NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION
NEW DELHI

JUDGMENT RESERVED ON: 06.02.2026
JUDGMENT PRONOUNCED ON: 04.08.2026

CONSUMER COMPLAINT NO. 314 OF 2012

With

IA/6797/2020 (Impleadment of parties)

(1) Deepak Bansal, House No. B-IV/283, Pakhowala Bagh, Barnala, Punjab.
(2) Ms. Kiran Bala, W/o Mr. Deepak Bansal, House No. B-IV/283, Pakhowala Bagh, Barnala, Punjab. **.....Complainants**

Versus

(1) Satguru Pratap Singh Apollo Hospitals, Ludhiana through their Managing Director, Satguru Pratap Singh Apollo Hospitals, Sherpur Chowk, G.T. Road, Ludhiana.
(2) Dr. Siddharth Garg, Senior Consultant Neurologist, Neurology Department, Satguru Pratap Singh Apollo Hospitals, Sherpur Chowk, G.T. Road, Ludhiana.
(3) Dr.(Ms.) M. Deepender Singh, Senior Consultant Neurologist, Neurology Department, Satguru Pratap Singh Apollo Hospitals, Sherpur Chowk, G.T. Road, Ludhiana.
(4) Dr. Gaurav, Anesthetist, Department of Anesthesia, Satguru Pratap Singh Apollo Hospitals, Sherpur Chowk, G.T. Road, Ludhiana.

.....Opposite Parties

BEFORE :
HON'BLE MR. JUSTICE A.P SAHI, PRESIDENT
HON'BLE MR. BHARATKUMAR PANDYA, MEMBER

For the Complainant : Mr. S. Hari Haran, Advocate

For the Opposite Parties : Dr. Lalit Bhasin, Ms. Vishali S., Advocates

ORDER

PER HON'BLE MR. BHARATKUMAR PANDYA, MEMBER

1. The brief facts of the case, as stated in the complaint, are that Smt. Kiran Bala (C-2) was leading a healthy life. However, on 17.09.2011 she noticed that there was an unusual leakage of water/liquid from her nose. She went to a local ENT specialist at Barnala who advised her bed rest of two weeks. Being dissatisfied with this advice, her husband, complainant no. 1 took her to OP-2 (Dr. Siddharth Garg) at

OP-1 Hospital, who advised for immediate hospitalization. The leakage from the nose was stated by Dr. Garg to be due to crack in the nasal area and she was advised endoscopical surgery by way of which some part of the flesh from the thigh areas shall be operated upon and affixed at the nasal area to stop the leakage. Accordingly a surgery was performed on the Patient/wife of the Complainant on 21.09.2011 and it was informed that everything was under control. However, instead of getting better her condition started deteriorating and the leakage of the fluid had not only not stopped but had in fact increased manifolds. On seeing the condition of the patient, OP-3 Dr.(Ms.) M. Deepender Singh, Senior Consultant Neurologist and OP-4 Dr. Gaurav, Anesthetist advised the patient to go through a lumbar drain procedure. Initially on hearing this, the complainant and other family members refused for that surgery but due to continuous persuasion of the OPs, they agreed for the same. Finally surgery of lumber drain was performed on 24.09.2011 and the same day she was shifted to general ward at around 7 PM. Soon thereafter, the patient experienced severe pain on her thighs and lower limbs. Around 6 to 7 painkiller injections were administered to her on the very night of the operation which yielded no results. The patient made repeated complaints of pain and numbness in thigh and in legs but complained At around 4 AM during the night, it was noticed that she could not feel her lower portion of the body and it was further noticed that the same was paralyzed.

2. However, when none of the treatment administered by OP-3 and 4 could yield any results it was suggested by them that she should be taken to another hospital for further management. Complainant shifted her to Medanta Hospital where MRI brain contrast test was conducted on her which clearly indicated that she got paralyzed due to the surgery performed by the OPs. Soon after the release from Medanta Institute of neurosciences, she was advised to approach Indian spinal injury Centre at New Delhi for the treatment. Upon visiting Indian Spinal Injury Centre on 02.12.2011, it was advised that there was no need of admission and the OPD treatment was started for which she was to visit the hospital regularly. Complainant hired a house on rent in the nearby area from where regular treatment could be taken. However, patient is still on wheel chair and is unable to carry out her

day-to-day activities. Being aggrieved, complainant filed a complaint before this Commission on 29.11.2012 alleging negligence of OPs in her diagnosis, treatment, surgery and post-operative care and consequential deficiency in service and praying for compensation .

3. The complaint was resisted by OPs by way of joint written statement filed by them on 27.12.2013 (Part I Vol. II). As per OPs, treating consultants and medical/nursing staff did their duty as per standard medical practice and there was no negligence or deficiency in service on their part. Hence the complaint is not maintainable and is liable to be dismissed in limine. As per OPs, the complaint was not maintainable as the patient (Mrs. Kiran Bala) who availed the services of the OPs was not made party to the complaint. However, this plea is academic in nature in as much as later on, an application no. IA/6797 of 2020 was filed by the complainant Deepak Bansal seeking impleadment of Kiran Bala as a co-complainant. This Commission vide order dated 18.03.2021 allowed the application and she was impleaded as a co-complaint. Order dated 18.03.2021 is reproduced below:

> *IA No. 6797 of 2020 has been filed by the Complainant seeking impleadment of Kiran Bala as a Co-Complainant as she is the patient and compensation for alleged medical negligence is being claimed for her treatment.*
>
> *Heard Mr. S. Hari Haran learned Counsel for the Applicant / Complainant and Mr. Lalit Bhasin learned Counsel for the Opposite Parties and perused the averments made in the Application. The said Application is allowed. Smt. Kira Bala is arrayed as Complainant No.-2. Amended Memo of Parties is taken on record.*

4. It is the averment of the OPs that correct line of treatment was given to the patient Smt. Kiran Bala and as such, there is no deficiency in service. As per Patient's history and examination, she was diagnosed with CSF Rhinorrhea. To confirm this diagnosis further tests i.e., CT cisternography and MRI were performed on her. Her relatives were explained in detail about the disease and the treatment available i.e., endoscopic repair/open craniotomy and repair of the CSF fistula. Her relatives were also informed that in 10 to 20% of the cases there is likelihood of recurrence of CSF rhinorrhea and in that case she may have to undergo open craniotomy and repair of the CSF rhinorrhea. It is further submitted that the surgery was uneventful and patient came out of anesthesia normally. The leakage of CSF from nose had stopped after surgery and there was no leakage detected on the day

of surgery that is 22.09.2011. However, on the next day i.e., 23.09.2011 it was noticed that there was a small amount of recurrence of leakage from her nose. Her relatives were again explained that there is a delay in healing of the repair defect as in some cases it takes time for glue and *fascia lata* to stick properly. In such type of patients if CSF flow is diverted via a lumbar drain which makes the area of repair dry, there are better chances of proper healing, and treating doctors advised that lumbar drain be placed for diverting the flow. Relatives of the patient discussed the same with a doctor known to them from Medanta Hospital and the said Doctor even talked telephonically with Dr. Deepinder Singh (OP-3), who explained them about the condition of the Patient, the recurrence of leakage and about need for lumbar drain. On receiving consent from the complainant, lumber drain procedure was performed under local anesthesia by OP-4 Anesthetist (Dr. Gaurav Kuthiala). The patient was attended properly at all time. However, in the morning of 24.09.2011, OP-3 doctor received a call that the patient was complaining of numbness and weakness in both the legs. Her MRI was done immediately. As per the report of the MRI, drain was inserted at the correct site and there was no evidence of any blood clot. However, there was a subtle hyper intensity in the cord suggestive of myelitis and arachnoiditis. The MRI brain of the patient was normal but MRI spine revealed that myelitis had progressed up to D2 level and this temporal progression of disease is typically seen in patients of transverse myelitis. OP-2 doctor was consulted and medication as per advice was started and even at that time there was no clinical sign suggestive of any infection like reddening of skin, discharge from drain insertion site, fever, headache, or raised blood counts. On the request of her relatives, the patient got discharged on 27.09.2011 morning. As per OPs the patient had misfortune of having been visited by transverse myelitis. At no point of time in the OP Hospital or in subsequent investigations (CSF Study, MRI) conducted at Medanta hospital, it was proved that she had developed CSF infection due to lumbar drain. Rather the progression of lesion kept on ascending from D10 level on 24.09.2011 at Opposite Party Hospital to D2 level in Medanta Hospital on 27.09.2011 even after the removal of lumbar drain. All allegations with respect to negligence in treatment and deficiency in service are completely baseless and frivolous. The paralysis of the Patient has no relationship

with the surgeries performed at or the post-surgery care provided during the patient's stay at the OP Hospital. Hence, the present Complaint ought to be dismissed.

5. The complainants filed common rejoinder to the written statement filed by the OPs. The Complainant also filed its evidence by way of affidavit on 13.03.2015 reiterating the averments made in the complaint. OPs also filed their evidence by way of affidavit on 18.05.2015 enclosing therein various medical literatures to support their contentions. Written arguments have also been placed on record by both the parties.

6. We have heard the counsel for the parties and perused the documents available on record. Learned counsels for both the parties were heard at length on 09.12.2025 and 06.02.2026 and following orders were passed:

09.12.2025

*"**1.** This is a complaint alleging medical negligence in the treatment of Mrs. Kiran Bala, who has been impleaded as a co-complainant on an application I.A. No. 6797/2020 filed by the complainant Mr. Deepak Bansal that has been allowed by this Commission vide an order dated 18.03.2021.*

***2.** Mr. S. Hari Haran, learned counsel for the complainant has given an outline of the chronology of events through a list of dates handed over by him urging that when she was about 36 years of age, she experienced a nasal discharge. She consulted a local ENT Specialist at Barnala, who advised her bed rest and further introduced her to one Dr. Siddharth Garg, the OP-2 herein, who is a Neurologist at Ludhiana. Dr. Garg according to the complainant advised hospitalisation and accordingly she was admitted in the OP-1 Hospital on 20.09.2011. The document brought on record of the Department of Emergency Medicine i.e. dated 20.09.2011 also records the time of arrival in the hospital at 9.30am and the mode of arrival is "walking".*

***3.** The complainant was informed that since there was a crack in the nasal area, therefore an endoscopy was to be conducted. The advice by Dr. Garg for admission is contained in his prescription dated 19.09.2011. This was done after the signing of the consent dated 22.09.2011. The consent has been signed by the complainant Mr. Deepak Bansal, who is the husband of the patient.*

***4.** On admission, the complaint of the patient was noted as suspected "CSF Rhinorrhoea". The patient also complained of Headache and Vertigo.*

***5.** The endoscopical surgery was taken up and the repairs were carried out. According to the complainant since the leakage continued even the next day, the patient was advised a lumbar drain procedure that was to be inserted through the spine to treat that part of the area beneath the skull that was required to be dried and then patched.*

***6.** Mr. Hari Haran then points out towards the operation notes dated 22.09.2011 prepared by the Surgeon namely the OP-3 Dr. (Ms.) M. Deepinder Singh, who conducted the nasal puncture after recording that the leak was identified.*

7. *As noted above, since the leak continued, steps for Lumbar drain procedure was advised that had to be undertaken.*

8. *Mr. Hari Haran then points out towards the anomalies recorded in the hospital records in respect of the MRI reports. He urges that prior to the repair procedure through endoscopy, the pre-operative and pre-anaesthetic check-up dated 22.09.2011 (page 53) records the existence of three MRI films, meaning thereby that MRI had been conducted and there were films available as recorded in the said document. He then points out that strangely there is no mention of any MRI in the check-list from the Operation Theatre to recovery dated 23.09.2011 which is at page 43 where the column against the MRI is blank. He therefore submits that the OPs had withheld the MRI's inspite of knowing the patient's condition, in as much as, if the MRI had been conducted on 22.09.2011, the consequences that were revealed later on of the paralysis of the two limbs that had set in (Myelitis), would have been existing, but the OPs failed to take appropriate steps and went ahead with the Lumbar Drain for which consent was taken on 23.09.2011 that was carried out.*

9. *On 23.09.2011, in the recovery notes of the Progress Sheets at 5.30pm, the patient had complained of discomfort and bilateral pain in both the lower limbs that was persisting. The recovery notes records that the pain was persisting from the "pre-procedure" time. The contention raised is that the patient went in walking, but came out with both her limbs paralysed with the performance of lumbar drain procedure. The MRI reports were withheld which the OPs did not disclose and their availability had been incorrectly reflected in the hospital documents as indicated above. It is submitted that on 25.09.2011 symptoms were noted of the downward movement of the pain and the recording of acute transfer of "Myelitis". It is urged that the symptoms regarding paralysis of the limbs were therefore clearly visible during the post-operative lumbar drain procedure which seems to have been carried without detecting the myelitis and treating the same and consequently, the patient became paralysed which indicates a clear negligence on the part of the OPs.*

10. *Mr. Bhasin, learned counsel for the OPs has urged that there has been no negligence in the surgery and the symptoms of the nasal leak were promptly diagnosed and appropriate steps taken in order to treat the nasal discharge. The allegations of the complainant were unfounded and are not maintainable.*

11. *At the outset, Mr. Bhasin has urged that the complaint itself was lodged by the husband Mr. Deepak Bansal, who was neither the patient nor was he authorized by his wife to file the complaint nor was he acting as an agent. The complaint has not been signed by the complainant and the addition of the patient as a co-complainant is seriously contested, about which objections have been raised in the written statement. It is urged that the affidavit that was filed along with I.A. No. 6797/2020 was also that of the husband and the Vakalatnama had not been signed by the patient, but by Mr. Deepak Bansal. He has pointed out to the 2014 Regulations, particular Regulation 2(d) to substantiate his submissions that Mr. Bansal cannot be treated even to be his wife's agent.*

12. *This lacuna was sought to be supplemented by a Vakalatnama dated 30.10.2020 and subsequently an affidavit on a 50 rupee stamp paper dated 23.08.2021 stated to have been signed by Kiran Bala adopting and endorsing the contents of the complaint has been filed that cannot be termed as a legal compliance. He submits that there is no amended complaint and the said affidavit confirms the fact that she had not instituted the complaint nor was it instituted in her name. The complaint had been filed in 2012, whereas this impleadment as a co-complainant on such a defective affidavit and pleadings came to be allowed on 18.03.2021 after almost 9 years of the filing of the complaint. He therefore submits that the very presentation of the complaint is neither in*

accordance with the procedure prescribed nor in fact is it a properly instituted complaint, as such the same cannot proceed for being considered.

13. *Mr. Bhasin urged that since he would not be available after lunch due to his engagement elsewhere, the matter may be adjourned to enable him to conclude his arguments on some other date.*

14. *As agreed, let the matter be listed on 06.02.2026."*

06.02.2026

"Heard Mr. S. Hari Haran, learned counsel for the complainant, and Dr. Lalit Bhasin, learned counsel for the opposite parties.

The arguments have been concluded on behalf of the opposite parties and rejoinder has also been given by the learned counsel for the complainant. A technical note has also been handed down on behalf of the opposite parties. The four judgments have been cited by Dr. Bhasin, two of the Supreme Court in the cases of ***Bombay Hospital & Medical Research Centre Vs. Asha Jaiswal & Ors. (Civil Appeal No. 1658 of 2010)****, decided on 30.11.2021 and* ***Mrs. Kalyani Rajan Vs. Indraprastha Apollo Hospital & Ors. (Civil Appeal No. 10347 of 2010)****, decided on 17.10.2023, and two of the National Commission in the cases of* ***N.V. Chandramohan Vs. Managing Director, Kovai Medical Centre and Hospital (Consumer Case No. 585 of 2014)****, decided on 15.09.2023 and* ***Mrs. Savitri Devi Vs. Dr. N.N. Khanna, Sr. Visting Surgeon, Mata Anandmai Chikitsalaye & Anr. (Revision Petition No. 82 of 2024)*** *decided on 26.11.2025.*

Learned counsel for the complainant has also invited the attention of the Bench to the observations made by the Apex Court in the case of V. ***Kishan Rao Zs. Nikhil Super Speciality Hospital and Anr. (2010) 5 SCC 513."***

7. Learned counsel for the complainants submits that due to medical negligence at the hands of the OPs, complainant was compelled to file the present complaint seeking compensation and damages for the negligent surgeries and deficient post-operative care by the OPs resulting into paralysis of the lower portion and limbs and permanent disability suffered at the hands of the OP. Complainant no. 1 took his wife to the OP-1 hospital for fixing the problem of unusual leakage from her nose. But little did they know that she will be paralyzed and will have to spend rest of her life on wheelchair. When none of the treatment administered by OP-3 and OP-4 could yield any results it was suggested that the Patient should be taken to another hospital for further management. Thereafter realizing that everything has gone out of control, the complainant took the decision to shift his wife to Medanta hospital. In Medanta hospital the complainant was made to understand that infection was due to surgery done by the OPs which resulted into paralysis of lower limbs of his wife. Complainant also took his wife to postgraduate Institute of medical education and research at

Chandigarh where she was detected with Myelitis. Myelitis is a disease involving inflammation of the spinal cord which disrupts central nervous system functions linking the brain and limbs. Treatment from Indian Spinal Injury Centre at New Delhi is going on since then. Negligence on the part of the OPs collectively left the complainant no. 2 and her family to suffer immensely throughout life. Complainant no. 2 is on a wheelchair and is not in a position to carry out her day-to-day basic activities and a tube has to be used for the removal of body waste. Complainant has relied on the following judgment of the Apex court:

(1) ***V. Kishan Rao Vs. Nikhil Super Speciality Hospital & Anr. (2010) 5 SCC 513***

48. *In the treatise on Medical Negligence by Michael Jones, the learned author has explained the principle of res ipsa loquitur as essentially an evidential principle and the learned author opined that the said principle is intended to assist a claimant who, for no fault of his own, is unable to adduce evidence as to how the accident occurred. The principle has been explained in Scott v. London & St. Katherine Docks Co. [(1865) 3 H&C 596 : (1861-73) All ER Rep 246] by Erle, C.J. in the following manner : (All ER p. 248 C-D)*

> *... where the thing is shown to be under the management of the defendant or his servants, and the accident is such as in the ordinary course of things does not happen if those who have the management use proper care, it affords reasonable evidence, in the absence of explanation by the defendants, that the accident arose from want of care.*

49. *The learned author at p. 314, para 3-146 of the book, Medical Negligence gave illustrations where the principles of res ipsa loquitur have been made applicable in the case of medical negligence. All the illustrations which were given by the learned author were based on decided cases. The illustrations are set out below:*

- *"Where a patient sustained a burn from a high frequency electrical current used for 'electric coagulation' of the blood (see Clarke v. Warboys [The Times, 18-3-1952 (CA)]);*
- *Where gangrene developed in the claimant's arm following an intramuscular injection (see Cavan v. Wilcox [(1973) 44 DLR 3d 42]);*
- *When a patient underwent a radical mastoidectomy and suffered partial facial paralysis (see Eady v. Tenderenda [(1975) 2 SCR 599 : (1974) 51 DLR 3d 79 (Can SC)]);*
- *Where the defendant failed to diagnose a known complication of surgery on the patient's hand for Paget's disease [see Rietz v. Bruser (No. 2) [(1979) 1 WWR 31 (Man QB)]];*
- *Where there was a delay of 50 minutes in obtaining expert obstetric assistance at the birth of twins when the medical evidence was that at the most no more than 20 minutes should elapse between the birth of the first and the second twin (see Bull v. Devon Area Health Authority [(1993) 4 Med LR 117 (CA)] , Med LR at p. 131);*
- *Where, following an operation under general anaesthetic, a patient in the recovery ward sustained brain damage caused by hypoxia for a period of four to five minutes (see Coyne v. Wigan Health Authority [(1991) 2 Med LR 301 (QBD)]);*

> • *Where, following a routine appendicectomy under general anaesthetic, an otherwise fit and healthy girl suffered a fit and went into a permanent coma (see Lindsay v. Mid-Western Health Board [(1993) 2 IR 147] , IR at p. 181);*
> • *When a needle broke in the patient's buttock while he was being given an injection (see Brazier v. Ministry of Defence [(1965) 1 Lloyd Rep 26] , Lloyd Rep at p. 30);*
> • *Where a spinal anaesthetic became contaminated with disinfectant as a result of the manner in which it was stored causing paralysis to the patient [see Roe v. Minister of Health [(1954) 2 QB 66 : (1954) 2 WLR 915 : (1954) 2 All ER 131 (CA)] . See also Brown v. Merton, Sutton and Wandsworth Area Health Authority (Teaching) [(1982) 1 All ER 650 (CA)]];*
> • *Where an infection following surgery in a "well-staffed and modern hospital" remained undiagnosed until the patient sustained crippling injury (see Hajgato v. London Health Assn. [(1982) 36 OR 2d 669 (Ont Sup Ct)] , OR at p. 682); and*
> • *Where an explosion occurred during the course of administering anaesthetic to the patient when the technique had frequently been used without any mishap (Crits v. Sylvester [(1956) 1 DLR 2d 502 (Ont CA)]).*"

> ***50.*** *In a case where negligence is evident, the principle of res ipsa loquitur operates and the complainant does not have to prove anything as the thing (res) proves itself. In such a case it is for the respondent to prove that he has taken care and done his duty to repel the charge of negligence.*

8. Per contra, it is the averment of the OPs that as per the complainant no. 2 (Patient) history and examination, she was diagnosed as having CSF Rhinorrhea. To confirm this diagnosis further tests i.e., CT Cisternography and MRI were done. After this her relatives were explained in detail about the disease and the treatment available i.e., Endoscopic repair/ open Craniotomy and repair of the CSF fistula. Patient's relatives were also informed that 10 to 20% of the cases there is a recurrence of CSF rhinorrhea and if it recurs Patient may have to undergo open craniotomy and repair of the CSF rhinorrhea. She was treated with due care and caution as per the standard medical practice and procedure keeping in view her complex medical conditions. At the time of surgery Patient's defect was identified endoscopically and was subsequently repaired using fibrin glue and *fascia lata* graft. But as leakage from the nose was detected on the next day of surgery, relatives of the patient were informed that lumbar drain procedure would be done in the patient. Lumbar drain is a procedure where a soft tube made of silicone is placed in the spinal's space through a skin to continuously drain CSF. OP-4 Anesthetist (Dr. Gaurav Kuthiala) did the lumbar drain procedure using local anesthesia. The procedure went on uneventfully and the Patient was shifted from OT to recovery room after the completion of procedure. Later on, she had some discomfort in both

thighs and legs which had started from pre-procedure time for which she was administered a small dose of pain killer in the recovery room. The discomfort settled down soon and she was shifted to the ward in stable condition by 6 PM on 23.09.2011. Even lumbar drain was also draining clear CSF. However, in the morning of 24.09.2011 she started complaining of numbness and weakness in both the legs. Immediately an MRI was done and the Consultant Radiologist gave his opinion that the drain was inserted at correct site and there was no evidence of blood clot. However, there was a subtle hyper intensity in the cord suggestive of myelitis and arachnoiditis. OP-2 Consultant Neurologist (Dr. Siddharth Garg) was consulted who started steroid and accordingly lumber drain was also removed on 25.09.2011.

9. During the course of hearing, Dr. Bhasin, on behalf of the OPs has contended that the arguments raised and as recorded in the order dated 09.12.2025 do not flow from the pleadings. It was submitted, on the basis of literature filed with the note titled "Imaging Review of Cerebrospinal Fluid Leaks, that CT cisternography is the gold standard for diagnosis and identification of the site of CSF leak which in fact was carried out by the hospital which was on the basis of such report. There is neither any evidence nor any medical literature nor any protocol shown by the complainant to establish that either MRI spine is a mandatory requirement or that MRI was in fact conducted before the main surgery. Similarly, neither before CSF leak surgery nor before lumbar drain procedure, the patient had any sign or symptom of, or reason for the treating doctors to suspect or rule out, Myelitis as alleged. Drawing from the article on page 9 of the technical note titled "Severe Myalgia associated with propofol sedation", it is explained that Myalgia is, though rarely, also a complication of medication of muscle relaxants and surgical stress. Mr. Bhasin drew out our attention to page 43-53 of the reply, being the medical record of treatment to support the contention that both the main CSF repair endoscopic surgery and that of placing the lumbar drain were carried out in sterile atmosphere and were uneventful and that there is no specific allegation also with regard to the conduct of the procedures. There is no substance in the contentions regarding the MRI report, and absence thereof as gold standard pre-investigation of cisternography was carried out. Due informed consents were obtained for both the procedures and that the the

professionals treating the doctors, who have vast experience and reputation in their respective fields, have acted with due and necessary skill and care and there is no evidence on record of any malfeasance or nonfeasance or negligence or wrong diagnosis or wrong treatment on the part of any of the professionals or the hospital. There is no expert opinion also placed on record by the complainant opining or technically bringing out deficiencies on the part of the Hospital or doctors. A series of Supreme Court decisions lay down that the finding of any negligence of treating doctors or hospital can not normally be arrived at in the absence of any expert opinion. Mr. Bhasin has also drawn out attention to the medical literature filed alongwith the evidence affidavits of OP to contend that the complication of myelitis can occur in few of the cases post-procedure which seems to have occurred in the present case. The occurrence is mainly idiopathic or a consequence of viral infection, and no doctor or hospital can or can be expected to guarantee against such unfortunate rare outcomes, and no negligence on that count alone, without any evidence in that behalf, can be imputed against the surgeon or the treating team. OP has relied on the following judgments of this Commission as well as Apex Court, and the other preceding judgments referred to and relied upon therein (below), to support the contention that for every unfortunate mishap which is encountered by a patient in the surgery, treatment or in hospital, though it is the natural tendency to find fault and blame the treatment, hospital and the doctors treating the patient, the hospital and doctor can not be balmed for the related complications and rare unfortunate outcomes for the patients. The medical professionals cannot be blamed and held negligent simply on the basis of the outcome or complications in the surgery or treatment unless it is established that there is deficiency in not following the standard protocol of treatment and in providing due care during the hospital stay. The complainant has produced or relied on no credible evidence at all to support conjectural allegations against the OPs:

(1) N.V. Chandramohan Vs. Managing Director, Kovai Medical Centre & Hospital in CC No. 585 of 2014 decided on 15.09.2023

*"**8.** We have considered the arguments of the counsel for the parties and examined the record. The complainant has neither given the instance of negligence nor adduced any evidence of negligence. The complainant relied upon 'discharge summary' and argued that as the opposite party itself had noted 'Cauda Equina Syndrome' in it, as such inference of negligence has to be drawn. 'Cauda Equina Syndrome' is the*

compression of a collection of nerves roots. Nerves send and receive electrical signals all across the body. When nerves root in the lumbar spine are compressed, cutting of sensation and movement occur, Nerve roots that control the function of the bladder and bowel are especially vulnerable to damage. According to medical literature as published in Medicine (Baltimore), National Library of Medicine dated 11.05.2018, that probability of 'Cauda Equina Syndrome', after undergoing single spinal administration of bupivacaine is 0.75%. Explanation for this complication is uncertain but could be due to needle or introducer trauma at the time of insertion or due to neurotoxic properties of bupivacaine. In the absence of any allegation/ evidence, it cannot be held that Dr. N. Amar had committed negligence in administering spinal epidural anaesthesia and nerve block as the chance of effect of neurotoxic properties is also there. Supreme Court in ***Jacob Mathew Vs. State of Punjab, (2005) 6 SCC 1 and Martin F. D'Souza Vs. Mohd. Ishafaq, (2009) 3 SCC 1****, held that in order to apply the principle of 'res ipsa loquitur' in the circumstances of a particular case, some evidence which, viewed not as a matter of conjecture but of reasonable argument, makes it more probable that there was some negligence, upon the facts as shown and undisputed, than that the occurrence took place without negligence. In the present case, there is chance of effect of neurotoxic properties of medicines as such by applying the principle of 'res ipsa loquitur' the opposite party cannot be held for committing negligence."*

(2) Bombay Hospital & Medical Research Centre Vs. Asha Jaiswal & Ors. in Civil Appeal No. 1658 of 2010 decided on 30.11.2021

35. *It may be mentioned here that the complainant had led no evidence of experts to prove the alleged medical negligence except their own affidavits. The experts could have proved if any of the doctors in the hospital providing treatment to the patient were deficient or negligent in service. A perusal of the medical record produced does not show any omission in the manner of treatment. The experts of different specialities and super-specialities of medicine were available to treat and guide the course of treatment of the patient. The doctors are expected to take reasonable care but none of the professionals can assure that the patient would overcome the surgical procedures. Dr Kripalani has been attributed to have informed the complainant that the patient's legs were not working but Dr Kripalani denied all the averments by filing of an affidavit.*

36. *As discussed above, the sole basis of finding the appellants negligent was res ipsa loquitur which would not be applicable herein keeping in view the treatment record produced by the hospital and/or the doctor. There was never a stage when the patient was left unattended. The patient was in a critical condition and if he could not survive even after surgery, the blame cannot be passed on to the hospital and the doctor who provided all possible treatment within their means and capacity. The DSA test was conducted by the hospital itself on 22-4-1998. However, since it became dysfunctional on 24-4-1998 and considering the critical condition of the patient, an alternative angiography test was advised and conducted and the re-exploration was thus planned. It is only a matter of chance that all the four operation theatres of the hospital were occupied when the patient was to undergo surgery.*

37. *We do not find that the expectation of the patient to have an emergency operation theatre is reasonable as the hospital can provide only as many operation theatres as the patient load warrants. If the operation theatres were occupied at the time when the operation of the patient was contemplated, it cannot be said that there is a negligence on the part of the hospital. A team of specialist doctors was available and also have attended to the patient but unfortunately nature had the last word and the patient breathed his last. The family may not have coped with the loss of their loved one, but the hospital and the doctor cannot be blamed as they provided the requisite care at all given times. No doctor can assure life to his patient but can only attempt to treat his patient to the best of his ability which was being done in the present case as well.*

(3) Mrs. Kalyani Rajan Vs. Indraprastha Apollo Hospital & Ors. in Civil Appeal No. 10347 of 2010 decided on 17.10.2023

34. Recently, this Court in a judgment in Harish Kumar Khurana v. Joginder Singh [Harish Kumar Khurana v. Joginder Singh, (2021) 10 SCC 291 : (2022) 1 SCC (Civ) 215] held that hospital and the doctors are required to exercise sufficient care in treating the patient in all circumstances. However, in an unfortunate case, death may occur. It is necessary that sufficient material or medical evidence should be available before the adjudicating authority to arrive at the conclusion that death is due to medical negligence. Every death of a patient cannot on the face of it be considered to be medical negligence. The Court held [Harish Kumar Khurana v. Joginder Singh, (2021) 10 SCC 291 : (2022) 1 SCC (Civ) 215] as under : (SCC pp. 299-300, paras 12-13 & 16)

> *'11. ... Ordinarily an accident means an unintended and unforeseen injurious occurrence, something that does not occur in the usual course of events or that could not be reasonably anticipated. The learned counsel has also referred to the decision in Martin F. D'Souza v. Mohd. Ishfaq [Martin F. D'Souza v. Mohd. Ishfaq, (2009) 3 SCC 1 wherein it is stated that simply because the patient has not favourably responded to a treatment given by doctor or a surgery has failed, the doctor cannot be held straightaway liable for medical negligence by applying the doctrine of res ipsa loquitur. It is further observed therein that sometimes despite best efforts, the treatment of a doctor fails and the same does not mean that the doctor or the surgeon must be held guilty of medical negligence unless there is some strong evidence to suggest that the doctor is negligent.*
>
> ***
>
> *14. Having noted the decisions relied upon by the learned counsel for the parties, it is clear that in every case where the treatment is not successful or the patient dies during surgery, it cannot be automatically assumed that the medical professional was negligent. To indicate negligence there should be material available on record or else appropriate medical evidence should be tendered. The negligence alleged should be so glaring, in which event the principle of res ipsa loquitur could be made applicable and not based on perception. In the instant case, apart from the allegations made by the claimants before NCDRC both in the complaint and in the affidavit filed in the proceedings, there is no other medical evidence tendered by the complainant to indicate negligence on the part of the doctors who, on their own behalf had explained their position relating to the medical process in their affidavit to explain there was no negligence.'*

***

36. As discussed above, the sole basis of finding the appellants negligent was res ipsa loquitur which would not be applicable herein keeping in view the treatment record produced by the Hospital and/or the Doctor. There was never a stage when the patient was left unattended. The patient was in a critical condition and if he could not survive even after surgery, the blame cannot be passed on to the Hospital and the Doctor who provided all possible treatment within their means and capacity. The DSA test was conducted by the Hospital itself on 22-4-1998. However, since it became dysfunctional on 24-4-1998 and considering the critical condition of the patient, an alternative angiography test was advised and conducted and the re-exploration was thus planned. It is only a matter of chance that all the four operation theatres of the Hospital were occupied when the patient was to undergo surgery. We do not find that the expectation of the patient to have an emergency operation theatre is reasonable as the hospital can provide only as many operation theatres as the patient load warrants. If the operation theatres were occupied at the time when the operation of the patient was contemplated, it cannot be said that there is a negligence on the part of the Hospital. A team of specialist doctors was available and also have attended to the patient but unfortunately nature had the last word and the patient breathed his last. The family may not have coped with the loss of their loved one, but the Hospital and the Doctor cannot be blamed as they provided the requisite care at all given times. No doctor can assure life to his patient but can only attempt to treat his patient to the best of his ability which was being done in the present case as well."

29. *Insofar as the applicability of principles of res ipsa loquitur, in the facts and circumstances of the case, it is to bear in mind that the principles get attracted where circumstances strongly suggest partaking in negligent behaviour by the person against whom an accusation of negligence is made. For applying the principles of res ipsa loquitur, it is necessary that a "res" is present to establish the allegation of negligence. Strong incriminating circumstantial or documentary evidence is required for application of the doctrine.*

30. *In Malay Kumar Ganguly v. Sukumar Mukherjee [Malay Kumar Ganguly v. Sukumar Mukherjee, (2009) 9 SCC 221 this court has observed in paragraph 34 as follows:*

> *"34. Charge of professional negligence on a medical person is a serious one as it affects his professional status and reputation and as such the burden of proof would be more onerous. A doctor cannot be held negligent only because something has gone wrong. He also cannot be held liable for mischance or misadventure or for an error of judgment in making a choice when two options are available. The mistake in diagnosis is not necessarily a negligent diagnosis."*

31. *The case in hand stands on a better footing, inasmuch as there was no mistake in diagnosis or a negligent diagnosis by Respondent 2. In the absence of the patient having any history of diabetes, hypertension, or cardiac problem, it is difficult to foresee a possible cardiac problem only because the patient had suffered pain in the neck region.*

(iv) N. V. chandramohan v. Managing Director, Kovai Medical Centre. CC/585/2014, order dated 15.09.2023, Para 8

8. We have considered the arguments of the counsel for the parties and examined the record. The complainant has neither given the instance of negligence nor adduced any evidence of negligence. The complainant relied upon 'discharge summary' and argued that as the opposite party itself had noted 'Cauda Equina Syndrome' in it, as such inference of negligence has to be drawn. 'Cauda Equina Syndrome' is the compression of a collection of nerves roots. Nerves send and receive electrical signals all across the body. When nerves root in the lumbar spine are compressed, cutting of sensation and movement occur, Nerve roots that control the function of the bladder and bowel are especially vulnerable to damage. According to medical literature as published in Medicine (Baltimore), National Library of Medicine dated 11.05.2018, that probability of 'Cauda Equina Syndrome', after undergoing single spinal administration of bupivacaine is 0.75%. Explanation for this complication is uncertain but could be due to needle or introducer trauma at the time of insertion or due to neurotoxic properties of bupivacaine. In the absence of any allegation/ evidence, it cannot be held that Dr. N. Amar had committed negligence in administering spinal epidural anaesthesia and nerve block as the chance of effect of neurotoxic properties is also there. Supreme Court in Jacob Mathew Vs. State of Punjab, (2005) 6 SCC 1 and Martin F. D'Souza Vs. Mohd. Ishafaq, (2009) 3 SCC 1, held that in order to apply the principle of 'res ipsa loquitur' in the circumstances of a particular case, some evidence which, viewed not as a matter of conjecture but of reasonable argument, makes it more probable that there was some negligence, upon the facts as shown and undisputed, than that the occurrence took place without negligence. In the present case, there is chance of effect of neurotoxic properties of medicines as such by applying the principle of 'res ipsa loquitur' the opposite party cannot be held for committing negligence.

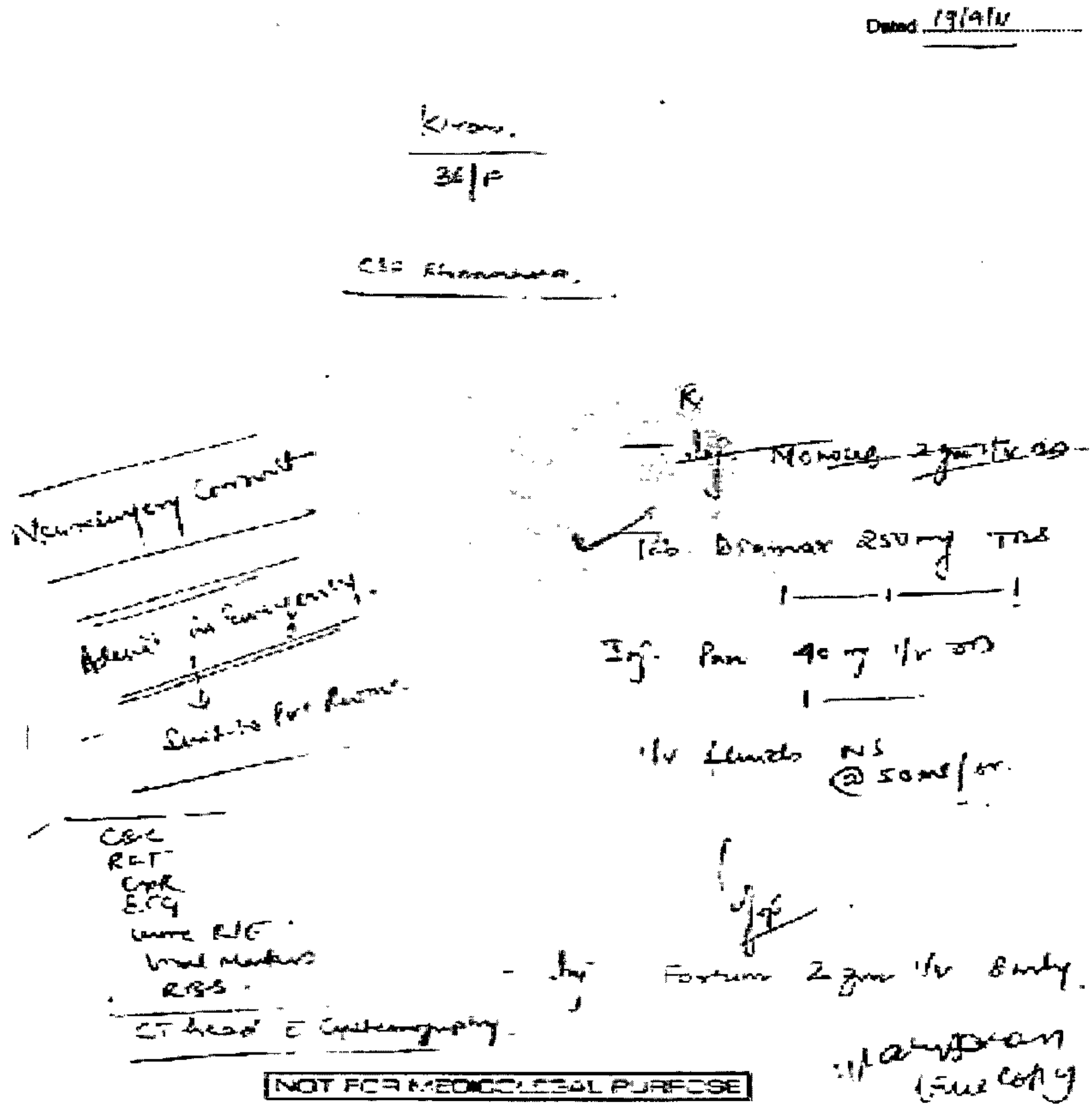
9. Allegation that the complainant was lured to undergo 'knee replacement surgery' by the opposite party has been denied. The opposite party stated that the complainant came to the hospital on 02.04.2014, complaining severe pain and stiffness in the left knee, with swelling, from last 2 months and also informed that he was diabetic and was on intermittent oral hypoglycaemic agents. The complainant was examined as an out-door patient by Dr. A.S. Thennavan, Senior Consultant Orthopaedician. On his pre-operative visit, his random blood sugar was 116 mg, which was normal and he did not have any symptoms of systematic involvement in diabetes. On examination, the

doctor found 'joint bone tenderness with limited range of movement associated with pain' in left knee. X-rays revealed Grade IV Osteoarthritic changes. There was no distal neurovascular impairment. General condition of the complainant was stable. The doctor counselled the complainant on various treatment options, which included conservative as well as invasive treatment in the form of knee replacement surgery. The pros and cons of both types of treatment were explained to the complainant. The complainant has concealed consultation on 02.04.2014. It is natural that if any patient consults with a doctor, then he would inform about all alternative modes of treatment. There is no allegation regarding negligence committed during treatment, for the period for which the complainant remained in the hospital.

10. In the rejoinder, Mr. Hari Haran has reiterated and read from the complaint paras 12 and 13 and stated that overall, the patient developed the severe Myelitis due to not only the procedures negligently carried out by the OPs, when the complaints of pain and numbness, which were the sign and symptoms of possible onset of Myelities as now understood, were repeatedly made, including telephonically to the OP-3 doctor, there was no serious investigation or treatment during the whole night and upto 5.30 pm of next day during which the patient had already lost the complete motor power of lower limbs. The patient is visited by the unfortunate outcome during and while under the exclusive care of the OP-1 Hospital and the treating doctors. Within 3 days of admission, and within 14-15 hours of lumbar drain procedure, a young patient of 36 years, with no co-morbidities, has lost her lower limbs and the bladder-bowel control, which cannot be merely the outcome of the complication unless the Hospital, nursing staff, resident and treating doctors have all been wholly negligent/deficient in also being knowledgeable and skilled and conscious and alive to the serious and likely complications from Lumbar Drain and in skillfully and knowledgeably identifying the risk-symptoms of pain and numbness which were rather completely overlooked. Thus, the facts are squarely covered by the principle of *res ipsa loquitur* and by the ratio of the Supreme Court decision in *V. Krishna Rao,* paras 49-50. The OP, apart from generally stating that they have taken every care and caution and that negligence can not be imputed without evidence brought in by the Complainant, or highlighting the absence of any expert opinion, have led no positive explanation and evidence as to how they are not negligent in the face of the evidenced loss of complete motor power within 15 hours under their care. The doctor's notes are sketchy and there is not specific visit or noting

between 530 pm of 23.09 and 10 am of 24.09 during which time the infliction was complete.

11. Having heard the parties, we may first extract the relevant pages from the record:


Dated

CBC
RFT
CxR
ECG

NOT FOR MEDICOLEGAL PURPOSE

Patient Name	Mrs. KIRAN BALA	Room No:	S15
Address	PAKHOWALA BAGH DARNALA PUNJAB INDIA	Hosp No :	188113
		IP No :	11/8475
Admission Date	20/09/2011	Age/Sex:	36 Yrs. /F
Discharge Date	27/09/2011		
Consultant(s)	Dr. Siddhartha Garg	Dr. Deepinder Singh	
	Neurology SR. CONSULTANT NEUROLOGIST	Neurosurgery, SR. Consultant Neurosurgery	

HOSPITAL COURSE:

Patient came with complaints watery nasal discharge. Patient taken up for repair of CSF Rhenorrhea endoscopically. On post operative day 1 patient had recurrence of CSF rhinorrhea, hence, lumbar drain was placed under LA by anesthetist. Next day patient started complaining of pain in thighs followed by progressive weakness of lower limbs. This weakness progressed in next 24hours to complete paraplegia with sensory level at D10. On CSF analysis, CSF- glucose was 88mg/dl, CSF protein 435 mg/dl, TLC 80 mm3, and Neutrophil 28%, Lymphocytes 72%, No AFB seen and no capsulated budding yeast cells seen. 2D MRI on 24-09-2011 and showed normal brain study. MRI spine showed normal study of cervical spine. MRI dorsal spine with contrast showed spinal cord myelitis with arachnoid enhancement. Inj. Methyl Prednisolone was given for 3 days. Patient has no improvement. Now attends have required for discharge. Patient to be taken to another hospital of their choice for further management.

ADVICE ON DISCHARGE:

Tab. Diamox	250 mg	PO	Thrice daily
Syp. Gelusil	3 tsf	PO	Thrice daily
Tab. Neksium	40 mg	PO	Once daily
Tab▶ Ceftum	500 mg	PO	Twice daily

SPECIFIC INSTRUCTIONS:

- Remove Merocele on 5th POD.

In case of Emergency please call (Phone: +91-161-6617111, 6617444) or your doctor Immediately.

Diet: As advised by dietician (Diet sheet enclosed)

Physical activity: As advised by physiotherapist

FOLLOW UP:

After 7 days in Ground Floor Neurology OPD Room No 019 with Dr. Siddhartha Garg.

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Discharge Summary

Patient Name	Mrs. KIRAN BALA	Room No:	515
Address	PAKHOWALA BAGH BARNALA PUNJAB INDIA	Hosp No :	188113
		IP No :	11/8475
Admission Date	20/09/2011	Age/Sex:	36 Yrs. /F
Discharge Date	27/09/2011		
Consultant(s)	Dr. Siddhartha Garg Neurology SR. CONSULTANT NEUROLOGIST	Dr. Deepinder Singh Neurosurgery, SR. Consultant Neurosurgery	

Allergies - Monocef

DIAGNOSIS:

- *CSF Rhinorrhoea*
- *Paraplegia with bladder & bowel involvement T10 level - ?Myelitis*

OPERATION PROCEDURE DONE:

- Endoscopic repair of CSF Rhinorrhoea

Operation Findings: Defect in, right fovea ethmoidalis identified and sealed using, Fat, fascia and glue.

- Post operatively Nasal cavity packed with merocele.

CHIEF COMPLAINTS:

Patient presented with c/o watery nasal discharge

GENERAL EXAMINATION:

Pallor: (-), Cyanosis: (-), Clubbing: (-), Oedema feet: (-), Oral cavity: (-), Lymphnodes: (-)
Temp: 98.4 degree F, PR: 80/min, BP: 130/80mm of Hg

SYSTEMIC EXAMINATION:

CVS : S1S2 normal, no murmur
R/S : B/L clear
Abdomen : Soft, non tender, BS (+)ve
CNS : HMF- Normal
Hallucination / Delusion - No
Cranial nerves - Normal
Motor system
Tone - Normal
Bulk - Normal
Power Rt 5/5 Lt 5/5

DTR's	B	T	S	K	A	Planters
Right	++	++	++	++	++	Flexor
Left	++	++	++	++	++	Flexor

Sensory system - Normal
Cerebellar - No
Meningeal signs - No
Gait - Normal

8 Vari Chron // true copy //

Mild frontotemporal cerebral atrophy is seen

No focal parenchymal enhancing lesion/enhancing exudates/acute vasculitic infarct or hydrocephalus seen in MRI brain.

Please correlate clinically.

Dr Shobhit Garg
Consultant Radiologist

Exam Performed On : 27/09/2011 19:28 By : ARJUN - Arjun Singh P

Report Prepared On : 28/09/2011 11:36 By : SHOBHIT - Dr Shobhit Kumar Garg

Report Authorized On : 28/09/2011 14:32 By Radiologist : SHOBHIT - Dr Shobhit Kumar Garg

Addendum Created On : 28/09/2011 14:32 By

MRI SCREENING WHOLE SPINE

Radiology Report

CONTRAST ENHANCED MRI BRAIN AND SCREENING WHOLE SPINE

Clinical details: Paraplegia. CSF leakage right side nose, post endoscopic repair.

Findings:

The study reveals that the brain parenchyma is normal showing no significant focal lesion. Bilateral basal ganglia and thalami are normal.

Opinion: Screening of spine reveals long segment intramedullary T2 hyperintense signal in the spinal cord extending from D2 vertebral level to the conus with minimal cord expansion and associated prominent meningeal enhancement along the surface of cord and conus, suggesting Myelitis and arachnoiditis. Suggest clinical and CSF correlation.

Mild frontotemporal cerebral atrophy is seen

No focal parenchymal enhancing lesion/enhancing exudates/acute vasculitic infarct or hydrocephalus seen in MRI brain.

Please correlate clinically.

Dr Shobhit Garg
Consultant Radiologist

Exam Performed On : 27/09/2011 19:28 By : ARJUN - Arjun Singh P

Report Prepared On : 28/09/2011 11:36 By : SHOBHIT - Dr Shobhit Kumar Garg

Report Authorized On : 28/09/2011 14:32 By Radiologist : SHOBHIT - Dr Shobhit Kumar Garg

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Medanta
Global Health Pvt. Ltd.
Radiology
CT Result Reports

Patient Name	Mrs. Kiran Bala	Encounter ID	10444716
Patient ID	MM00160093 Age/Gender 36Y/Female	Encounter Date	28/09/2011 18:41
Nationality	India	Order No	RDIP00000158558
Service No		Order Date	28/09/2011 18:41
Order Location	Nursing Unit/E-7th Floor NU1	Reporting Date	29/09/2011 09:51
Ordering Practitioner	Dr Sumit Singh	Reporting Practitioner	Dr Monika Aggarwal

Order Format	Is the Patient Pregnant	No

Clinical Comments:
Event Description:
Event Date Time : 29/09/2011 09:51
Results

Result Status

CT PNS/FACE/ORBITS (PLAIN)

Radiology Report

NON CONTRAST CT PNS ***28-09-2011***

Findings:

There is mild deviation of the nasal septum to the left side.
There is a tube seen in the right nasal cavity.
Right agger nasi cells are hazy.
There is mucosal thickening seen in bilateral frontal sinuses, right more than left. There is blockage of right frontal sinus recess.
There is diffuse haziness of anterior and posterior group of right ethmoid air cells and left anterior group. Right sphenoid sinus is hazy with non visualization of its inferior wall and blockage of right spheno-ethmoidal recess. The left sphenoid sinus is normal.
Air fluid level is seen in the right maxillary sinus with blockage of right osteomeatal complex.
Mucus plug is seen in the left maxillary sinus with patent left osteomeatal complex.
Nasal cavity is blocked due to hypertrophy of the nasal mucosa and middle turbinates.
Nasopharynx is unremarkable.
Bony margins of the sinuses and orbits are intact.

IMPRESSION

Right pansinusitis.

THE MEDICITY I nte

Medanta
Global Health Pvt. Ltd.
Radiology
MRI Result Reports

Patient Name	Mrs. Kiran Bala	Encounter ID	104447110001
Patient ID	MM00160093 Age/Gender 36Y/Female	Encounter Date	27/09/2011 15:27
Nationality	India	Order No	RDEM00000022882
Service No		Order Date	27/09/2011 15:27
Order Location	Clinic/EMERG & TRAUMA	Reporting Date	28/09/2011 11:36
Ordering Practitioner	Emergency Team	Reporting Practitioner	Dr Shobhit Kumar Garg

Order Format	Is the Patient Pregnant?	No

Clinical Comments:

Event Description:	Result Status
Event Date Time : 28/09/2011 11:36	
Results	

MRI BRAIN CONTRAST

Radiology Report

CONTRAST ENHANCED MRI BRAIN AND SCREENING WHOLE SPINE

Clinical details: Paraplegia. CSF leakage right side nose, post endoscopic repair.

Findings:

The study reveals that the brain parenchyma is normal showing no significant focal lesion. Bilateral basal ganglia and thalami are normal.

No restriction is seen on diffusion weighted images to suggest acute infarct.

Inferior cerebellar vermis is hypoplastic. Cerebellum is otherwise unremarkable. Brainstem is normal.

Empty sella is noted.

There is mild prominence of cortical sulci, sylvian fissures and basal cisterns, suggesting mild frontotemporal cerebral atrophy. Ventricular system

A thin continuous fluid signal intensity track is seen in the upper nasal cavity on right side reaching upto the right cribriform plate. However, no definite defect could be appreciated.

No abnormal parenchymal / meningeal enhancement seen.

Note is made of pansinus inflammatory mucosal disease (R>L).

Screening of spine reveals long segment intramedullary central T2-hyperintenstiy in the spinal cord extending from D2 vertebral level to the conus with minimal cord expansion. No abnormal flow voids are seen in the dorsal region. Prominent meningeal enhancement is seen along the surface of cord and conus. Straightening of cervical spine is seen with loss of normal cervical lordosis. Diffuse posterior bulge of C5-C6 and minimal posterior bulge of C6-C7 disc is seen indenting the thecal sac.

L5 vertebra is sacralized. Schmorl¿s nodes are seen in endplates of L1 & L2 vertebral bodies. Minimal posterior bulge of L4-L5 disc is noted.

There is no evidence of spinal canal stenosis. No evidence of cord compression is seen.

<u>Opinion</u>: Screening of spine reveals long segment intramedullary T2 hyperintense signal in the spinal cord extending from D2 vertebral level to the conus with minimal cord expansion and associated prominent meningeal enhancement along the surface of cord and conus, suggesting Myelitis and arachnoiditis. Suggest clinical and CSF

Sitaram's The Mercury:
Sector 18, Gurgaon, Haryana - 122 001, India
+91 124 4141 414 Fax: +91 124 4834 111

60

Mrs. KIRAN BALA
P. ID : 188113
D.O.B : 20/05/1975

SATGURU PARTAP SINGH
Apollo Hospitals
Ludhiana
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Doctor's Progress Notes

Form # SPSAH/13A

PAIN ASSESSMENT SCALE

0	1	2	3	4	5	6	7	8	9	10
No pain	Just noticeable pain	Mild pain	Uncomfortable pain	Annoying pain	Moderate pain	Just Bearable pain	Strong pain	Severe pain	Horrible pain	Worst pain

Date	Time	
		Pain Score (If applicable) :-
		Intervention if any :-
21/9/11		C/S Dr. ... Pain
		C/o headache — GC same
		No vomiting — afeb
		No fever — vitals stable
		Plan
		Continue same T/t
		Inj. Tramadol
		+ Inj. Emset 1/v stat
		(Sd/-)
21/9		CSB Dr ...
		History reviewed
		Plan
		Endoscopic CSF repair in case of
		... will try ...

12/05

(Sd/-)

Date	Time	
		Pain Score (If applicable) :-
22/9		Intervention if any :- s/b RMO on duty
		GC stable
		N/S - WNL
		1/o - adeq
		Afebrile
		DS - 9/0
		Adv - CST
		[illegible] to [illegible] on call [illegible]
23/[illegible]		Lumbar Drain
	4.30	Under all asepsis lumbar drain put in L3-4 space (R) para median approach using [illegible] [illegible] [illegible] lumbar drain put & tunnelled drain secured c [illegible]
		Adv -
		- Keep drain sac above bed level
		- [illegible]
		To stay supine [illegible] head lifting

[illegible signature]

Name : Mrs. KIRAN BALA
Pat ID : 188113
D.O.B : 20/09/1975

SATGURU PARTAP SINGH Apollo Hospitals Ludhiana
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Doctor's Progress Notes

Form # SP9A1

PAIN ASSESSMENT SCALE

0	1	2	3	4	5	6	7	8	9	10
No pain	Just noticeable pain	Mild pain	Uncomfortable pain	Annoying pain	Moderate pain	Just Bearable pain	Strong pain	Severe pain	Horrible pain	Worst pain

Date	Time	
		Pain Score (If applicable) :-
		Intervention if any :-
		Recovery Notes
23/9/11		
5.30 p		Post lumbar drain, pt Conc., awake
		Clear CSF draining out in
		Collection bag
		Vitals stable
		HR 88/mt
		BP 136/72 mmHg
		Afebrile
		Pt Complains of discomfort in bilateral
		lower limbs & persisting since
		procedure time
		VAS 2-3/10
		Adv • Inj Morphine 2mg ½ stat
		• Shift to ward.
		• Watch for fever, any change
		in sensation.
		• Inform Dr Devinder

12/0

Date	Time	
		Pain Score (If applicable) :-
		Intervention If any :-
28/9/13	5:20	CSB Dr Deepak
		Pt is a case of lumbar discitody eg.
		Clear c/o drag pass the drain
		Pt c/o mild pain in lower limb
		(? due to root irritation)
		c/o neuro limb weakness or sensory deficit
		Rx adv
		Start Rx as charted
		Inj Ceftriaxone and Tramadol
		to ... given
		... sign ... in c/o pallor
		[signature]

Name: Mrs. KIRAN BALA
Pat ID : 1881/3
D.O.B : 20/09/1975

SATGURU PARTAP SINGH Apollo Hospitals Ludhiana
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Doctor's Progress Notes

Form # SPSAH/13A

PAIN ASSESSMENT SCALE

0 No pain | 1 Just noticeable pain | 2 Mild pain | 3 Uncomfortable pain | 4 Annoying pain | 5 Moderate pain | 6 Just bearable pain | 7 Strong pain | 8 Severe pain | 9 Horrible pain | 10 Worst pain

Date	Time	
		Pain Score (If applicable) :- 8/10
		Intervention if any :-
24/9/11		C.S.B R/NO duty I/P complaints of severe pain in both legs and thighs weakness in both hands and legs Power :- 4/5 Inj (CSG).
25/9/11 10:00 AM		I/P C/O pain in bl. legs N/O weakness both legs O/E Power Bl Legs 4/5 Hands 4/5 Rx Tab MRI LS Spine urgent to R/p Reload.

Date	Time	
		Pain Score (If applicable) :-
		Intervention if any :-
24/9/11		Neurology Consult
		c/o weakness of Lower Limbs
		x today morning
		Plan:
		• Ct/ CE study
		[signature]
23/9/11 4 pm		GC & observation
		Pt is conscious & oriented
		Pt c/o Numbness & ↓ movement in LL
		O/E - [illegible] vitals WNL
		Systemic -
		P/A NAD, distended. Informed to Dr Sidd
		Plan Inj NEKSIUM 40mg IV Stat
		Inj DROTIN 80mg IV Stat
		[signature] 2192

66.

Name : Mrs. KIRAN BALA
Pat ID : 188113
D.O.B : 20/09/1978

SATGURU PARTAP SINGH
Apollo Hospitals
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Doctor's Progress Notes

Form #.SPSAH/13A

PAIN ASSESSMENT SCALE

0	1	2	3	4	5	6	7	8	9	10
No pain	Just noticeable pain	Mild pain	Uncomfortable pain	Annoying pain	Moderate pain	Just bearable pain	Strong pain	Severe pain	Horrible pain	Worst pain

Date	Time	
		Pain Score (If applicable) :-
		Intervention if any :-
	25/5/2011	c/o Dr. Siddhartha Garg
		AC + observation
		[illegible] [illegible]
decreased		[illegible] stable
sensations below umbilicus		Acute Transverse Myelitis
Tone [illegible]		
not moving lower limbs		
		Plan.
		- Continue Solumedrol
		Supportive [illegible] &
		Physiotherapy
		[illegible] 10061

Date	Time	
		Pain Score (If applicable) :-
		Intervention if any :-
25/9/23	9	CSB Dr Deepinder
		Patient is conscious, afebrile
		No improvement in motor power
		- No CSF Rhinorrhea
		- Lumbar drain Drain clear CSF.
		→ L/E - No redness / swelling / tenderness at the site of insertion.
		Adv
		Continue treatment as advised by neurologist
		→ Remove lumbar drain as there is no CSF rhinorrhea at present
		- will review SOS
		[signature]

Name : Mrs. KIRAN BALA
Pat ID : 1161113
D.O.B : 30/09/1975

SATGURU PARTAP SINGH Apollo Hospitals Ludhiana
touching lives

Doctor's Progress Notes

Form # SPSAH/13A

PAIN ASSESSMENT SCALE

0 No pain · 1 Just noticeable pain · 2 Mild pain · 3 Uncomfortable pain · 4 Annoying pain · 5 Moderate pain · 6 Just tolerable pain · 7 Strong pain · 8 Severe pain · 9 Horrible pain · 10 Worst pain

Date	Time	
		Surgery
		Pain Score (If applicable) :-
25/9		Intervention if any :- Urgent commit for abdominal
	7:30pm	distension
		Patient received
		Post op patient of Endoscopic
		repair of CSF rhinorrhoea,
		c/o abdominal distension
		since today morning
		Not passing stool & flatus
		x 4-5 day
		↑ vomiting
		c/o
		Conscious
		oriented
		Not in acute distress
		Pulse - 84/min

Complications

The principal complication associated with lumbar drain placement is infection, with rates as high as 4.2% reported in the literature.[6, 7, 8] . Antibiotic prophylaxis using a cephalosporin is typically given for the duration of the drainage.

Rarer complications associated with lumbar drain placement include nerve root injury or irritation associated with catheter placement. Overdrainage could also be associated with cranial neuropathy (particularly of the 6th cranial nerve), and formation of a subdural hematoma.[7] Accordingly, patients with a lumbar drainage catheter in place must be closely observed to prevent overdrainage with positional changes, such as standing from a seated or lying position without adjustment of the drain.

What are the symptoms of transverse myelitis?

Transverse myelitis may be either *acute* (developing over hours to several days) or *subacute* (usually developing over 1 to 4 weeks). Initial symptoms usually include localized lower back pain, sudden *paresthesias* (abnormal sensations such as burning, tickling, pecking, or tingling) in the legs, sensory loss, and *paraparesis* (partial paralysis of the legs). Paraparesis may progress to *paraplegia* (paralysis of the legs and lower part of the trunk). Urinary bladder and bowel dysfunction is common. Many patients also report experiencing muscle spasms, a general feeling of discomfort, headache, fever, and loss of appetite. Depending on which segment of the spinal cord is involved, some patients may experience respiratory problems as well.

In conclusion, the silicone subarachnoid catheter or teflon epidural catheter employed in a lumbar subarachnoid drainage system is very simple to use and efficacious in treating or preventing CSF fistulas. With a well-informed medical and nursing staff, complications should be minimal.

Complications of lumbar spinal fluid drainage.

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Abstract

Cerebrospinal fluid fistula is an unfortunate, yet well-recognized, complication of basilar skull fracture, skull base surgery, and neurotologic procedures. Treatment commonly involves the use of continuous lumbar drainage. A retrospective chart review of 32 consecutive patients who required placement of lumbar drain by the otorhinolaryngology and neurosurgical services from March 1988 through July 1991 was undertaken to assess possible complications. The complications found were readily separated into minor and major categories on the basis of the possibility of permanent morbidity or mortality. Minor complications, including subjective complaints of headache, nausea, vomiting, etc., were noted in 59% of patients. Major complications were observed in four of 32 patients (12.5%), including unilateral occlusion of the posterior cerebral artery and unilateral true vocal cord paralysis. Alleviation of all complications was achieved by cessation of lumbar drainage. These cases are presented with discussion of pathogenesis. These findings demonstrate the possibility of potentially serious complications that mandate close monitoring of patients who require continuous lumbar drainage.

2. Pain
   a. Nerve root irritation
      (1) Nerve root irritation may occur in relation to the position of the lumbar drain.
      (2) Signs and symptoms include presence of radicular leg pain, numbness or tingling, and changes in deep tendon reflexes.
      (3) Treatment includes changing the patient's position, slightly withdrawing the catheter, providing analgesic medication, or removing the catheter (Thompson, 2000).
3. Immediately life-threatening or serious complications
   a. Tension pneumocephalus
      (1) Tension pneumocephalus occurs in patients with a dural fistula resulting from a siphoning effect. A negative pressure gradient is created by the combination of head elevation and excess CSF drainage. As the fluid drains out, air enters the intracranial space at the site of the fistula.
      (2) Signs and symptoms include sudden decrease in level of consciousness or development of neurologic deficit (Graf, Gross, & Beck, 1981; Park, Strezlo, & Friedman, 1983).
      (3) Treatment includes shutting off the drainage tube, placing the patient in a supine or a slight Trendelenburg position, administering high-flow oxygen, and performing ongoing assessment. The physician should be notified immediately (Graf et al., 1981; Park et al., 1983).
   b. Herniation
      (1) Herniation may occur in the presence of increased ICP or result from CSF draining too rapidly, causing a downward shifting of intracranial contents (Bloch & Regli, 2003).
      (2) Signs and symptoms include decrease in level of consciousness, irritability, confusion, weakness, paresis, posturing, abnormal breathing pattern, and changes in pupillary reactivity and size.
      (3) Treatment includes blocking the drain, immediately notifying the physician, performing ongoing assessment, and implementing nursing measures to treat herniation. (See *Guide to the Care of the Patient with Intracranial Pressure Monitoring*, also from the AANN Reference Series for Clinical Practice.)
   c. Subdural hematoma
      (1) Subdural hematoma may result from overdrainage or from CSF draining too rapidly.
      (2) Signs and symptoms include decrease in level of consciousness, irritability, confusion, weakness, paresis, and changes in pupillary reactivity.
      (3) Treatment includes blocking the drain, performing ongoing assessment, and immediately notifying the physician (Thompson, 2000).
   d. Intradural hematoma
      (1) Intradural hematoma has been reported as a complication at the insertion site of a lumbar drain in thoraco-AAA repair (incidence rate 3.2%; Weaver et al., 2001). It may occur following drain removal.
      (2) Signs and symptoms include progressive lower extremity paresis, loss of reflexes, and decreased muscle tone.
      (3) Treatment includes immediately notifying the physician and performing ongoing assessment and potential surgical evacuation.

VI. Patient and Family Education

A. Explain the need to
   1. maintain head of bed position to promote accuracy and safety of treatment, because it reduces the risk of overdrainage (Thompson, 2000).
   2. request nursing assistance prior to any patient movement to prevent dislodgement, disconnection, or overdrainage (Thompson, 2000).
   3. avoid sneezing, coughing, or straining because it may increase CSF drainage. The physician should specify whether the patient is to avoid coughing or other Valsalva maneuvers (Clevenger, 1990).

B. Explain that there will be some discomfort at the drain insertion site or a mild headache after placement. Should discomfort occur, the patient should notify his or her nurse so that pain medications may be ordered and given as needed.

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Radiodiagnosis

Ref. No.	: 595133	Date	:24/09/2011
UHID	: 188113	Ack. Date	:24/09/11 01:00PM
Name	: Mrs. KIRAN BALA	Print Date	:24/09/11 04:28PM
Age / Sex	: 36 Yrs./F	Referred by	:Dr. Siddhartha Garg
Company	:CASH		
	: 11/8475	Bed No.	:536
Ward	: PRIVATE (FIFTH FLOOR		
Dept Ref No	:	Primary Sample:	
Method/Instrument	:	Result Date	: 24/09/2011 04:28:00PM

MRI- Spine (2 Region)

MRI CERVICAL SPINE WITH CONTRAST

Multi planar imaging of cervical spine were performed using T1 FSE, T2 FRFSE, T2 GRE sequences. T1 weighted sequences were repeated after I/V administration of contrast.

MR study shows straightening of the cervical curvature.

Normal vertebral body height and alignment are maintained.

Vertebral marrow shows normal MR signal intensity.

No canal compression is seen.

Visualized cervico-dorsal spinal cord shows normal morphology and signal intensity.

Neural foramina & exiting nerve roots are normal in appearance.

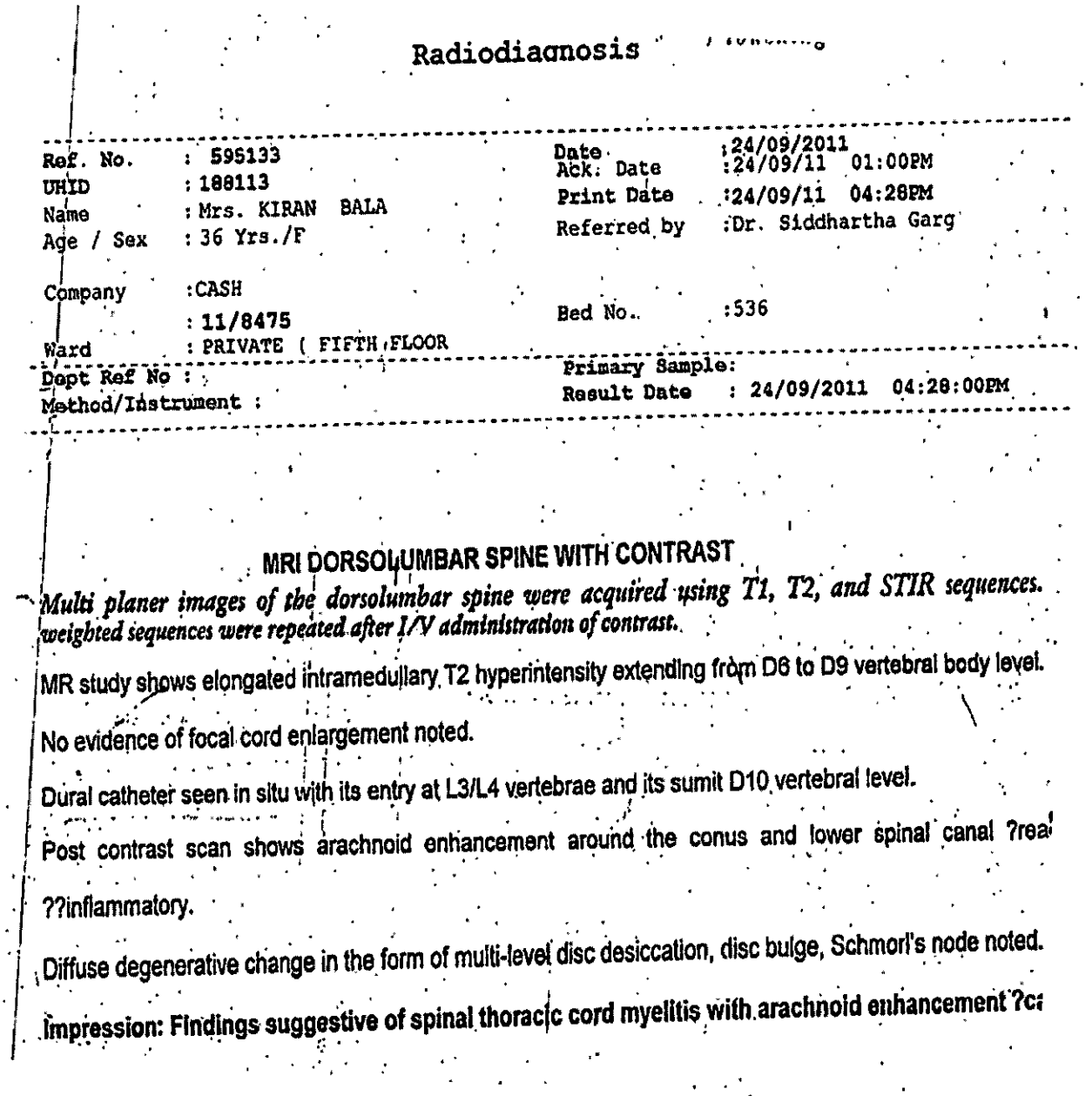
There is no evidence of AAD or cervico-medullary junction abnormality.

No para-spinal soft tissue abnormality seen.

Impression: An essentially normal study of cervical spine.

Dr.Siddharth Prakash (10077)
ASSOCIATE CONSULTANT
RADIODIAGNOSIS & IMAGING

Dr.Lovneesh Garg (10014)
HOD& SR. CONSULTANT
RADIODIAGNOSIS& IMAGING



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Method/Instrument	:	Result Date	: 24/09/2011 04:28:00PM

MRI DORSOLUMBAR SPINE WITH CONTRAST

Multi planer images of the dorsolumbar spine were acquired using T1, T2, and STIR sequences. weighted sequences were repeated after I/V administration of contrast.

MR study shows elongated intramedullary T2 hyperintensity extending from D6 to D9 vertebral body level.

No evidence of focal cord enlargement noted.

Dural catheter seen in situ with its entry at L3/L4 vertebrae and its sumit D10 vertebral level.

Post contrast scan shows arachnoid enhancement around the conus and lower spinal canal ?rea

??inflammatory.

Diffuse degenerative change in the form of multi-level disc desiccation, disc bulge, Schmorl's node noted.

Impression: Findings suggestive of spinal thoracic cord myelitis with arachnoid enhancement ?c

12. We have carefully considered the material on record including the affidavits of the treating doctors and the rival contentions and have carefully and minutely gone through the decisions cited before us and extracted above. The fundamental allegation, and question posed by the complainant in the complaint, is that a healthy, young and otherwise perfectly fine patient with no other complications or ailments, having suffered the ailment of CSF Rhinorrea, was admitted for CSF endoscopic surgery on 20.09.2011 and within three days of the admission and after two surgeries, was visited with

inexplicable consequence of Myelitis and paraplegia of the lower limbs with bladder and bowel involvement, for which the hospital and the treating doctors are answerable. More narrowly, it appears to be so and most relevant, the care, investigations and treatment during 24 hours, including absence of any specialist visit or advise or investigation qua the complaints of the patient during the critical night of 23.09.2011, from 530 pm of 23.09.2011 onwards, when the patient's pre-drain complaints of pain and numbness continued and exacerbated and were informed, up to 430 pm or so of 24.09.2011 when the MRI spine report was obtained after conducting MRI at 1 pm, is questioned for which the negligence and liability due to absence of specialist investigations, diagnosis and treatment is, fundamentally and inter alia alleged. As per the discharge summary at page 17 of the complaint, the patient was in the OP-1 hospital till 27.09.2011. The medical documents on record suggest that on 22nd, the CSF repair endoscopic surgery was carried out successfully and uneventfully by Dr. Deepinder, but on the next day of 23rd, the fluid CSF leakage was observed, which necessitated placing of the lumbar drain which procedure was carried out by experienced anesthetist Dr.Gaurav, which also, as per the affidavits of the OP on records, was perfectly placed at around 3.40 pm. However, as per recovery notes on the progress sheet on page 62 of the OP's reply, the patient complained of discomfort in bilateral lower limbs persisting since pre-procedure time. It is also noted by Dr. Gaurav at 5.30 pm that "inform dr. Deepinder". It is the allegation in the complaint that the bilateral pain in the lower limbs continued and increased regarding which repeated complaints were made but apart from administering pain-killers no effective and meaningful consultation or investigation was carried out and consequently by 4 am of 24th, the patient experienced and suffered complete numbness in the lower limbs which was diagnosed as acute transverse myelitis on 25.09.2011 which also, as revealed subsequently, impacted the bowels and urinary bladder control. While it is the allegation that the surgeon Dr. Deepinder did not visit the patient despite the complaints of sever pain, the reply avers that the doctor had visited the patient at 9 pm on 23rd, though the medical record is silent about such visit or the advise, treatment or investigation if any suggested by Dr. Deepinder. On 24th morning, at around 10 am, MRI was directed which was conducted at 1.00 pm and the report, received at 4.30 pm which is suggestive of "spinal thoracic cord myelitis with arachnoid

enhancement?" and also "arachnoid enhancement around the conus and lower spinal canal". The doctor's notes from the time of lumbar drain at 4.30 pm till the diagnosis of "acute transverse myelitis", at pg 62-66 are perused by us along with the explanation about the occurrence of the myelitis as given by the OPs in the reply and in the affidavits. After minutely perusing the same, we observe that there was no history of any spinal complaint or any averment or explanation of the OP of any co-relation of lumbar spinal region and nerve functioning therein with the CSF Rhinorrhea or surgery, as either pleaded or explained by the OPs. Nor is there any specific explanation of Therefore, the position of the spinal inflammation and observations in the MRI has, in our opinion, to have its genesis at nowhere but in the procedure of lumbar drain. It has been explained through literature that the myelitis has idiopathic or viral origin, but none of these factors logically or medically seems attributable for the patient's infliction of myelitis. The patient's condition was otherwise fine and there was no spinal issue or issue of any viral infection affecting the spine, which also is subsequently concluded through CSF culture report. The OPs together were obliged, in our considered opinion in the present case, to provide a technical, self-explanatory and detailed explanation of (i) The most probable genesis of the onset of the Myelitis, and such accelerated progress within 15 hours resulting in motor power of 0/5, and (ii) the meaning and implication and most probable cause of findings as recorded in the MRI report alongwith explanation thereof and (iii) Why there is no periodic monitoring of motor power after the drain procedure (iv) Why the likely complication of onset of myelitis, or the pain/numbness in the lower limbs as symptoms of likely aftereffect/complications post drain-placement, when seen with the increased pain and numbness when in fact noted, was not considered critical, and if so considered, what steps of treatment/investigation were taken during the night. It is easy to label, and it may also in fact be, a complication or a phenomenon caused by or due to even a pre-hospitalisation event or infection, or which arose due to either some complication or some idiopathic reasons, but that does not explain the complete medical inaction to be conscious of, investigate and arrest the accelerated progress thereafter. As a matter of fact, we even fail to comprehend as to why, in the face of an unfortunate sudden Myelitis developing to a patient within a short time during the night, the Hospital itself as a responsible institute, and as a part of

self-learning and system-perfection measures, has not considered it fit to analyse the episode and has not placed the internal technical report obtained, if any, when the episode itself, considering the nature of the complaints with which a non-comorbid young patient of 36 years had been admitted and treated in the hospital, and which from the yardstick of any ordinary man, in any case, is not ordinary or acceptable, and when the particular risk itself has not even been mentioned in the likely risk in the consent form obtained by the hospital.

13. We are conscious of the fact that there is no positive evidence of any violation of or deviation from any treatment protocol on record, nor is there any expert opinion on record. Still, on the facts as emerging from the medical documents, we have come to a considered conclusion that the consulting and advisory notes of the treating surgeons and consultants leave much to be desired as the notes themselves lack continuity, progressive record of the condition of the patient and the treatment and the investigative directions and, on the other hand, reveals, that during the critical night of 23rd, no substantive action, urgency, care or investigative urgency is disclosed by the Medical experts and the whole team who were in charge of the patient or who were entrusted with patient care, or who, as pleaded, were telephonically informed. The MRI result itself, which showed inflammation at the drain-site, and which lead subsequently to the clinical diagnosis of Myelitis involving bladder and bowels, was received on 24th at 4 pm, which, as is obvious, could have come much much earlier, when it is indeed not the case of the hospital or otherwise inferable that the patient condition required any restriction on movement for shiting the patient for MRI. Though lumbar drain is stated to be a mere "bed side" procedure, and though there is no positive evidence led by the complainant or otherwise emerging from the record, of any negligence or lack of skill or application of such skill in the procedures themselves, the outcome and diagnosis of Myelitis within 24 hours of the procedure of lumbar drain would strongly lead to the circumstantial conclusion that the most probable cause of Myelitis, in the facts of the present case, suffered by the patient is categorically to be found, on preponderance of probability, only in the procedure of placing lumbar drain, though, we would refrain from rendering any such finding of a negligent and defective or deficient expertise of Dr. Gaurav, who undertook the procedure, in deference to and in light of a series of

Supreme Court and this Commission's decisions relied upon by the OPs which lay down that the finding of deficiency in the medical procedure or the treatment or skill and medical decisions of the professional cannot be arrived in the absence of positive evidence thereof and unless the medical and academic expert opinions are obtained and available, which technically lead credence to such conclusion. Though a minute perusal of the decision of the Supreme Court in *V. Krisna Rao*, particularly para 38 onwards as exemplified by instances and observations in para 48-50, would indicate that the principle of *res ipsa loquitur* can be and should be invoke in appropriate cases based on facts, and that an expert opinion also may not always be necessary, we are of the considered opinion that it would not be safe and proper to conclude that the placement of lumbar drain itself was deficient in any way or exhibited any lack of expertise because though most likely, it is impossible to conclude the same on the basis of available evidence. As such, the likelihood of the emergence of Myelitis can at least theoretically be attributable to even the pre-hospitalization infection or even to accidental movement by the patient herself, we are of the opinion that an expert's endorsement was necessary before we could validly conclude any deficiency in the lumbar drain placement process itself and therefore we also conclude that the onset and sudden acceleration of Myelitis itself it is no evidence of any medical negligence or deficiency in the procedure. It even remotely does not appear to us that there was anything deficient or wanting with regard to the conduct of the first CSF repair surgery.

14. Nevertheless, the circumstances do suggest to us that the repeated and pre-procedure complaints of the patient of continuing pain and increasing numbness in the lower limb, and enhancement therein after the procedure, in any case, needed to be taken as an alarm by the medical officer and caregiving team leading to proper communication with the experts because it is evident from the final quick outcome that though rare and infrequent, but a very serious and life-changing complication could and did arise from or after the procedure as a complication. The team of experts and residents, within the parameter of normal possession and application of expertise, skill and technical knowledge can validly be expected to be on an enhanced degree of responsiveness and urgency in calling the higher experts, carrying out the investigations, and take appropriate steps even remotely indicative of the complications

likely from the surgery or procedure, when the procedure undertaken is also likely to cause as serious a complication as Myelitis. It is not clear, as indeed it cannot be, as to whether any more urgent and more timely MRI and the diagnosis of inflammation, which otherwise clinically is also noted in the doctor's notes, in the area of drain could have prevented the injury or complication or the extent thereof. What we do see is that there is no proper and satisfactory explanation about the time consumed by the hospital's system from 5.30 pm of 23rd when the patient was already complaining of pain and numbness in the thighs and in the legs to 1 pm of 24th before the MRI result and consequent consultation and treatment could start, particularly in the face of the repeated and continuos complaints of "pain and numbness in the lower limb". The whole team, the resident incharge and the nursing staff could and should have obviously been able to clinically take measure/diagnose the continuing reduction in the motor power of the lower limbs, indicative of some urgent investigation or treatment. On 24th when RMO visited the patient, the motor power of the lower limb had already reduced to one out of 5. The treating surgeon Dr Deepinder and the anesthetist who placed the lumber drain, should have sensitised the resident doctors and the nursing incharge and staff to exhibit extra urgency and preparedness to be looking out for the signs of loss of senses in the lower limb and more appropriately seeking and insisting for the expert opinions. The hospital system itself should have ensured speedier MRI and speedier expert-neuro advise which perhaps could have resulted in the speedier diagnosis and treatment. Our final conclusion is that there is collective lack of urgency with which the team of incharge experts and the hospital's system could have responded given the procedure underwent and the complaint/feed back constantly provided by the patient. There is some lack of transparency and clarity in the doctor's notes, which could have provided more detailed picture of the line of technical pros and cons, the decisions, if any, taken during the night and the treatment options considered.

15. After noting that we are unable to find any positive deficiency in the conduct of the procedure and the line of treatment when it was in fact provided, we still deem it proper to collectively hold the hospital, Dr. Deepinder and Dr. Gaurav Kathiala liable not for any positive medical negligence *per se*, but for not having sensitised and having prepared the team attending the patient in their absence during the night, of all possible

patient-complaints which needed further quick consultative and diagnostic actions, particularly those of continuing pain and numbness in the lower extremities in the context that lumbar region has been punctured and has continuing invasive in *situ drain*, which obviously need both additional specific care of the drain and quickness of identifying the signs of sensory loss. We are also of the opinion that after RMO noting on 24th early morning of pain, numbness and motor power of one out of five, the hospital system and protocol in such circumstances after such procedure, should have shown more accelerated, informed and expert response from the available or augmented expert resources while also ensuring the treating surgeon's and anesthetists visit, if so required. There is nothing in the doctor's notes or progress sheets as to what positive actions, particularly, to rule out or identify the likelihood of onset of myelitis, which was definitely required to be anticipated or foreseen as a likely complication of the lumbar drain procedure, were taken in response to the patients complaints.

16. The fact that the constant and more frequent monitoring of the patient particularly and including with reference to the complaints of pain or tingling or spasm or loss or reduction of sensation in the lower limbs of a patient who has been placed lumber drain is discernable even in the medical literature which has been placed on record by the OP and which has been extracted *supra*. Otherwise also, when the present experience has disclosed that the sensory loss in the lower limbs or Myletis has emerged perhaps within few hours of placing of the lumber drain and in any case was diagnosed within 20 hours of placing of such drain, would indicate that such caution and more involved and rigorous monitoring of the patient's condition was imperative. While it cannot be expected that the most experienced experts who handled the surgery/procedure themselves should be physically present at all the times, as revealed by the doctor's notes, the conduct of the team present in the hospital including the RMO, and Dr. Deepender when contacted telephonically by the RMO or by the complainant, is also clearly indicative of the conduct and caution which does not seem to match up to the requirements of monitoring of the patient post placement of the drainage in the face of evidenced loss of sensory power. As per page 60 of the OP's affidavit, [which though is not of any medical professional but of the AGM (Finance) Mr. Rajesh Gambhir,] part of which has been reproduced *supra*, the complications of the lumbar drain includes under

the category of "immediately life threatening or serious complications", inter alia, the complication of subdural hematoma, the treatment for which as mentioned includes blocking of drain, performing ongoing assessment and immediately notifying the physician. Such other life threatening complications are listed to be herniation and intradural hematoma all of which would require immediate actions. However, as can easily be inferable, even before the treatment, it is only the constant monitoring and informed evaluation of the patient's clinical condition and being conscious of the likelihood of such complications and being adequately prepared for meeting the eventualities is the compulsory and imperative component of the patient care, wherein, as per the evidence on record, the OP hospital and the incharge team, Dr. Deepender Singh, the surgeon incharge, and Dr. Gaurav Kuthiala, the anesthetist, have failed to ensure the necessary actions. The hospital and the doctors have filed more or less identical affidavits and in para 12 to 14 it has generally been averred that the patient was attended properly at all time. However, the affidavits, though mentions that Dr. Deepender had visited the patient at 9 PM, the medical documents record neither the visit by Dr. Deepender nor any advise or treatment prescribed by Dr. Deepender. There is no categorical explanation in the affidavits as to why the risk or likelihood of Myletis was not evaluated or investigated speedily and in any case it does not record or explain that whether after due application of mind even a decision to postpone, and if so, for what reason, the MRI or other investigation report are not considered relevant or necessary till 1 PM of 24.09.2011. It is the categorical averment also in para 13 of the affidavit that there was subtle hyper intensity in the cord suggestive of Myletis. We have also minutely gone through the literature to support the explanation of the OPs that the onset of Myletis is idiopathic or viral infection and it has nothing to do with care or treatment provided by the OP in as much as there is no sign or evidence of any infection at the drain site and there is no evidence to suggest that the lumber drain procedure has in any way caused the Myletis. Though we agree with Mr. Bhasin in this behalf, we do not agree that the degree of care, caution, preparedness and responsiveness to quickly identify and investigate the likely complication from lumber drain, has been exhibited by the incharge hospital team or by the attending professionals i.e. OP-1, OP-3 and OP-4. We also on the basis of the record conclude

that Dr. Siddharth Garg, OP-2, as and when the consultation was sought, has duly, timely and effectively responded leaving no room for any adverse observation or conclusion.

17. Turning to the quantum of compensation, after considering the totality of the facts and circumstances, and after considering the age of the patient, the financial, physical and emotional burdens faced by the patient and the family, and also the disclosures in the complaint and thereafter about the patient's progress in recovery and the expenses incurred on further treatment, and after considering the nature of deficiency of the hospital and treating experts as discussed and noted by us supra, we have found the claim of lump sum Rs. 2 crores damages as made in the complaint to be excessive, unfounded and exaggerated and not demonstrated to have any nexus with the quantum of financial loss or mental agony or stress to justify such astronomical sum. Though the complainant has filed the copies of bills/vouchers on 13.03.2015 along with the evidence, there is no table or summary of such expenses. On the basis of all these factors, we are of the considered opinion that a lumpsum compensation of Rs. 15 lacs with 6% interest from the date of complaint till the date of payment shall be just, reasonable and proper in the facts and circumstances of the case. We also direct that 90% of the liability shall be borne by the Hospital while 5% each shall be borne by the two doctors. The cost of Rs.25,000/- to be paid to the complainants shall also be borne by the Hospital. The order shall be complied with on or before 04.10.2026, failing which the enhanced rate of interest of 9% shall apply on the amount remaining unpaid from 04.10.2026 onwards.

18. The complaint is partly allowed.

Sd/-

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(A.P. SAHI, J.)
PRESIDENT

Sd/-

.....

(BHARATKUMAR PANDYA)
MEMBER

aj/