses were felt, the pulse oximetry showed 100% reading, chest was normal, CVS (cardio vascular system) was normal, no paraesthesia and there was no swelling of foot. The lower limbs of the complainant no 1 remained paralysed for 4-5 hours due to effect of spinal anaesthesia, the distal pulses were felt and pulse oximetry showed 100% reading post-surgery in post-operative room. The complainant no 1 after regaining the consciousness did not feel sensation in the right foot and fingers and accordingly the opposite party no 3 was informed who advised the complainant no 1 that sensation would be regained after removal of bandages. The complainant no 1 was recommended to be discharged on 05.08.2016 with medical prescription but actually left the opposite party no 2 on 06.08.2016 and was asked to report after a week for review. The opposite party no 2

noticed foot drop on 05.08.2016 and the complainant no 1 continued to loss sensation from 05.08.2016 to 09.08.2016. The complainant no1 was referred to the opposite party no 4, consultant neurologist who prescribed medicines for a week. The opposite party no 4 also noticed right foot drop. The opposite party no 4 explained the complainants no 2 & 3 that neurological recovery might take 6 weeks to 8 months. The complainant no. 1 after 09.08.2016 did not contact to the opposite parties no 3 & 4 for follow up action as per medical advice. The complainant no 1 did not regain sensation in the right foot up to knee till 13.08.2016 and was removed to Yashoda Hospital, Hyderabad. The complainant no 1 was diagnosed with Right Lower Limb Irreversible Ischemia; Right Popliteal Artery occulusion; Foot Drop; Vitamin D Deficiency and Hyperthyroidism. The right leg of the complainant no 1 above knee was amputated and was discharged from Yashoda Hospital on 24.08.2016.

17. We have perused the medical record submitted by both the parties. First we shall analyse the medical record prepared at the opposite party no 2. The perusal of Out-Patient Case Record MLC No 3311 prepared by Department of Emergency Medicine of the opposite party no 2 reflects that the complainant no 1 was brought to the opposite no 2 on 03.08.2016 at 9.45 am with complaint that he had fallen down from bike around 8.15 am. There was no head injury, vomiting, LOC (loss of consciousness). The complainant no 1 was conscious, coherent, abrasions over right dorsum of hand & elbow, abrasions over great toe, right knee painful on flexion. The treating doctor after investigation diagnosed RTA-Soft Tissue Injury and advised consultation with the opposite party no 3 as follow up. The opposite no 3 during check up on 03.08.2016 noticed complaint of pain in right knee and difficult to walk as informed by the complainant no 1. The opposite party no 3 on physical examinations as per Out-Patient Assessment Form observed swelling over right knee, painful and tenderness and abrasion on right foot and hand. The opposite party no 3 being Consultant Orthopaedic Surgeon diagnosed fracture in tibial condyle medial and advised X-ray of right knee (AP & Lat.). The complainant was admitted in ward and treatment of Open Reduction Internal Fixation (ORIF), cancellous screw right tibial condyle and SP3 besides medicines was

recommended. The opposite party no 2 as per Doctors Daily Progress Form prepared on 03.08.2016 at about 2 pm noticed distal pulses, warmth and no neurological deficit. The opposite party no 2 as per Doctors Daily Progress Form prepared on 05.08.2016 at 11.30 am before recommending discharge of the complainant no 1 noticed mild foot drop in right leg but at that time also noticed distal pulses were good and no discolouration of lower limb.

17.1 The Discharge Summary dated 05.08.201 prepared by Department of Orthopaedics of the opposite party no 2 at the time of discharge of the complainant no 1 reflects that the complainant no 1 was diagnosed with “tibial condyle fracture right” and surgery procedure which was done on the complainant no 1 was “right medial condyle locking plate”. The perusal of further summary reflects that when the complainant no 1 came to the opposite party no 2 at that time, the complainant no 1 sustained injury to right knee with pain thereafter and there was no other external injury, head injury, loss of consciousness, vomiting or ENT Bleed. The Discharge Summary further reflects that the complainant no 1after clinical evaluation and necessary investigation was diagnosed as communited- medial fracture tibial condyle right and accordingly surgery was planned. The surgery was conducted on 04.08.2016 and right medial condyle locking plate was done under spinal anaesthesia. The post-operative period was noticed to be uneventful. The complainant no 1 was put on necessary medicines and discharged in a haemodynamically stable condition. The complainant no 1 was asked to come after one week in OPD for review. The opposite party no 3 signed the discharged summary. The complainant no 1 reported the opposite party no 3 on 09.08.2016 and at that time foot drop was noticed and the complainant no 1 was referred to the opposite party no 4 for neuro physician opinion. The opposite party no 4 examined the complainant on 09.08.2016 with history of post trauma. The opposite party no 4 prescribed medicines and asked the complainant no 1 to come after one week for review.

17.2 The complainant no 1 was admitted in Yashoda Hospitals on 13.08.2016 where on 13.08.2016 Real Time Color Doppler Ultrasonography of Right Lower Limb Arterial System was conducted. The Report dated 13.08.2016 reads as under:-

The common femoral, superficial femoral, profunda, popliteal, posterior tibial, anterior tibial and dorsalis pedis arteries were examined.
Common femoral, proximal superficial femoral, profunda femoral arteries were showing normal triphasic flow, reveal normal color filling and peak systolic velocity.

Distal superficial femoral artery, popliteal artery, anterior tibial artery, posterior tibial artery, dorsalis pedis arteries were showing biphasic flow pattern with spectral boarding. (Surgical complications are considered as inherent, expected risk rather than normal)

Deep subcutaneous edema noted in distal 1/3rd of the lower leg.

No evidence of obstruction or significant narrowing.

17.3 The CT Peripheral Angiography of the complainant no 1 was also done on 16.08.2016. The Lower Limb angiography revealed that there was complete loss of normal attenuation of muscles of legs with faint peripheral contrast which might be indicative of ischemic myonecrosis and mild right knee joint effusion was also noted. The impression was i) non-opacification of right popliteal artery (over a length of approximately 4 cm) at the level of joint space and below; ii) Reformed right anterior tibial, posterior tibial and peroneal artery showed faint contrast opacification on delayed imaging and iii) complete loss of normal attenuation of muscles of right leg with faint peripheral contrast enhancement which might be indicative of ischemic myonecrosis.

17.4 The Discharge Summary further reflects that the consultants Dr. Jaydip Ray Chaudhuri, Dr. Devender Singh and Dr. C. N. Chandra Sekhar diagnosed Right Lower Limb Irreversible Ischemia, Right Popliteal Artery Occlusion, Foot Drop, Vitamin Deficiency and Hypothyroidism. The two surgeries were done on 16.08.2016 and 17.08.2016. Right Leg Fasciotomy was done under epidural anaesthesia and right foot above knee Amputation and Debridement were done under general anaesthesia. The operative findings were that all the muscles in leg were dead and necrotic. The complainant no 1 was planned for surgery for A K amputation in view of right popliteal artery occlusion.

18. Foot drop is a symptom characterized by the inability to lift the front part of the foot (dorsiflexion weakness) due to nerve injury most commonly the peroneal nerve. The most common cause of foot drop is injury or compression of the peroneal nerve in the leg and it may be due to trauma, prolonged pressure, neurological disorder etc. Foot drop, as per Article **Foot Drop written by Subhadra L. Nori and Micheal F. Stretanski: Stat Pearls Publishing; 2024, January** which was referred by respective counsel for the complainants and opposite parties is defined as under:-

> **Foot drop a neuromuscular condition characterized by weakness or paralysis of the dorsiflexor muscles, causing difficulty lifting the forefoot during gait and resulting in a high-steppage walking pattern. The condition can result from compressive neuropathies, trauma, autoimmune, inherited, and spinal, as well as neurodegenerative, compressive, or psychological disorders…… Diagnosis relies on a thorough neurological examination, metabolic workup, imaging, and electrodiagnostic studies to determine the site and severity of the lesion. Treatment depends on the underlying cause and typically begins with conservative measures such as physical therapy, splinting, pain control, and electrical stimulation. Surgical interventions such as nerve decompression, nerve or tendon transfers, or ankle fusion may be indicated in complex or traumatic cases.**
>
> **Foot drop is characterized by the inability to dorsiflex the forefoot due to weakness in the dorsiflexor muscles.**

18.1 The counsel for the complainants also cited medical literature **"Essential Orthopaedics"** written by J. Maheshwari and Vikram Mhaskar : Jaypee Brothers Medical Publishers, page 63 wherein it is mentioned that a patient with a nerve injury commonly presents with complaints of inability to move a part of the limb, weakness and numbness. The cause of nerve injury may or may not be obvious. In case the cause is obvious, say a penetrating wound along the course of a peripheral nerve (e.g. glass cut injury to the medial nerve), the nerve affected and its level is easy to decide. Similarly, nerve injury may occur during an operation as a result of stretching or direct injury. It is essential to perform a systematic motor and sensory examination of the involved limb. The foot drop remains in planter flexion due to weakness of the dorsiflexors. It occurs in common peroneal nerve palsy. The counsel for the complainants also referred Natarajan's Textbook of **"Orthopaedics**

and Traumatology” page 367 wherein with respect to popliteal artery injury mentioned as under:-

> **Popliteal artery is injured often by a supracondylar fracture of the femur or comminuted T or Y intercondylar fractures of the lower end of the femur and also following knee dislocation. It is further stated that in the supracondylar fracture, the distal fragment gets flexed by the origin of the gastrocnemius made. The popliteal artery gets damaged by the sharp edge of the fixed lower fragment.**
>
> **Clinical Features**
>
> **The patient presents with a history of injury in the lower thigh and a tense swelling around the knee, particularly in the popliteal fossa. The limb is cold and the dorsalis pedis and posterior tibial pulsations may be absent. The limb may rapidly develop gangrene, unless energetic steps are taken to relieve the compression in the popliteal fossa.**

It is also mentioned closed fracture injuries may also cause distal ischaemia or gangrene. The acute traumatic ischaemia is commonly caused by the closed injuries. The amputation is also defined in said book as the surgical removal of a part or whole of a limb. It is stated that ablation of a limb is an extreme step and an irreversible operation. The number of traumatic amputations performed because of mangled unsalvageable limb due to high velocity road traffic accidents is in increasing trend. The amputation should be considered only if the limb is dead (gangrenous or unsalvageable trauma), dying (grossly ischaemic), dangerous (due to malignancy), dud (useless limb) and distressing (persistent infection).

18.2 The counsels for the complainants further cited another article **“Popliteal Artery Complications of Total Knee Replacement-Our Experience in Large Volume Centre and Review of Literature”** written by Nitin S, Reddy A and Muralidhar S wherein it was discussed that arterial vascular injury is a rare complication of total arthroplasty. It deserves attention as consequences are devastating and involves amputation of the limb. It was concluded that prompt diagnosis depends on two things which are clinical assessment of complications and

careful Doppler assessment. Another article cited on behalf of the complainants was **“One of the most urgent vascular circumstances: Acute limb ischemia”** written by Rezzan D Acar, Muslum Sahin and Cevat Kirma wherein it is mentioned that acute limb ischemia is a sudden decrease in limb perfusion that threatens limb viability and requires urgent evaluation and management. The thrombosis of a limb artery may be one of main cause of acute limb ischemia. The assessment determines whether the limb is viable or irreversible damage. It was also reported that prompt diagnosis and surgery reduce the risk of limb loss and morality. The counsels for the complainants also explained by referring Pulse Oximetry which is a way to measure how much oxygen blood is carrying. The blood oxygen level is checked by using a small device called pulse oximeter.

18.3 The counsels for the opposite parties cited article **“Traumatic Blue Toe Syndrome with Tibial Plateau Fracture: A Rare Case of Foot Ischemia and Toes Gangrene in Spite of Patent Arterial Injury”** written by Mehdinasab Sayed Abdolhossein Alamshah and Seyed Mansoor and published in Journal of Orthopaedics. It is reported in this article as under:-

> **Tibial plateau fractures involve articular surface and condylar portion of the proximal tibia. These fractures occur as a result of several trauma on the knee joint; therefore, the associated soft tissue injuries are frequently seen with these fractures in popliteal fossa. Neuro-Vascular injury is one of the complicated damages that contain popliteal artery are thrombosis in the form of direct intimal injury or arterial disruption. Possible plantar are thrombosis as an embolic complication of popliteal artery intimal flap in the form of traumatic blue toe syndrome is a rare concomitant clinical entity with this fracture which has not been reported in our experience. This is a report of a minimal displaced fracture of the tibial plateau in a young patient who was admitted for driving injuries with cyanosis of four toes and severe planter pain due to ischemic foot. He had normal symmetrical pedal pulses, but developed gangrene of toes leads to distal foot amputation.**

The counsel of the opposite parties also referred article **“Delayed**

Presentation of popliteal artery transaction following undisplaced lateral condyle fracture of tibia" written by Gupta, Mohit; Vora, Harshil J.; Patil, Sanjay N.; Pundkare, Gopal T. and published in Journal of Orthopaedics and Spine. It is mentioned that popliteal artery injury around the knee joint has been reported more frequent and common than any other major vessel injuries. This injury is associated with high energy trauma which includes knee dislocations or complex fractures of the distal femur or proximal tibia. The Popliteal artery injury carries a high risk of limb amputation because initial clinical features present normal vascular circulation without the signs and symptoms of ischemia or obvious vascular injury. In such a type of injury the diagnosis could be delayed because the arterial deficit may progress slowly, being the main cause of limb amputation.

19. We shall now consider the liability of the opposite party no 1 in alleged medical negligence pertaining to the complainant no 1. The complainants pleaded their cause of action against the opposite party no 1 and also claimed compensation from the opposite party no1 jointly with the complainants no 2 to 4. The opposite party in the written version stated that the complaint is not maintainable against the opposite party no 1as the complainant no 1 was not treated in the opposite party no 1 hospital and the opposite party is not vicariously liable towards the claim of the complainants. The counsels for the opposite parties also argued that the opposite party no 1 is not vicariously liable for the alleged claim of the complainants. It is correct that the complainants have not elaborated about the liability of the opposite party no 1and there is no convincing material or document on record which can establish liability of the opposite party no 1 qua the complainants or in particular qua the complainant no 1. The complainants have not placed any supporting document to fasten the liability on the opposite party no1. We after considering rival contentions of the parties are of opinion that the opposite party is not vicariously liable qua the claims of the complainants.

20. The complainants also fastened the liability and responsibility of medical negligence on the opposite parties no 2 to 4. It is apparent that the complainant no 1 was brought to the opposite no 2 for treatment of Tibial Condyle fracture of right leg where he was attended and operated by the opposite party no 3 and a medial

condyle locking plate with screws was inserted in the complainant no 1. The complainant no 1 post surgery complained of loss of sensation and movement in the right foot. The opposite party on 05.08.2016 noticed foot drop but recommended discharge of the complainant no 1 from the opposite party no 2. The complainant again came to the opposite party no 2 on 09.08.2016 who referred the complainant no 1 to opposite party no 4 who was a neuro surgeon for consultation. The opposite party no 4 also noticed foot drop post trauma and prescribed medicines to the complainant no 1 and asked him to come again for review after one week. The opposite party no 4 in response to interrogatories also stated that he examined the complainant no 1 on 09.08.2016 and at that time the complainant no 1 was not having pain or any colour change in the limb besides this pulse rate was normal. The opposite party no 4 accordingly opined that it was a post traumatic common peroneal neuropathy (neuropraxia). However, the complainant no 1 did not come for follow-up after 09.08.2016. The main contention of the complainants against the opposite party no 4 and also argued by the counsels of the complainants is that the opposite party no 4 after noticing foot drop in the right leg of the complainant no 1 should have refer the complainant no 1 to the vascular surgeon which the opposite party 4 has failed to do so and as such the opposite party no 4 was negligent in discharge of his medical duties. The opposite party no 4 in response to interrogatories stated that pulses were normal and as such it was not necessary to refer the complainant no 1 to vascular surgeon. The opposite party no 4 was a qualified vascular surgeon and prescribed medicines including steroids besides physiotherapy to the complainant no 1as per his professional expertise. It is also not in dispute that the opposite party no 4 asked the complainant no 1 to come after one week for review but the complainant no 1 did not follow medical advice of the opposite party no 4. It appears that the opposite party no 4 took appropriate care towards the complainant no 1 and cannot be said to be negligent in the treatment of the complainant no 1. The complainants could not establish medical negligence qua the complainant no 1. The opposite party no 4 cannot be held guilty for medical negligence towards the complainant no. 1 and he is not liable to compensation to the complainants.

21. Now we shall examine and analyse the liability of the opposite parties no 2 and 3 for the medical negligence qua the complainant no 1. It is admitted fact that the opposite party no 3 was engaged with the opposite party no 2 as a consultant although opposite party no 3 was not under regular employment with the opposite party no. 2. Accordingly the opposite party no 2 shall also be vicariously liable for the acts of the opposite party no 3.

22. We shall now examine whether the opposite party no 3 is actually guilty of committing medical negligence qua the complainant no 1 while performing surgery on 04.08.2016 and in post-surgery care. It is apparent from the record that the opposite party no 3 on 04.08.2016 inserted medical condyle locking plate in right knee with screws under spinal anaesthesia for treatment of Tibial Condyle fracture of right leg of the complainant no 1. The complainant no 1 post-surgery did not feel sensation in the right foot. The opposite party no 3 on 05.08.2016 before recommending discharge of the complainant no 1 noticed foot drop and referred the complainant no 1 to the opposite party no 4 on 09.08.2016 who also noticed foot drop in right leg of the complainant no 1. The foot drop post traumatic is stated to be quite common in high velocity injuries around the knee joint especially in tibial condyle fractures which can be managed by orthopaedic surgeon and these injuries might take 6 weeks to 6 months before recovery. The opposite party no. 3 got pulse oximeter test done on the date of admission and post-operative day which was showing 100% reading and distal pulses were felt on clinical examination and accordingly the opposite party no 3 ruled out vascular injury. There was no apparent sign of vascular injury in the complainant no 1. The complainant no 1 when examined by the opposite party no 4 on 09.08.2016, the complainant no 1 was not having pain and there was no change in colour of the limb and the pulses of the complainant no 1 were normal which again ruled out any vascular injury in the complainant no 1. The opposite party no 4 being a neuro-surgeon opined that it was a post traumatic common peroneal neuropathy (neuropraxia) and prescribed short course of steroids and physiotherapy. It is reflecting with precision that till 09.08.2016 there was no apparent indication of vascular injury although the complainant no 1 was experiencing foot drop and accordingly there was no

necessity to refer the complainant no 1 to vascular surgeon due to reason of pulses being normal. The complainant no 1 was asked to come after one week for review but the complainant no 1 did not turn up after 09.08.2016 and did not contact opposite parties no. 3 & 4 for follow up action.

The injury to popliteal artery was first surfaced on 13.08.2016 when the complainant no 1 was taken to Yashoda Hospital where he was diagnosed with Right Lower Limb Irreversible Ischemia; Right Popliteal Artery occulusion; Foot Drop; Vitamin D Deficiency and Hyperthyroidism resulting into amputation of the right leg above knee of the complainant no 1.

22.1 We find support for these facts from the medical literature referred by the contesting parties. It is mentioned in the Article **Foot Drop written by Subhadra L. Nori and Micheal F. Stretanski: Stat Pearls Publishing; 2024, January** referred by respective counsels for the complainants and opposite parties that foot drop can result from compressive neuropathies, trauma, autoimmune, inherited, and spinal, as well as neurodegenerative, compressive, or psychological disorders. In the present case the complainant no 1 was victim of trauma i.e. road accident. The treatment for foot drop may begin with conservative measures such as physical therapy, splinting, pain control, and electrical stimulation. In the present case, the opposite party on 09.08.2016 prescribed physiotherapy and medicines for pain control. It is mentioned in article **Essential Orthopaedics** as referred herein above that a patient with a nerve injury commonly presents with complaints of inability to move a part of the limb, weakness and numbness and nerve injury may occur during an operation as a result of stretching or direct injury. It is important to refer textbook **Orthopaedics and Traumatology** with respect to popliteal artery injury wherein it is mentioned that the popliteal artery is injured often by a supracondylar fracture of the femur or comminuted T or Y intercondylar fractures of the lower end of the femur and also following knee dislocation. The popliteal artery can be damaged by the sharp edge of the fixed lower fragment. It is also mentioned that closed fracture injuries may also cause distal ischaemia or gangrene and the acute traumatic

ischaemia is commonly caused by the closed injuries. We would also refer article **Traumatic Blue Toe Syndrome with Tibial Plateau Fracture: A Rare Case of Foot Ischemia and Toes Gangrene in Spite of Patent Arterial Injury** cited by the counsels for the opposite parties wherein it is mentioned that t**ibial plateau fractures involve articular surface and condylar portion of the proximal tibia.** The counsel of the opposite parties also referred article **Delayed Presentation of popliteal artery transaction following undisplaced lateral condyle fracture of tibia** wherein it is mentioned that popliteal artery injury around the knee joint has been reported more frequent and common than any other major vessel injuries and this injury is associated with high energy trauma which includes knee dislocations or complex fractures of the distal femur or proximal tibia. It is also mentioned that the popliteal artery injury carries a high risk of limb amputation because initial clinical features present normal vascular circulation without the signs and symptoms of ischemia or obvious vascular injury. It is also mentioned that in such a type of injury the diagnosis could be delayed because the arterial deficit may progress slowly being the main cause of limb amputation.

22.2 It is apparent with high probability that due to road accident caused to the complainant no 1 popliteal artery, a crucial blood vessel located behind the knee in the popliteal fossa serving as the direct continuation if the femoral artery, of the right leg got damaged and such an injury is limb threatening medical emergency and injury to popliteal artery can cause damage to the peroneal nerve which is a major branch of the sciatic nerve originating from spinal nerves L4-S2 and controls sensation and movement in lower leg, foot and toes. It is appearing that the complainant no 1 felt persistence foot drop due to damage which might have caused to peroneal nerve. The popliteal artery injury around the knee joint caused to the complainant no 1was associated with high energy trauma as in the present case which includes knee dislocations or complex fractures of the distal femur or proximal tibia. The popliteal artery injury caused to the complainant no 1 due to road accident was coupled with high risk of limb amputation as resulted in case of the complainant no 1. In case of the complainant no 1, the initial clinical features present normal vascular circulation without the signs and symptoms of ischemia or obvious vascular

injury as the opposite party no 3 noticed normal distal pulses and oximeter showed 100% reading besides this there was no change in the colour of the foot of the complainant no1. The diagnosis of the complainant no 1 due to this reason was delayed as the arterial deficit related to popliteal artery progressed slowly and appearing to be main cause of limb amputation of the complainant no 1.The problem of damage to peroneal nerve could be treated by neuro surgeon like the opposite party no 4 and reference to vascular surgeon was not required. The opposite party no 3 accordingly referred the complainant no 1 to the opposite party no 4 due continuous foot drop which was a right way of treating the complainant no 1.

23. We have considered the prime contention of the complainants and as also argued by the counsels for the complainants that the complainant no 1 was able to move his right foot before the surgery but he lost sensation after surgery and the opposite party no 3 even after noticing foot drop on 05.08.2016 as evident from Doctor's Diary Progress Report did not take proper care for foot drop but recommended to discharge him on 05.08.2016 which is sufficient to establish medical negligence of the opposite party no 3. The counsels for the complainants after referring Report of Real Time Color Doppler Ultrasonography of Right Lower Limb Arterial System conducted on 13.08.2016 at Yashoda Hospitals and as referred herein above vehemently argued that diagnosis of injury to popliteal artery resulting into ischemia is important and initial assessment plays an important role. It is correct that the opposite party no 3 on 05.08.2016 and opposite party no 4 on 09.08.2016 noticed foot drop but did not prefer or chose to conduct additional tests such as ultrasound Doppler & CT argiogram to rule out vascular injury although it was contended on behalf of the opposite parties that distal pulses were felt and oximeter was showing reading of 100% and these symptoms ruled out vascular injury. We have already observed that the popliteal artery injury is coupled with high risk of limb amputation and the initial clinical features present normal vascular circulation without the signs and symptoms of ischemia or obvious vascular injury. The opposite party no 3 noticed normal distal pulses and oximeter showed 100% reading besides this there was no change in the colour of the foot of the complainant no1 after surgery on 04.08.2016. The diagnosis of ischemia was delayed as the

arterial deficit related to popliteal artery progressed slowly and was main cause of limb amputation of the complainant no 1. Even if it is presumed that the opposite party no 3 & 4 did not refer the complainant no 1 to vascular surgeon or did not prescribe additional tests as argued by the counsels for the complainants but at the most it can only be taken as error in assessment but cannot be accepted as medical negligence. The opposite parties no 3 & 4 and more particularly the opposite party no 3 acted in good faith after making suitable assessment of the condition of the complainant no 1 as per his medical expertise and acumen. There is absolutely no evidence that the opposite no 3 was negligent while performing surgery on 04.08.2016 and did not take appropriate post-surgery care. The complainant did not lead cogent evidence to prove negligence of the opposite party no 3 while performing surgery on 04.08.2016 or post-surgery as observed by the Supreme Court in **Dr. C. P. Sreekumar V S. Ramanujam** which was also referred by the counsels for the opposite parties.

The Discharge Summary prepared at Yashoda Hospital which was also referred by the counsels for the complainants reflected that there was non-opacification of popliteal artery over a length of approximate 4 cm at the level of joint space and below-s/o occlusion and complete loss of normal attenuation of muscles of leg with faint peripheral contrast enhancement which may represent ischemic myonecrosis and counsels for the complainants argued that amputation was caused due to right popliteal artery occlusion. We have already referred medical literature as cited by both parties. As per said medical literature popliteal artery is injured often by a supracondylar fracture of the femur or knee dislocation. The arterial vascular injury deserves attention as consequences are devastating and may involve amputation of the limb. The prompt diagnosis depends on two things which are clinical assessment of complications and careful Doppler assessment. The acute limb ischemia is a sudden decrease in limb perfusion that threatens limb viability and requires urgent evaluation and management and the prompt diagnosis and surgery reduce the risk of limb loss and morality. It is worth mentioning here that till 09.08.2016 there was no indication of vascular injury in the complainant no 1 although the complainant no 1 complained about foot drop continuously. The

opposite party no 4 informed the complainants no 2 &3 that the recovery might take 6 weeks to 6 months. The complainant no 1 did not turn up for follow up after 09.08.2016 and went to Yashoda Hospital only on 13.08.2016 and as such the complainant no 1 lost 4 days without further treatment which might aggravate problem of the complainant no 1. The argument advanced by the counsels for the complainants was without any force.

23.1 The counsels for the opposite parties countered prime allegation of the complainants that the opposite party no 3 did not take proper post-operative care by consulting vascular surgeon despite the complainant no 1 was complaining about loss of sensation in the right foot and argued that the opposite party no 4 examined the complainant no 1 who being neurologist prescribed the suitable medicines. It was vehemently argued that the lower limb of the complainant no 1 remained paralyzed for 4/5 hours due to effect of spinal anaesthesia and distal pulses were felt post-operative surgery and pulse Oximeter showed 100% reading. We have also considered the arguments advanced on behalf of the opposite parties that on 09.08.2016 right lower limb of the complainant no 1 was normal in colour and warm which ruled out any vascular insufficiency and the opposite party no 4 also on examination did not find any symptom of vascular injury. The Report dated 13.08.2016 pointed towards injury to popliteal artery which might have caused due to trauma i.e. the road accident on 03.08.2016 and there is no evidence that the injury to popliteal injury was caused during surgery conducted on 04.08.2016. We are in agreement with the arguments advanced by the counsels for the opposite parties that there was no negligence on the part of the opposite party no 3. We are convinced that the popliteal artery resulting in complete loss of normal attenuation of muscles of leg representing ischemic myonecrosis got injured due to road accident on 03.08.2016 and not during surgery conducted by the opposite party no 3 on 04.08.2016.

24. The complainant no1 unfortunately met with an accident on 03.08.2016 and received right tibial condyle fracture which resulted into amputation of right leg above knee. The sympathy is with the complainant no 1 and his family members who are the complainant no 2 to 4. The sympathy cannot replace burden to prove

medical negligence on the part of opposite parties. It was for the complainants to establish medical negligence by leading cogent and convincing evidence and mere assertions in complaint or deposition in affidavit tendered in evidence are not sufficient to establish medical negligence as observed by this Commission in **Nalini V Manipur Hospital & others.** The complainants pleaded negligence in treatment of the complainant no 1 and deficiency in service but could not prove that the opposite parties no. 3 & 4 were negligent in treatment of the complainant no. 1. The opposite parties 3 & 4 and in particular the opposite party no 3 treated the complainant no 1 and conducted surgery as per established procedure and protocol. The opposite party no 3 has acted like a reasonable man on considerations which ordinarily regulate the conduct of human affairs. There was no apparent or noticeable omission on the part of the opposite party no 3 in the treatment of the complainant no 1. The opposite party no 3 has taken appropriate care in the treatment of the complainant no. 1. There is no allegation against the opposite party no 3 that he breached an ethical protocol in the treatment of the complainant.

24.1 The opposite party no 3 as per **Bolam Rule** had exercised the ordinary skill of an ordinary competent man in the treatment of the complainant no1. The opposite party no 3 while treating the complainant no1 was possessing appropriate skill and knowledge for the purpose of treatment of the complainant no 1. The Supreme Court in **Jacob Mathew V State of Punjab** clearly observed that a surgeon cannot and does not guarantee that the result of surgery would invariably be beneficial to the extent of 100% for the person operated on and the only assurance which can be given is that he is possessed of the requisite skill in that branch of profession which he is practicing.. The opposite party no 3 followed a practice, protocol and procedure which are acceptable to the medical profession. It is correct that the complainant no 1 could not achieve desired result in improvement of his physical condition post-surgery and his physical condition get further deteriorated resulting into amputation but as observed by the Supreme Court in **Neeraj Sud & another V Jaswinder Singh (minor) & another** that deterioration of the condition of the patient post-surgery is not necessarily indicative or suggestive of the fact that the surgery performed or the treatment given to the patient was not proper or

inappropriate or that there was some negligence in administering the same. It is not always necessary that in every case the condition of the patient would improve and the surgery is successful to the satisfaction of the patient. It is not case of the complainants that the opposite party no 3 was not possessing requisite qualification or skill for the treatment. There is no evidence to prove that the opposite party no 3 failed to exercise due diligence, care or skill while performing surgery of the complainant no 1 on 04.08.2016. The opposite party no 3 cannot be held liable for medical negligence due to mere fact that the right leg of the complainant no 1 above knee level was amputated. There is no evidence that the opposite party no 3 has failed to exercise the due skill possessed by him in discharging of his duties i.e. during the treatment of the complainant no 1. The opposite party no 3 cannot be levelled with negligence as he performed his duties with reasonable skill and competence. The opposite party no 3 conducted surgery in good faith for the benefit of the patient i.e. the complainant no 1 and in accordance with recognized surgical practices and was not deviated from accepted medical standards or that the outcome was the result of any dereliction of duty by the opposite parties. There was no deficiency of service on the part of the opposite parties in treatment of the complainant no1.

25. We have considered the arguments and rival contentions of the contesting parties. A doctor is under an obligation to provide high quality, ethical medical care to the patients which involves diagnosis of illness and its appropriate treatment. A doctor is supposed to perform recognized medical procedures with skill and care with follow up actions. The doctors must treat patients attentively and consciously. Simultaneously medical negligence should not be infer in casual manner rather it must be established with cogent, rational and convincing evidence by the person who is claiming negligence qua medical professional. It is established on record that the opposite party no 3 had carried out all procedures during surgery and post-surgery with due diligence and in accordance with the prevailing medical standards. We in view of above discussion of the opinion that the complainants have failed to discharge the burden of establishing negligence or deficiency in service on the part

of the opposite parties. Accordingly, the present complaint is dismissed as being devoid of merit. The pending applications, if any, also stand disposed of accordingly.

.....
DR. INDER JIT SINGH
PRESIDING MEMBER

.....J
DR. SUDHIR KUMAR JAIN
MEMBER

SUKHBIR SINGH/Court-3/A