National Consumer Disputes Redressal

Ashish vs Fortis Hospital on 17 May, 2023

NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION NEW DELHI CONSUMER C

BEFORE: HON'BLE DR. S.M. KANTIKAR,PRESIDING MEMBER

For the Complainant :

Dated : 17 May 2023 ORDER

Appeared at the time of arguments:

For Complainant

:

Mr. Sandeep Kapoor, Advocate

For Opposite Party

:

Ms. M. Malika Chaudhuri, Advocate

Pronounced on: 17th May 2023

ORDER

1. The Complainant- Mr. Ashish (for short, the 'patient') filed the instant Complaint through his guardian - Raj Kumar against Fortis Hospital, Shalimar Bagh, Delhi (OP) for alleged medical negligence and deficiency in service, which resulted into his disability. He was seeking compensation of Rs. 2,90,25,000/-.

2. Brief facts are that Mr. Ashish - 23 years of age, met with a road accident in the afternoon of 09.11.2013 and suffered head injury, fracture right leg, hand and his right eye. He was taken to Rohtak Medical College at 7pm. The x-ray, USG abdomen and CT Head was done and it was informed that except fracture of right arm and femur, the USG and CT was normal. On the next day around 5 pm, he was shifted to Fortis Hospital (OP) and kept under supervision of Dr. Agrawal and Dr. Puneet Kumar Jain of Orthopedic Department. The patient was completely conscious, his Glasgow Coma Scale (GCS) was E4V5M6. On 11.11.2013, the patient suffered sudden breathlessness with tachycardia and de-saturation in the ICU and he was put on ventilator. It was due to alleged carelessness and non-presence of senior doctor. Further, his health was deteriorated day by day. It was alleged that CT Head and NCCT was performed on 11.11.2013, but the same was not reviewed by Neurologist. MRI brain was not advised. The patient was in unconscious condition since 11.11.2013 with GCS-E2M3V1, but no Neurologist or Neurosurgeon visited the patient till 20.11.2013 despite advice of Anesthesia and critical care team. At the first time on 20.11.2013, Dr. Amit Saha visited the patient and advised MRI brain. The MRI was reported as "extensive confluent area of cytotoxic edema with extensive petechial haemorrhages involving the bilateral fronto-occipital-parietal periventricular white matter, corpus callosum, cerebellar white matter and internal capsule". Since the condition of the patient was not improving because of carelessness and negligence of the treating doctor, the attendants decided to shift the patient to PGIMS, Rohtak. At the time of shifting, the attendants were shocked to see the patient's entire back, bottom and lower body had bedsores. It was alleged due to negligence of hospital authorities, because they had not provided proper care and facilities like Alpha bed. The Complainant further submitted that all the resources were exhausted and the family reached the stage of bankruptcy. Therefore, the patient was shifted to Govt. hospital, everything leaving in the hands of God. It was further alleged that after the discharged from OP Hospital, the OP Hospital did not provide ambulance to shift Rohtak Hospital. The patient was admitted in ICU in Rohtak Hospital. His condition was deteriorated. He was unable to sit or lie down, he was unable to eat by himself. His life was ruined due to negligence of the OP Hospital. Due to gross negligence, his brain damaged. The patient was discharged from Medical College Rohtak on 26.03.2014, however, his treatment and physiotherapy was still going at home. He was B.Tech (Electronics) and was working for a Japanese Company, but due to negligent treatment his future became completely dark at young age. Therefore, he filed the Complaint to claim Rs. 2,90,25,000/-.

3. The Hospital filed the reply through the facility Director Mr. Jasdeep Singh, who submitted that the Complaint was frivolous only misconceived and vague. The Complainant failed to prove an act of omission on the part of OP. He further submitted that after the road accident, the patient was admitted at PGIMS, Rohtak on 09.11.2013 and treated for one day. He took LAMA discharge and brought to OP Hospital at 4.00 pm on 10.11.2013. He was examined in the emergency room and had history of transient unconsciousness at the time of accident and then he became conscious. The SPO2 was 80% and it was improved to 90% after oxygen administration. He was admitted in the ICU. His pulse was 130 per minute. The Ortho Team examined him and observed that he had very low oxygen saturation. He was administered oxygen at 10 ltrs per minute. He suffered due to high velocity trauma. He suffered diffused brain axonal injury. His right leg fracture was treated at Civil Hospital, Jhajjar and was shifted to Medical College, Rohtak. The OP further submitted that due to multiple fracture of long bones, it predisposes to ARDS and diffused axonal injury. He was transported from Rohtak to New Delhi, which was pre-disposing factor for fat embolism. The OP submitted that the patient suffered Fat Embolism syndrome (FES). He relied upon the textbook - Rockwood and Green's Fractures in Adults, Finks Textbook of Critical Care. He further submitted that the patient was given proper treatment, therefore, survived from the life threatening complication of trauma because of timely intervention. The CT chest confirmed ARDS and MRI were suggestive of diffuse axonal injury and fat embolism. Such injuries carry high mortality and morbidity as described in the textbooks and literatures.

4. In the early morning at 5.55am on 11.11.2013, the patient became breathless and his oxygen saturation dropped, which immediately improved by assisted bag mask ventilation. The patient was immediately intubated and put on ventilator at 6.10 am. The informed consent for the same was taken. Consultant anaesthesia was also called immediately for anticipated difficult airway with special instruments. It has been duly recorded in the Anesthetist in the Doctors Daily notes that the relatives of the patient were explained the situation in detail and consent was taken for intubation and mechanical ventilation. The Anesthetist duly recorded in clinical notes that there was a suspicion of Fat embolism from long bone fractures or Venous Thromembolism.

5. Heard the arguments from the learned Counsel for both the sides. Perused the entire medical record and few medical literatures on the subject.

6. In the instant case, the contention of the Complainant was that he was taken to Fortis Hospital for correction of fracture. On careful perusal of medical record, it is the patient suffered high velocity trauma and initially on 09.11.2013, took a treatment at Civil Hospital, Jhajjar; and Medical College, Rohtak. The patient took LAMA discharge from Medical College, Rohtak and got admitted in OP Hospital on 10.11.2013 as an emergency. After relevant investigations, he was diagnosed as acute axonal injury. The patient further suffered respiratory distress, he was intubated and treated in the ICU throughout the hospitalisation from 11.11.2013 to 20.11.2013. Thus, the allegation of the Complainant that he was taken to OP Hospital for correction of fracture is not sustainable.

7. I have perused the few standard books on Orthopedics (Campbell's; Rockwood & Green's), which clearly mentioned about the more chances of Fat embolism in cases of high velocity trauma in the cases of fractures, long bones. The text is reproduced as below:

" Fat embolism syndrome( FES) after fractures is thought to occur from tissue damage caused by marrow embolization of marrow elements with their subsequent breakdown into toxic free fatty acids within the lung. FES may present with a wide spectrum of acute lung injury severity with oxygenation impairment ranging from mild asymptomatic reduction in oxygen saturation to ARDS with severe shunt physiology"

"The pathophysiology of FES is complex and probably has both a mechanical component and a secondary biochemical process. In the initial phase, fat and marrow displaced form the bones and enter the venous system, and travel through the heart to enter the lungs[1]. There the emboli may cause shunting sever hypoeximia and right ventricular dysfunction.fat may travel paradoxically to other organs via systemic circulation, either by transpulmonary passage or through an intracardiac shunt, most commonly through a patent foramen ovale. The secondary phase may involve inflammatory mediators responsible for interstitial edema or acute respiratory distress syndrome. Diagnosis of FES remains one of exclusion."

"Treatment of FES remains supportive, no specific drug regimens are recommended.".

"The sever hypoxemia associated with FES must be aggressively treated, usually with 100% oxygen via endotracheal tube. Even with ideal pulmonary care lung function may further deteriorate, with a clinical picture resembling Acute Respiratory Distress Syndrome. "

8. Considering the entirety in my opinion, due to high velocity trauma, the Complainant suffered deceleration injury i.e. axonal injury to the brain. Due to high inflammatory mediators in the long bone fracture he developed ARDS. However, due to sedation, the initial CT scan of brain showed normal result which remains for few hours to few days. In fact, the efforts of OP Hospital saved the life of the patient from the serious complications of the injury, however thereafter the Complainant raised such unwanted allegations. The patient was being weaned from ventilator and he chose to go back to Rohtak, Medical College, but for natural course of disease he tried to put blame on the OP hospital. It is also evident from the medical record that the patient was treated in ICU and provided the alpha bed to prevent bedsores. The OP-Hospital ICU Care was as per the standards, which did not show any deficiency in patient's management.

9. The law on medical negligence through various judgments is very clear. I would like to rely upon the case Jacob Mathew vs. State of Punjab[2], in which Hon'ble Supreme Court held as under:

"When a patient dies or suffers some mishap, there is a tendency to blame the doctor for this. Things have gone wrong and, therefore, somebody must be punished for it. However, it is well known that even the best professionals, what to say of the average professional, sometimes have failures. A lawyer cannot win every case in his professional career but surely he cannot be penalized for losing a case provided he appeared in it and made his submissions."

10. Recently, in the case of Dr. (Mrs.) Chandarani Akhouri & Ors V Dr.M.A. Methusethupathi & Ors.[3], the Hon'ble Supreme Court held in para (27) that:

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

11. It should be borne in mind that 'no cure is no negligence'. The doctors and the treating team at the OP-Hospital have treated the patient with reasonable standard of practice. The doctors made all the efforts to save the patient and treated him in the ICU throughout the hospitalisation. The patient took LAMA discharge and again got admitted in Medical College, Rohtak for further management. Thus, conclusively, there was neither failure of duty of care nor medical negligence attributable to the Hospital and the Doctors.

The Consumer Complaint is devoid of merit. The same is dismissed. There shall be no Order as to costs.

[1] FINKS Textbook of Critical Care [2] (2005) SSC (Crl) 1369 [3] 2022 LiveLaw (SC) 391 ..... DR. S.M. KANTIKAR PRESIDING MEMBER