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DISTRICT CONSUMER DISPUTES REDRESSAL COMMISSION, KANCHIPURAM DISTRICT @ CHENGALPATTU

PRESENT: THIRU. U.KASIPANDIAN, B.A., M.L., ... PRESIDENT
THIRU.M.JAWAHAR, B.A. L.L.M., ... MEMBER-I
TMT.K.A.VIMALA, B.PT., ... MEMBER-II

CC.No.77/2018
THIS WEDNESDAY THE 29th DAY OF APRIL 2024

P.Indirakumari,
Rep. by her husband and power agent
P.Leeladhar Rao,
Great Lakes, 303, 3rd Floor,
1, 7th Cross street, Lake Area,
Nungambakkam, Chennai - 34. :: **Complainant.**

//Vs.//

1. Gleneagles Global Health City,
   Rep. by Chairman,
2. Dr.Satheesh Grahadurai,
   Senior Consultant,

Both at Gleneagles Global Health City,
439, Cheran Nagar, Sholinganallur,
Medavakkam Road, Perumbakkam,
Chennai – 600 100. :: **Opposite parties.**

Counsel for the complainant : M/s.E.Nandakumar, Advocates.

Counsel for the 1st opposite party : M/s.T.Sai Krishnan, Advocates.

Counsel for the 2nd opposite party : M/s.N.Senthilnathan, Advocates.

This complaint having came up for final hearing before us on 17.04.2024, in the presence of M/s.E.Nandakumar, Advocates for the complainant, M/s.T.Sai Krishnan, Advocates for the 1st opposite party and M/s.N.Senthilnathan, Advocates for the 2nd opposite party, and having perused the documents and evidences of both and this Commission delivered the following:

ORDER

PRONOUNCED BY THIRU. U.KASIPANDIAN, PRESIDENT.

1. This complaint is filed by the complainant under Sec.12 of the Consumer Protection Act, 1986, opposite parties seeking direction, directing the opposite parties to pay 15 lakhs towards deficiency in service and to pay Rs.4,75,000/- towards mental agony totaling Rs.19,75,000/- and Rs.10,000/- as costs;

2. Brief averments in the complaint is as follows:-

The complainant begs to submit that he is filing this complaint on behalf of his wife Mrs. P. Indira Kumari aged 68 years. On 9.11.2017, the complainant's wife complained of some difficulty in moving freely to walk few steps to the toilet in the night and she felt a bit uncomfortable on 9.11.2017. The next day she consulted their family doctor Dr. Srikanth who diagnosed that she had shown symptoms of seizure and had prescribed medicines for the same. The said Family Physician advised her to undergo various tests and scan in this regard and to consult neurologist for review.

On 24.11.2017, his wife was brought to the 1st opposite party's hospital as out patient for review with Gleneagles Global Health City Hospital. She was advised to go for a review with Interventional Neurologist. Accordingly she consulted Dr.Srinath, the Head of the department of Neuro Science and the 2nd opposite party Dr.Satheesh Grahadurai at Gleneagles Global Health City. She was admitted on 29 11 2017. The hospital recorded her previous medical history as follows:

a. Mrs Indira Kumari 68 years, female, admitted with h/o weakness over left side of body on 14.11.17 recovered within 5 to 10 minutes.

b. No history of repeated weakness/seizures/vomiting/ENT bleed.

c. K/c/o DM/HTN on medication

d. Nil surgical history"

The complainant states that his wife was able to move all the limbs with a power grade of 5/5 of all limbs. Only from the night of 24.11.2017, she was having minor discomfort in moving her limbs. In order to avoid such occasional discomforts in mobility, she decided to take treatment to cure the minor discomfort in her limbs. The discharge summary records the sub title on examination of the patient in the following terms:

a. Moving all limbs

b. Power grade 5 in all limbs

c. Sensory exam normal - physical senses touch, smell, taste, hearing, sight normal

d. No cerebellar signs-no cerebellar diseases

e. Vitals stable all vitals were stable

f. Afebrile-not feverish"

She was moving all limbs with power grade 5. This discloses the fact that there was absolutely a normal functioning of limbs and no symptoms of recurrent attacks. The complainant further states that Dr. Satheesh Grahadurai conducted D.S.A test (Digital Angio of Brain). After examining the report of the D.S.A test, Dr. Satheesh Grahadurai advised a procedure for inserting a stent in one of the veins, on the right side of the brain. According to him, one vein on the right side of the brain is very thin with an opening of 10% only and suggested for inserting a stent in the said vein to make function 100% for the flow of blood. On 01.12.2017, Dr.Satheesh Grahadurai, 2nd opposite party, performed a surgical procedure known as RIGHT MIDDLE CEREBRAL ARTERY (M1 SEGMENT) INTRACRANIAL STENTING, under local anesthesia. The Discharge Summary observes in page 4, Course in Hospital *"patient tolerated the procedure well and there was no untoward reaction to contrast media. Patient's neurological status is the same as pre-procedure status".* The hospital findings are as follows; Arch vessels appear normal Also *"Peripheral pulses were well felt at the end of procedure. Patients neurological status is same as pre-procedure status".* The post

operative note discloses that post procedure, there was *"normal filling up of the branch vessels".* The opposite party observed the sudden onset of weakness of left side with dysarthria and left facial asymmetry approximately 6 hours post procedure. The discharge summary further reveals "on 3.12.17, patient had worsening of power on left side". The patient was advised aggressive physio therapy and continuous medical management. It is important to note here that on 4.12.2017 patient had improvement with" left upper limb grade 1 and left lower limb grade 2. *"Further after 6.12.17, it was noted" patient was currently having left hemiparasis with power grade 1/5 on upper limp and 2/5 in lower limb. Patient is advised to continue limb physiotherapy and speech and occupational therapy"* The patient was said to move all the limbs with a power grade of 5/5 of all limbs prior to surgery. Before the surgery, she used to walk without any physical support and she did not have any problem in respect to her speech. After the surgery, when she was in the ICU, even under the constant observation of doctors, she suffered the above said complications occurred and the complainant was informed that she had a paralytic stroke. The complainant states that his wife was 68 years old and that she had only weakness over left side of the body on a single day only on 9.11.2017. The doctor's advice after surgical procedure was for aggressive physiotherapy and continuation of medical management like limb physiotherapy, speech and occupational therapy. The complainant's wife was suffering from limited problems and minor discomforts in movement of limbs on 9.11.2017. Instead of giving treatment to provide with a remedy to minimize the above said problems, the opposite party's surgical procedure has caused her post procedural stroke requiring limb physiotherapy and speech therapy. Before the surgery she did not have any problems of her speech capabilities and she was also having a power grade of 5/5 of all limbs. The condition of patient during discharge was power grade 5 on right side, left 1/5 in upper limb, 2/5 in lower limb. The complainant's wife had minor problems in her limbs

making it uncomfortable for her to move about freely on 9.11.2017 and not before that. The opposite party instead of suggesting a non surgical way of treatment, had hastily carried out a surgical procedure which had worsened the condition of the patient. The opposite party should not have performed the surgery when there is possibility of such risk factors. Instead of curing the patient, the opposite party had left her with an attack of paralytic stroke involving non-movement of left hand and left leg, facial asymmetry and speech. A surgery in the brain is always like touching the tip of the iceberg. The opposite party claims that they have explained in detail the risks associated with the surgery, but if the complainant or his wife had been explained of such risks as stated in above paras, they would not have consented to the surgical procedure. They would have opted for alternate treatment. Nobody would choose fire from frying pan. Nobody would give consent for a surgical procedure which might result in paralytic stroke accompanied by weakening of limbs, speech power and also Left Facial UMN palsy. The complainant states that a written consent letter was obtained from him. But, it was never explained to him that there would be post operative complications like paralytic stroke and *"worsening of power on left side"* as noted in the discharge summary. Hence it is clear that it was not an "informed consent". After the surgical procedure his wife is completely sick without self mobility after the said paralytic stroke which was due to the unsafe medical advice and surgery performed by the opposite party. A willing suspension of disbelief on the part of the patients in respect to doctors and their treatment. The complainant's wife has been advised to undergo Physiotherapy for which complainant and his wife took lot of pains and incurred heavy expenditure to move up and down in the hospital for the said treatment on three occasions. All the aforesaid facts prove that the opposite party and their doctors had committed deficiency in service and the complainant's wife suffered only due to the negligence of the said Doctors of the opposite party, who treated her. The opposite party's hospital

in their reply to the notice has pointed out that the procedure was carried out uneventfully, but, the post procedure had left the patient with complications mentioned in the previous Paras. They themselves have admitted in para 3 in page 2 of their reply notice*. "the stent is precisely placed in the appropriate stenosed segment in order to improve the blood flow to the brain".* Hence it is proved from that the complainant and his wife were given false hopes and promises of *"improving the blood flow to the brain".* Further they claim in page 3 of their reply notice that the diagnosis was done properly upon careful consideration of the entire patient's medical history, test reports and medical opinion from the neurological specialists. The 1" Opposite Party's hospital in their reply notice stated that the patient was diagnosed with *"recurrent transient ischemic attacks (i.e., minus stroke)"* and the diagnosis itself is wrong because she had some discomfort only on 9.11.2017. Hence the diagnosis itself is wrong as the patient was not suffering with recurrent TIA. The patient was moving freely on her own without any physical support for undergoing different tests, for consulting the Neurologist and for OP treatment in the above hospital and subsequent to that as an in-patient. She was not bed ridden prior to the surgery. The Opposite Parties document A1, the discharge summary clearly brings out the fact that she got the major stroke inflicted on her when she was in the ICU after the surgery. In the multiple counseling sessions, it was only to explain the patient and complainant about the forthcoming procedure in the hospital. The pros and cons were not discussed with neither the patient nor the attendants. The possibility of a paralytic stroke was not at all suggested or opinioned by the 2nd opposite party or his team of doctors. The complainant and the patient and the other attenders would not have opted for the surgery, if they were informed about the possible paralytic stroke, after the insertion of the stent in the brain. The patient and the complainant knocked the doors of the 1st opposite party's hospital and sought the medical assistance of opposite parties only for remedy and cure for the patient's

minor problem of difficulty in movement of leg. Now, the patient is bed ridden seeking somebody's help for each and every day to day activities. Taking shelter under the consent letter and a wrong diagnosis of Recurrent TIA is nothing but the tactics of the opposite party to escape from the liability. The occurrence of the paralytic stroke while the patient was in ICU shows the inefficiency of opposite party and also the wrong course of event rendered to her. The patient came to the hospital as a normal person with a minor problem of difficulty in moving the limbs and not as a person suffering from paralytic stroke. After the insertion of stent, it was observed by the opposite party in their discharge summary in page 4 under the sub title *"procedure":*

a. *"Patient tolerated the procedure well and there was no untoward reaction to contrast media"*

b. "Patients neurological status is the same as pre-procedure status".

She was discharged as a paralytic with instructions on the therapies and medications along with Opposite Party's reviews. After inflicting paralytic stroke on the patient, the doctor did not think that it is their responsibility to make her as normal as was when she went for the DSA test, as normal as she was when she entered the surgery room for the insertion of the stent in the brain. The patient who entered the 1st opposite party's Hospital premises as a normal person who came for tests and remedy was sent out of the hospital as a paralytic with instructions to undergo therapy. She is now going to various hospitals for cure of the paralytic stroke inflicted on her. She spent 47 days in the Institute of Sidha at Tambaram from 15-02-2018 to 02-04-2018. *"She developed sudden onset of weakness of the left side with dysarthria and left facial asymmetry at 8.15 PM in the ICI on the day the stent was sent into the brain"* The statement that stenosed segment of MCA was stented precisely at the right area may be correct in their view but did not result in curing the patient. But the reasons for bringing down the power of the limbs, paralytic stroke, facial asymmetry and distorted speech are not explained. Normal understanding of lay man in the case of a paralytic stroke is as

follows: A patient who is inflicted at home with paralytic stroke if taken to hospital within an hour gets it reversed by treatment with injections and regains the original strength in the limbs affected by the stroke. The patient walked to all the places in the hospital on her own without any assistance (the OPD, surgery room for OST test and again to the surgery room for insertion of stent) for herself. It cannot be denied by the doctor. The statement in reply notice that the mobility condition of the patient was not in a stable manner is totally incorrect, abusive and mischievous. She was perfectly in a stable manner. The said statement is made out to justify their treatment and subsequent infliction of paralytic stroke. Her mobility condition was snatched away by the doctor after inflicting paralytic stroke in the ICU of the Hospital. The complainant, aged 81 years, who is expected to lead a peaceful life, is facing sleepless nights in taking care of his wife. He feeds her and helps her in taking medicines prescribed by the Hospital doctor. The opposite parties cannot disown the condition of the patient by prescribing some medicines at the time of discharge and therapies. The so called *"temporary condition is due to the infliction of paralytic stroke, on account of deficiency of service and medical negligence".* After four months of vigorous physiotherapy by qualified persons and by conducting the exercises required to restore the original status of the patient, she continues to lay in the bed cursing herself for the present state. She spent 47 days (15-2-2018 to 2-4-2018), along with her husband, in the Institute of Siddha, a Central Government Hospital under the control of Director General of Health Services for getting herself cured of the paralytic stroke. Even after 5 months after the infliction of the paralytic stroke, she is still bed ridden. The horrible memories of getting Paralytic stroke when she was in the ICU and the information of having got it inflicted on her has created mental agony. Their diagnosis is wrong, the treatment subsequently rendered was accompanied with risks, complications and adverse side effects. It is a blatant lie found in the reply notice is that the "patient and

attenders of completely understanding the benefits, risks, complications and possible outcomes of the intracranial stenting provided there" being an expressed content. The complainant affirms that no sane man would consent to such procedure if explained to him the risks, complications and adverse side effects from which his wife is suffering now. The complainant submits that the opposite party admits in para 4 page 3 of the reply to the notice that the said stroke suffered by the patient was clearly given as an inherent risk associated with the surgery which was duly explained to the patient and her attenders in detail". The reply in para 5 of page 3 further clarifies the outcome of the surgery in their own words "*power grade of limbs would just indicate one's physical ability which would very much depend on the occurrences of strokes and weakness of the limbs".* Their own admission that the patient had a *"complicated medical history wherein she had experienced recurrent strokes"* and also further averred that *"she was with a highly complicated medical condition, medical history and diagnosis"* is absolutely false. Even assuming that it was correct, if the patient was in the category of highly complicated medical condition, the opposite party should have been doubly careful in advising a surgical procedure of inserting a stent in the brain. This is a clear cut case of medical negligence. Complainant's wife was perfectly alright physically, when she went for consultation, for DSA test and for insertion of stent. She walked into the surgery room also for herself without any physical support. She got the paralytic stroke when she was in the ICU under the care of doctors. The hospital and the 2nd opposite party are squarely responsible for making a normal person a paralytic patient. The papers for the test as well as for the insertion of the stent were signed for cure and recovery only and not for making patient paralytic. Complainant's wife went for cure to the hospital but became paralytic, bed ridden and rendered with speechless condition, The patient was 68 years old. Instead of worsening her medical condition he could have treated her with any other alternate treatment. In spite of his complete knowledge of the

patient's medical history, he had undertaken to risk a surgical procedure associated with the brain. Normally, any tampering with the brain, is likely to result in nervous breakdown or paralytic stroke. If the opposite party had not performed the surgical procedure, the patient would have been suffering from only her earlier discomfort of mobility in limbs. On the contrary, the opposite party's surgery had rendered her bed ridden and left facial paralysis and loss of speech. Her condition had become likes from "smoke to smother" or "frying pan to fire". Sometimes the non performance of a surgery may not cure a patient but would not certainly complicate the pre existing lines. The opposite parties cannot take shelter under an evasive reply as given in their legal notice. The opposite party tries to escape from the liability that the unanticipated ischemic stroke event suffered by the patient evidenced as an inherent risk associated reply the procedure was purely unfortunate. This statement in para 6 in page 4 of the reply notice is quite contradictory. The opposite party admits that the stroke is an inherent risk associated with the procedure but he admits that was unanticipated. When the Opposite party is aware of the inherent risk, he should have anticipated the stroke, being a Senior Consultant in Neuro Intervention and Neuro Radiology. The Opposite Party cannot treat the patient as guinea pigs and venture to experiment on them. Sometimes it is better to avoid a surgical procedure in respect of senior citizens. Surgical procedures should be carried out only when the benefits are more and risks are less and are required to save the patient. The complainant has spent Rs.6,36,176/- towards hospital expenses. The patient would not have suffered much if she had been left with her earlier problems and if the Opposite party had taken a decision to treat the patient by avoiding surgery. The complainant is a consumer because he paid a valuable consideration from his pocket to the opposite parties for his wife's treatment. The complainant states that there is deficiency in service and unfair trade practice on the part of the opposite parties. The cause of action arises on

01.12 2017, the date of surgery. The opposite party hospital is situated within the jurisdiction of this Hon'ble forum. The complainant holds both the Opposite parties liable for deficiency in service and unfair trade practice. The complainant's wife was managing her physical discomfort in her limbs with pain killers and with the help of a maid. Now after the surgery she had been bed ridden requiring to take aggressive physiotherapy. The complainant and his wife are senior citizens. The patient at the age of 68 is advised aggressive physiotherapy by the Opposite Party because of the adverse effects of surgery. The complainant estimates his loss to the tune of 15 lacs because of the his wife's inability, post operative effects and bed ridden condition arising out of deficiency in service and unfair trade practice. He claims an amount of Rs.4,75,000/- towards mental agony and Rs.10,000/- towards posts. The complainant's claim against the opposite parties' is totaling Rs.19,75,000/- and Rs.10,000/- towards costs. The complainant prays that the Hon'ble Forum may be pleased to pass an order holding the opposite parties liable for deficiency in service and unfair trade practice. He further prays that this Forum may be pleased to pass an order directing the opposite parties jointly and severally pay Rs.15 lakhs towards deficiency in service, Rs.4.75.000/- towards mental agony totaling Rs.19, 75, 000/- and Rs.10,000/- as costs and any other order that may deem fit and necessary. Hence, the present complaint.

3. **The brief contention of written version of the opposite party is as follows:-**

At the outset, the opposite parties submit that the averments & allegations made by the complainant in the above complaint are all false, misleading and unsustainable under law, except to those averments which are specifically admitted herein and further put the complainant to strict proof of the same. The opposite parties respectfully submit that the patient namely Mrs.P.Indirakumari aged 68 yrs was first

brought to the out-patient department of 1st opposite party hospital on 24/11/2017 and was diagnosed with recurrent transient ischemic attacks (i.e., minor stroke) (right carotid circulation. It would be significant to point out that the patient had a medical history of hypertension diabetes mellitus & hypercholesterolemia and was on continuous medication for the same. Further, the complaints reported by the patient on her previous medical history & existing clinical condition along with the observations in the MRI report of the brain as provided by her at the time of OP consultation would clearly reveal that there were multiple acute lacunar infarcts recurrent minor strokes suffered by the patient in different territories of the brain. The CT Angiogram report of the brain also showed short segment of severe stenosis (90%) in bilateral M1 segments. **The Diagnostic digital subtraction angiogram DSA revealed significant stenosis more than 90% in the proximal right MI segment of MCA.** Hence, it is apparently evident that the patient had a blockage of 90% in the proximal right MI segment which was causing major interruption in the blow flow to the same. Given the medical conditions, the patient upon her in patient admission on 29.11.2017 was subjected to all necessary tests, baseline investigations as required under the standard medical protocol and was advised for Right middle cerebral artery (M1 segment) Intracranial stenting, which is clearly identified in several medical literatures to be the most appropriate treatment for a patient with such underlying clinical conditions, which continue to exist despite medical management. **The opposite parties further submit that it is quite evident from the medical history & test reports that the patient who was under continuous medical management has been encountering recurrent minor strokes on account of the 90% blockage which had to be mandatorily intervened by the intracranial stenting in order to prevent the major stroke. The treating doctors in view of the worsening condition of the patient and anticipating the complete blockage of the bilateral**

segments had duly advised the patient and her attenders for the intracranial stenting which is found to be the most minimally invasive non-surgical interventional procedure for treating the medical condition of the patient. In this regard, the treating doctors have had multiple counseling sessions with the patient, complainant & their sons and have explicitly discussed about the treatment options, the pros & cons of the procedure including but not limited to the associated risks which includes major stroke, complications & possibility of adverse outcomes in carrying out the same. It may also be noted that the said counseling document have been duly signed & acknowledged by the patient Mrs.P.Indira Kumari & her son one Mr.P.Girijasankar rao. Upon getting well acquainted with the treatment options, the benefits & risks of the intracranial stenting, the patient and complainant have given their expressed consent to the said procedure. Accordingly the said procedure i.e. Right middle cerebral artery (MI segment Intracranial stenning was planned and carried out on. It is very vital to point out that the procedure was carried out uneventfully as the stenosed segment of MCA was stented precisely at the right area which paved way to adequate opening of the stenosed segment and normal filling up of the branch vessels as evidenced in the patient's records. The fact that the patient was haemodynamically stable at the time of the procedure and that no neurological deficits were present after the completion of the same as evidenced in the relevant medical records would indeed indicate that the said procedure was clearly uneventful, which made her to be shifted to neuro critical care ICU. Hence, it is quite clear that the said procedure was conducted properly & without any lapses However, six hours post procedure (i.e., at 8.15pm on 01.12.2017) the patient unexpectedly and suddenly developed a stroke which was totally unfortunate & unpredictable. Upon occurrence of the stroke, the medical team had immediately raised the stroke alert and performed all the necessary

test including CT & MRI brain as per the standard medical protocols. Consequently, the patient was put under the appropriate medications upon the expert opinion given by the stroke team. It is imperative to point out that the said stroke suffered by the patient was clearly given as an inherent risk associated with the procedure which was duly explained to the patient, complainant and their sons in detail, as clearly evidenced in the counseling document and in the consent form. It is further submitted that the peri - procedural ischemie strokes are predominantly perforator strokes which occurs mainly due to forceful displacement of atheroma into perforator ostia. Subsequently, the patient was kept under medical management & constant observation in the ICU till 04.12.2017 for any signs of worsening of the effects of stroke. Since, the patient was found hemodynamically stable, she was then shifted to ward on 04.12.2017 and later discharged on 09.12.2017 with appropriate instructions on the supportive/rehabilitative therapies & medications along with required OP reviews. Para wise counter:

The averments stated by the complainant in para 1 & 2 of the complaint are not within the knowledge of the opposite parties and as such they are not inclined to comment upon the same. The averment made by the complainant in para 3 of the complaint that the patient had no history of repeated weakness is clearly misleading as it is quite evident in the OPD consultation record that the patient was having clear history of one week repeated attacks of left upper & lower limb weakness. Further the said repeated attacks of weakness is due to minor strokes sustained by the patient as clearly evidenced in the CT Brain & MRI Brain reports. The averment made by the complainant in para 4 of the complaint that the patient was able to move her limbs normally and that it was only from 24.11.2017 she was having minor discomfort in the limbs is totally false & deceitful, as it is apparently evident in the OPD consultation record dated 24.11.2017 that the patient was having clear history of one week

repeated attacks of left upper & lower limb weakness. The further averiment made by the complainant that the patient was only having occasional minor discomfort is clearly misleading and is in absolute contradiction with the medical history of one week repeated attacks of left upper & lower limb weakness as provided by the patient & complainant themselves at the time of OP consultation on 24.11.2017, which is more fully evident in the said OPD consultation record. It would be pertinent to point out that the conclusion/assumption arrived at by the complainant that the patient was functioning normally with no symptoms of recurrent attacks just because the power grade of her limbs were (5/5) only indicates the lack of medical knowledge on the recurrent minor strokes sustained by the patient& misconception about her clinical condition. Moreover, the averment of the complainant that the patient had no symptoms of recurrent attacks is clearly false as the patient had sustained repeated attacks of weakness even one week prior to the OPD consultation made in the OP.No. 1 Hospital on 24.11.2017 and CT & MRI reports, which are all matter of record. The averment made by the complainant in para 5of the complaint that O.P.No.2 advised for a procedure for inserting stent in one of the veins on the right side of the patient's brain and that the O.P.No2 opined that the vein on the right side of the brain was very thin with opening of only 10% who further suggested for inserting a stent in the said vein to make it function 100% for the flow of blood is false & misleading. In this connection, it is strictly contended that it was upon the initial evaluation of the patient's test reports, she was diagnosed with significant intra luminal blockage (>90%) in a major artery connecting to the right part of the brain and not thinning of vein, as wrongly alleged by the complainant. Further, the said problem was majorly interrupting the normal blood flow to the right part of the brain. Accordingly, the O.P.No.2 had only advised for a non-surgical minimal invasive interventional procedure which involves precise placement of a stent in the narrowed stenosed artery on the right side of the

brain to just improve the blood flow and that the patient was never assured of 100% blood flow, as wrongfully claimed by the complainant. The averment made by the complainant in para 6 of the complaint that O.P.No.2 performed a surgical procedure under local & IV anesthesia on the patient is clearly misleading as the said procedure namely Right Middle cerebral artery (M1 segment) intracranial stenting is only a minimally invasive non-surgical interventional procedure carried out under general anesthesia wherein there is a real time visualization of the blockage which is physically seen under fluoroscopic guidance and the stent is precisely placed in the appropriate stenosed segment. Further to it, the observations & findings in page 4 of the discharge summary as specified by the complainant pertains to the 4 vessel digital subtraction cerebral angiogram done on 29.11.2017 and not that of the procedure of Right Middle cerebral artery (M1 segment) intracranial stenting done on 01.12.2017. The averment by the complainant in para 7 & 8 of the complaint relates to a matter of record and as such the opposite parties are not inclined to comment upon the same. The averment made in para 9 of the complaint that the patient had worsening of power on left side which is due to the normal pathophysiological changes (Infarct & surrounding edema) occurring in the brain secondary to the unfortunate stroke suffered by the patient. Further, the advise of the aggressive physio therapy & continuous medical management was given by the opposite parties is only based on thorough clinical & radiological evaluation of the appropriate test report (CT Scan). The averment by the complainant in para 10 of the complaint relates to a matter of record and as such the opposite parties are not inclined to comment upon the same. The averment made by the complainant in para 11 of the complaint that the patient suffered complications despite constant observation of the doctors is totally baseless and irrelevant as the said complications were a direct result of the unfortunate post procedural stroke suffered by the patient which is totally unpredictable and cannot be

prevented through constant monitoring of the patient, which is only done to pick up the clinical signs of occurrence of stroke, if any and to forthwith respond to the same by implementation of the relevant standard medical protocols& medical management. In this regard, it is stated that the patient after the uneventful procedure was shifted to Neuro critical care ICU. However, six hours post procedure (ie at 8.15pm on 01.12.2017) the patient unexpectedly and suddenly developed a stroke which was totally unfortunate & unpredictable. Upon occurrence of the stroke, the medical team had immediately raised the stroke alert and performed all the necessary test including CT & MRI brain as per the standard medical protocol and consequently, the patient was put under the appropriate medications upon the expert opinion given by the stroke team. It may be noted that the said stroke suffered by the patient was clearly given as an inherent risk associated with the procedure which was duly explained to the patient, complainant and their sons in detail, as clearly evidenced in the counseling document and in the consent form. The averment made by the complainant in para 12 of the complaint that the patiem had weakness over left side of the body only on 09.11.2017 is clearly misleading & false, as it is quite evident through the OPP) consultation record dated 24.11.2017 that the patient was having clear history of one week repeated attacks of left Upper & lower limb weakness, as informed by the complainant & patient themselves. Further, the patient was duly advised as per the standard medical protocols to undergo aggressive physiotherapy. Speech & occupational therapy and continuation of medical management based on her prevailing clinical condition, post occurrence of the unfortunate stroke event. The averment made by the complainant in para 13 of the complaint that the patient was suffering from limited problems and minor discomforts on 09.11.2017 is clearly misleading & false, as it is quite evident through the OPD consultation record dated 24.11.2017 that the patient was having clear history of one week repeated attacks of

left Upper & lower limb weakness, as informed by the patient & complainant themselves, The allegation made by the complainant that instead of minimizing the patient's problems the surgical procedure adopted by the opposite party had caused her post procedural stroke requiring limb physiotherapy & speech / occupational therapy is utterly false & untenable and hence denied. In this regard, It is further stated that the diagnosis was done properly upon careful consideration of all the patient's medical history, test reports & medical opinion from the neurological specialists and accordingly the patient was found to be suffering with significant stenosis of 90% in proximal right M1 segment of MCA, 80% left distal M1 segment of MCA. >50% right VA origin. Consequently, the patient's medical condition was elaborately discussed with the patient & her attenders along with appropriate advise on the treatment options. It may be noted that considering the recurrent TIA's in the right carotid circulation the necessity benefits & risks/complications of the intracranial stenting were explicitly discussed with the patient and her attenders in consideration of the fact that there was no progress for the patient in the process of medical management and in the anticipation of complete blockage of the M1 segment of right MCA in continuing the same, which may lead to a major stroke. It may also be noted that the said procedure advised by the doctors is medically evidenced in the literatures to be the most appropriate one for a patient with such underlying medical conditions particularly in the event where medical management was not found to be helping her condition. This further goes to show beyond doubt that the procedure was not an unsafe one as wrongfully alleged by your client but the best possible treatment to the patient with the said medical conditions as evidenced in the corresponding medical literature. It is further stated that the patient and attenders after completely understanding the benefits, risks, complications and possible outcomes of the intracranial stenting provided their expressed consent based on which the said procedure after meticulous

planning was duly carried out on 01.12.2017 as planned. It is strenuously contended that the procedure advised by the O.P.No.2 was in the best interest of the patient so as to improve the blood flow to the brain in order to prevent occurrence of major stroke. While so, it is revealed beyond doubt that the unanticipated ischemic stoke event suffered by the patient is clearly evidenced to be a high impact inherent risk associated with the procedure was purely unfortunate and that the blatant accusation made by the complainant against the procedure advised by the O.P.No.2 without understanding the patient's clinical condition, her medical requirement & necessity/reasons for advising the said procedure, is totally preposterous. The averment by the complainant in para 14 of the complaint relates to a matter of record and as such the opposite parties are not inclined to comment upon the same. The averment made by the complainant in para 15 of the complaint that the patient had minor problems in her limbs on 09.11.2017 & not before that is clearly misleading & false, as it is quite evident through the OPD consultation record dated 24.11.2017 that the patient was having clear history of one week repeated attacks of left upper & lower limb weakness, as informed by the patient & complainant themselves. The allegation made by the complainant that the opposite party instead of suggesting a non- surgical procedure had hastily carried out a surgical procedure which had worsened the condition of the patient is utterly false & baseless. In this regard, it is vehemently contended that the said procedure underwent by the patient is a minimally invasive non-surgical interventional procedure wherein the stent is precisely placed in the appropriate stenosed segment under fluoroscopic guidance. It would be relevant to point out that considering the recurrent TIA's in the right carotid circulation the necessity, benefits & risks/complications of the intracranial stenting were explicitly discussed with the patient and her attenders in consideration of the fact that there was no progress for the patient in the process of medical management and in the

anticipation of complete blockage of the M1 segment of right MCA in continuing the same, which may lead to a major stroke. It may also be noted that the said procedure advised by the doctors is medically evidenced in the literatures to be the most appropriate one for a patient with such underlying medical conditions particularly in the event where medical management was not found to be helping her condition. This further goes to show beyond doubt that the procedure was not hastily carried out by the opposite party no.2 as wrongfully alleged by the complainant. While so, the procedure adopted by the op.no.2 was medically appropriate and is clearly evidenced to be the best option which was medically found to be having minimal risk considering the existing clinical condition of the patient and the fact that she was not responding to the medical management. The further allegation made by the complainant that instead of curing the patient the opposite party left her with an attack of paralytic stroke is totally untrue and the complainant is put to strict proof thereof. In this connection, it is strictly contended that the procedure advised by the O.P.No.2 was in the best interest of the patient so as to improve the blood flow to the brain in order to prevent occurrence of major stroke. While so, it is revealed beyond doubt that the unanticipated ischemic stoke event suffered by the patient is clearly evidenced to be a high impact inherent risk associated with the procedure purely unfortunate and that the blatant accusation made by the complainant against the procedure advised by the O.P.No.2 without understanding the patient's clinical condition, her medical requirement & necessity/reasons for adoption of the said procedure, is totally preposterous. The allegation made by the complainant in para 16 of the complaint that he and his wife would not have consented to the surgery if they had been explained about the risks and that the complainant has given a written consent letter but was never explained about the post operative complications seems to be utterly ridiculous as the same could be easily disproved in the light of the counselling/ high risk consent

document recorded on 01.12.2017& consent form dated 30.11.2017 which clearly reveals that the patient. Complainant & their son were explicitly informed about every possible risks & complications associated with the procedure and that the said form/document have been signed by the complainant, his son & the patient after having been fully acquainted with such risks & complications involved in the said procedure. The allegation made by the complainant in para 17 of the complaint that she suffered the paralytic stroke due to unsafe medical advise & surgery performed by the opposite party is far beyond truth and hence denied. In this regard, it is reiterated that considering the recurrent TIA's in the right carotid circulation the necessity, benefits & risks/complications of the intracranial stenting were explicitly discussed with the patient and her attenders in consideration of the fact that there was no progress for the patient in the process of medical management and in the anticipation of complete blockage of the MI segment of right MCA in continuing the same, which may lead to a major stroke. It may also be noted that the said procedure advised by the doctors is medically evidenced in the literatures to be the most medical appropriate one for a patient with such underlying Medical conditions particularly in the even where medical management was not found to be helping her condition. This further goes to show beyond doubt that the procedure was not an unsafe one as wrongfully alleged by the complainant but is medically proven to be the best possible treatment to the patient with the said underlying conditions, as evidenced in the corresponding medical literatures. With respect to para 18 of the complaint, it is submitted that the opposite parties were completely unaware of the pain underwent by the patient on account of the travel as the same was never informed to the OP's by the complainant at any point of time whatsoever Had it been informed by the complainant, then the opposite parties would have definitely advised to get the therapies done at the nearest recommended medical centre or allotted a room to the patient at the guest house

located inside the O.P.No.1 hospital. The allegation made by the complainant in para 19 of the complaint, it is strictly denied and the opposite parties vehemently contend that they have not committed any medical negligence or deficiency of services as wrongfully alleged by the complainant. The allegation made by the complainant in para 20 of the complaint that the opposite parties have given false hopes to the patient & complainant is totally false & misleading. In this regard, it is contended that it is a matter of record & fact that the procedure was carried out uneventfully and in pursuant to which the post procedure angiogram revealed adequate opening of the stenosed segment and normal filling up of the branch vessels, which clearly indicates that post placement of the stent the narrowed artery was opened optimally resulting in the improved blood flow through the stented artery and with normal filling into the major branch vessels. Hence, it is clearly evident that the there were no complications encountered during the procedure. Further, the Right MCA stenting report dated 01.12.2017 it is clearly evidenced that the patient's neurological status was the same as pre-procedure and there were no fresh neurological deficits after the patient was extubated. In view of the above, it is apparently evident that the procedure carried by the 2nd opposite party was successful and there is no false hope given to the patient as wrongfully alleged by the complainant. On the other hand, the stroke sustained by the patient was purely an unfortunate event happened during the post procedural observation period in the neuro critical care ICU, which has also been clearly mentioned & informed to the patient, complainant & their sons to be a material inherent risk after which the consent related documents were duly signed by them. The patient's medical history, test reports and medical opinion from neuro specialists were duly analysed by the opposites and before arriving at the diagnosis and accordingly medical advise was rightfully given for the most appropriate procedure in consonance with the medical protocols. The allegation made by the complainant in

para 21 of the complaint that the opposite parties wrongly diagnosed the patient with recurrent transient ischemic attacks is clean misleading as it is quite evident in the OPD consultation record that the patient was having clear history of one week repeated attacks of left Upper & lower limp weakness (minor stroke), as provided by the patient & complainant themselves during the said consultation. Further, the said repeated attacks of weakness is due to minor stroks sustained by the patient as clearly evidenced in the CT Brain & MRI Brain repoma Further to it, the stroke sustained by the patient was purely an unfortunate eve happened during the post procedural observation period in the neuro critical care ICU which is also been clearly mentioned & informed to the patient, complainant& their so to be a material inherent risk only after which the consent related documents were duty signed by them. The allegation made by the complainant in para 22 of the complaint that during the multiple counselling sessions the patient & complainant were never informed about the pros& cons of the procedure or the possibility of a stroke and if it were informed then they would not have opted for the procedure are totally frivolous & misleading. In this regard, it is strictly contended that the patient, complainant & their sons were indeed explained in detail about the pros & cons of the procedure including but not limited to the risks, complications which includes major stroke as well as clearly found to be evident in the counselling high risk consent document recorded on 01.12.2017 & consent form dated 30.11.2017, which further indicates that the said form/document have been signed by the complainant, patient & their son only after having been fully acquainted with sa risks & complication involved in the said procedure. The averment made by the complainant in para 23 of the complaint that he & his wife (the patient) knocked the doors of the opposite parties with minor problem of difficulty is clearly misleading as it is quite evident in the OPD consultation record that the patient was having clear history of one week repeated attacks of left upper & lower limb weakness

(minor stroke), as provided by the patient & complainant themselves during the said consultation. Further, the said repeated attacks of weakness is due to the strokes sustained by the patient as clearly evidenced in the CT Brain & MRI Brain reports which is not at all a minor problem but are rather medically evidenced to be the significant alarming factors which would lead to a potential major stroke, if left untreated. The allegation made by the complainant in para 24 of the complaint that the paralytic stroke suffered by the patient was due to the insufficiency of the opposite parties wrong course of event rendered to her is totally absurd and accordingly denied. In this regard, it is strictly contended that the opposite party no.2 is an interventional stroke specialist with more than 15 years of enriched experience in the particular field who had carried out more than 500 neuro interventional procedures and is more than efficient & experienced to perform the said procedure. Further, the wrong course of event as indicated by the complainant was purely an unfortunate event happened during the pest procedural observation period in the neuro critical care ICU, which is also been clearly mentioned & informed to the patient, complainant& their sons to be a material inherent risk after which the consent related documents were duly signed by them. With respect to para 25 of the complaint, it is submitted that the observations & findings in page 4 of the discharge summary as specified by the complainant pertains to the 4 vessel digital subtraction cerebral angiogram done on 29.11.2017 and not that of the procedure of Right Middle cerebral artery (M1 segment) intracranial stenting done on 01.12.2017. The allegation made by the complainant in para 26 of the complaint that after inflicting the paralytic stroke on the patient, the doctor did not think it was their responsibility to make her back to normal state is completely false, baseless and untenable. In this connection, it is strongly contended that the post procedural stroke encountered by the patient was not something that was inflicted on the patient as wrongfully alleged but purely an

unfortunate event happened during the post procedural observation period in the neuro critical care (CU, which is also been clearly mentioned & informed to the patient, complainant & their sons to be a material inherent risk after which the consent related documents were duly signed by them. It is further submitted that the doctor did have utmost concern on the patient's recovery from the said unfortunate stroke event and was not irresponsible as wrongfully alleged by the complainant. It may be noted that the recovery in a patient who suffered stroke is a long duration process wherein supportive rehabilitative therapies are the ideal mode of treatment as per the standard medical protocol. Hence, the in-patient hospitalization was not essentially required for the patient to undergo such advised therapies and also because of the fact that the patient was haemodynamically stable. Further, the O.P.No.2 & team of neuro specialists at the time of discharge have duly advised the patient with medications along with the physiotherapy& occupational therapy in order to gradually recover from the impacts of the stroke and to attain full power grade in the limbs. It would be relevant to point out that the condition of the patient at the time of discharge is only a temporary one which be gradually restored back to its original state, subject to the proper compliance of medications and therapies as advised by the Doctors. The allegation made by the complainant in para 27 of the complaint that the patient who came as a normal person was discharged as a paralytic and that she went to various hospitals for cure of the paralytic stroke inflicted on her are all utterly absurd as the post procedural stroke encountered by the patient was not something that was inflicted on the patient as wrongfully alleged but purely an unfortunate event happened during the post procedural observation period in the neuro critical care ICU, which is also been clearly mentioned & informed to the patient, complainant& their sons to be a material inherent risk after which the consent related documents were duly signed by them. The further averment made by the complainant that the patient spent 47 days in

the institute of siddha at Tambaram is not within the knowledge of the opposite parties. The averment by the complainant in para 28 of the complaint relates to a matter of record and as such the opposite parties are not inclined to comment upon the same. However, the averment made by the complainant in so far as the stent was sent into the brain is technically wrong as the procedure involves precise placement of stent in the appropriate stenotic segment under fluoroscopic guidance. The allegation made by the complainant in para 29 of the complaint that the precise stent placement in the stenosed segment of MCA did not cure the patient merely indicated lack of understanding of the said procedure and his misconception towards the same. In this regard, it is contended that it is a matter of record & fact that the said procedure was carried out uneventfully and in pursuant to which the post procedure angiogram revealed adequate opening of the stenosed segment and normal filling up of the branch vessels, which clearly indicates that post placement of the stent the narrowed artery was opened optimally resulting in the improved blood flow through the stented artery and with normal filling of the major branch vessels. Hence, it is clearly evident that there were no complications encountered during the procedure. Further, it is clearly evidenced in the Right MCA stenting report dated 01.12.2017that the patient's neurological status was the same as pre-procedure and there were no fresh neurological deficits after the patient was extubated. In view of the above, it is apparently evident that the procedure carried by the O.P.No2 was uneventful & successful. On the other hand, the stroke sustained by the patient was purely an unfortunate event happened during the post procedural observation period in the neuro critical care ICU, which is also been clearly mentioned & informed to the patient, complainant & their sons to be a material inherent risk after which the consent related documents were duly signed by them. It is submitted that the reduction the limb power facial asymmetry and distorted speech are the effects of the unfortunate post

procedural stoke suddenly encountered by the patient in the Neuro critical care ICU. It is further submitted that the unfortunate stroke suffered by the patient ie peri procedural ischemic stroke is more likely to be a predominantly perforator stroke which occurs mainly due to forceful displacement of atheroma into perforator ostia, which can neither be predicted at any time prior to its occurrence nor immediately reversed through any medical means. With respect to para 30 of the complaint it is submitted that unlike normal stroke scenarios in this particular case even though the patient had a unfortunate post procedural stroke in the hospital Neuro Critical Care ICU, the intravenous clot buster medication (IVIPA) could not be administered to the patient for reversing the stroke as per the standard medical protocols since she was already loaded on Intravenous and tablet form of blood thinners which were clear contra indications to administer the said medication. With respect to para 31 of the complaint, it is contended that the patient was indeed having difficulty in mobility as and when there was a minor stroke encountered by her. It is apparently evident in the OPD consultation record dated 24.11.2017 that the patient was having clear history of one week repeated attacks of left Upper & lower limb weakness which is also evident in the CT & MRI brain reports of the patient. Further, it is clearly admitted by the complainant in para 1 of his legal notice dated 30.01.2018 that the patient suddenly felt uncomfortable with regard to her mobility would clearly indicate that the patient's mobility condition was not in a stable manner. The allegation made by the complainant that the contention of unstableness in mobility is to justify the treatment and subsequent infliction of paralytic stroke and that the patient's mobility condition was snatched away by the doctor are all clearly baseless and absurd for which the complainant is put to strict proof thereof. The averment made by the complainant in para 32 of the complaint as to the present condition of the patient is not within the knowledge of the opposite parties as the patient or complainant did not turn up for the

periodical OP reviews as advised by the doctor. However, it is clearly evidenced that the medical post procedural complication is purely an unfortunate event which is clearly proven to be not on account of medical negligence or deficiency of services committed by the opposite parties, as wrongfully alleged by the complainant. The allegation made by the complainant in para 33 of the complaint that the opposite parties cannot disown the condition of the patient by prescribing some medicines & therapies at the time the of discharge is utterly false. In this regard is further submitted that the recovery in a patient who suffered stroke is a long duration process wherein supportive rehabilitative therapies are the ideal mode of treatment as per the standard medical protocol. Hence, the in-patient hospitalization was not essentially required for the patient to undergo such advised therapies and also because of the fact that the patient was hemodynamically stable. Further the O.P.No.2 & team of neuro specialists at the time of discharge have duly advised the patient with medications along with the physiotherapy & occupational therapy in order to gradually recover from the impacts of the stroke and to attain full power grade in the limbs. Hence, it is very much evident that the doctor never disowned the condition of the patient by just prescribing some medicines and therapies as wrongfully alleged by the complainant. The further allegation made by the complainant that the infliction of paralytic stroke was on account of the deficiency of service & medical negligence is denied as false and the complainant is put to strict proof of the same. The averment made by the complainant in para 34 & 35 of the complaint as to the present condition of the patient is not within the knowledge of the opposite parties as the patient or complainant did not turn up for the periodical OP reviews as advised by the doctor. However, it is clearly evidenced that the medical post procedural complication is purely an unfortunate event which is clearly proven to be not on account of medical negligence or deficiency of services committed by the op's, as wrongfully alleged by the complainant. With respect to the

averment made by the complainant in para 36 of the complaint. that the paralytic stroke was inflicted on the patient causing mental agony is clearly wrong & misleading as the unfortunate stroke encountered by the patient is medically evident to be an inherent risk/post procedural complication associated with the procedure which was duly explained to the patient complainant& their son in detail, as clearly evidenced in the counseling document and in the consent form. With respect to the averment made by the complainant in para 37 of the complaint, it is further stated that the diagnosis was done properly upon careful consideration of all the patient's medical history, test reports and medical opinion from the neurological specialists and accordingly the patient was found to be suffering with significant stenosis of 90% in proximal right M1 segment of MCA, 80% left distal M1 segment of MCA. >50% right VA origin. Consequently, the patient's medical condition was elaborately discussed with the patient & her attenders along with appropriate advise on the treatment options. It may be noted that considering the recurrent TIA's in the right carotid circulation the necessity, benefits & risks/ complications of the intracranial stenting were explicitly discussed with the patient and her attenders in consideration of the fact that there was no progress for the patient in the process of medical management and in the anticipation of complete blockage of the M1 segment of right MCA in continuing the same, which may lead to a major stroke. It may also be noted that the said procedure advised by the doctors is medically evidenced in the literatures to be the most appropriate one for a patient with such underlying medical conditions particularly in the event where medical management was not found to be helping her condition. This further goes to show beyond doubt that the diagnosis was very precise and the procedure was medically found to be the best possible treatment to the patient with the said medical conditions, as evidenced in the corresponding medical literatures. The patient, complainant & their son after completely understanding the benefits,

risks, complications and possible outcomes of the intracranial stenting provided their expressed consent based on which the said procedure after meticulous planning was duly carried out on 01.12.2017 as planned. The allegation made by the complainant that he and his wife would not have consented to the surgery if they had been explained about the risks and that the complainant has given a written consent letter but was never explained about the post operative complications seems to be utterly ridiculous as the same could be easily disproved in the light of the counselling high risk consent document recorded on 01.12.2017 & consent form dated 30.11.2017 which clearly reveals that the patient complainant & their son were explicitly informed about every possible risks & complications associated with the procedure and that the said form/document have been signed by the complainant, patient & their son only after having been fully acquainted with such risks &complication involved in the said procedure. The averments made by the complainant in para 38 of the complaint are two different statements which do not have any sort of relevance whatsoever and as such the opposite party is not inclined to comment upon the same. With respect to para 39 of the complaint it is contended that the fact in so far as the patient experienced recurrent strokes is a matter of record (OPD consultation report dated 24.11.2017, CT & MRI brain reports) and had a medical history of hypertension. diabetes mellitus & hyper cholesterolemia and was on continuous medication for the same would clearly indicate the complicated nature of the medical history & clinical condition of the patient. With respect to the averment made by the complainant in para 40 of the complaint, first of all, the said procedure advised by the op-no2 was never a surgical one, as the said procedure namely Right Middle cerebral artery (MI segment) intracranial stenting is only minimally invasive non surgical interventional procedure carried out under general anesthesia wherein there is a real limb visualization of the blockage which is physically seen under fluoroscopic guidance and the stent is

precisely placed in the appropriate stenosed segment. It is further stated that the diagnosis was done properly upon careful consideration of all the patient's medical history, test reports and medical opinion from the neurological specialists and accordingly the patient was found to be suffering with significant stenosis of 90% in proximal right M1 segment of MCA, 80% left distal M1 segment of MCA, >50% right VA origin. Consequently, the patient's medical condition was elaborately discussed with the patient & her attenders along with appropriate advise on the treatment options. It may be noted that considering the recurrent TIA's in the right carotid circulation the necessity, benefits & risks/complications of the intracranial stenting were explicitly discussed with the patient and her attenders in consideration of the fact that there was no progress for the patient in the process of medical management and in the anticipation of complete blockage of the M1 segment of right MCA in continuing the same, which may lead to a major stroke. It may also be noted that the said procedure advised by the doctors is medically evidenced in the literatures to be the most appropriate one for a patient with such underlying medical conditions particularly in the event where medical management was not found to be helping her condition. This further goes to show beyond doubt that the O.P.No.2 was absolutely careful in advising the said procedure as the line of treatment and that the said procedure is found to be the best possible treatment to the patient with the said medical conditions as evidenced in the corresponding medical literatures. Hence, it is proved beyond doubt that there is absolutely no medical negligence committed by the opposite parties as wrongfully alleged by the complainant. The averment made by the complainant in para 41 of the complaint that the patient suffered complications despite constant observation of the doctors is totally baseless and irrelevant as the said complications were a direct result of the unfortunate post procedural stroke suffered by the patient which is totally unpredictable and cannot be prevented through constant monitoring of

the patient, which is only done to pick up the clinical signs of occurrence of stroke, if any and to forthwith respond to the same by implementation of the relevant standard medical protocols & medical management. In this regard, it is stated that the patient after the uneventful procedure was shifted to Neuro critical care ICU. However, six hours post procedure (i.e at 8.15pm on 01.12.2017) the patient unexpectedly and suddenly developed a stroke which was totally unfortunate & unpredictable. Upon occurrence of the stroke, the medical team had immediately raised the stroke alert and performed all the necessary test including CT & MRI brain as per the standard medical protocol consequently the patient was put under the appropriate medications upon the expert and opinion given by the stroke team. It may be noted that the said stroke suffered by the patient was clearly given as an inherent risk associated with the procedure which was duly explained to the patient, complainant & their son in detail, as clearly evidenced in the counseling document and in the consent form. Hence, it is clearly revealed that the consent was given by them only after having complete knowledge over the risk of post procedural major stroke and after acknowledging the same had duly provided the consent and that the complainant is now blatantly blaming the opposite parties just because there was an unfortunate post procedural stroke event encountered by the patient, despite being fully aware that there has been no fault committed by the O.P.No.2 in performing the said procedure. With respect to the averment made by the complainant in para 42 of the complaint, it may be noted that considering the recurrent TIA's in the right carotid circulation the necessity benefits & risks/complications of the intracranial stenting were explicitly discussed with the patient and her attenders in consideration of the fact that there was no progress for the patient in the process of medical management and in the anticipation of complete blockage of the M1 segment of right MCA in continuing the same, which may lead to a major stroke. It may also be noted that the said procedure advised by the doctors is

medically evidenced in the literatures to be the most appropriate one for a patient with such underlying medical conditions particularly in the event where medical management was not found to be helping her condition. While so, the procedure adopted by the o.p.no.2 was medically appropriate and is clearly evidenced through medical literatures to be the only option which was medically found to be having minimal risk considering the clinical condition of the patient and the fact that she was not responding to the medical management. The further allegation made by the complainant that instead of curing the patient the opposite party left her with an attack of paralytic stroke is totally untrue and the complainant is put to strict proof thereof. It is further contended that the procedure advised by the 2nd opposite party was in the best interest of the patient so as to improve the blood flow to the brain in order to prevent occurrence of major stroke. While so, it is revealed beyond doubt that the unanticipated ischemic stroke event, suffered by the patient is clearly evidenced to be a high impact inherent risk associated with the procedure was purely unfortunate and that the blatant accusation made by the complainant against the procedure advised by the 2nd opposite party without understanding the patient's clinical condition her medical requirement & necessity/reasons for adoption of the said procedure is totally preposterous. It is further submitted that the non-performance of the right MCA stenting procedure for the patient with such underlying medical conditions will potentially deteriorate her pre-existing condition to suffer a major stroke, as more fully evidenced in the medical literatures. The reply notice dated 27.02.2018 issued by the opposite parties is not evasive but explicitly clarifies on the medical insights of the procedure and the post procedural complication suffered by the patient which are blatantly claimed by the complainant as medical negligence and deficiency of services due to lack of medical knowledge on the recurrent minor strokes sustained by the patient& misconception about her clinical condition. With respect to the averment

made by the complainant in para 43 of the complaint, it is hereby clarified that the occurrence of the stroke on a particular patient cannot be anticipated whatsoever prior to its occurrence as it is an unpredictable event which may rarely happen to certain patients during the post procedural period, as evidenced in the relevant medical literatures. Further, there is nothing that can be medically done to prevent such sort of small vessel post procedural stroke event which is exactly the reason why it is classified as inherent high risk & complication associated with the said procedure. The allegation made by the complainant in para 44 of the complaint that the opposite parties have made the patient as guinea pigs and venture to experiment on them is denied as false & absurd and the complainant is put to strict proof thereof. With respect to the averments made by the complainant in para 45& 46 of the complaint, it is submitted that the avoidance of the right MCA stenting procedure for the patient with such underlying medical conditions will potentially deteriorate her pre- existing condition to suffer a major stroke, as more fully evidenced in the relevant medical literatures. The allegation made by the complainant in para 47 of the complaint that the opposite parties have committed deficiency in service and unfair trade practice is denied as false, frivolous & unjustifiable and the complainant is hereby put to strict proof of the same. In this regard, it is highly important to point out that a medical complication is nothing but an unpredictable adverse event caused by pre-existing medical condition, which falls beyond the doctor's control. It would not be out of place to point out that all the patients are not the same in health, habits, immunity or healing power, recovery and have varying susceptibility to medical complications. On the other hand, a medical negligence/ deficiency of service however assumes there was a lapse of either quality or control wherein the treating doctor fails to Provide adequate care & precaution while advising/carrying out a medical procedure. In the present case, there are clear cut evidences which would undoubtedly establish that the opposite party

No.2 had made the accurate diagnosis and had rightfully advised & duly counseled the patient, complainant &their sons whereby explaining all the inherent other risks & complications associated with the procedure for the most appropriate & minimally invasive non-surgical procedure in the best interest of the patient and had duly carried out the same in an uneventful manner based upon the written consent provided by the patient, complainant & their son. Hence, it is quite evident that there is neither any medical negligence nor deficiency of services committed by the opposite parties whatsoever and that the stroke suffered by the patient in the Neuro critical care ICU was only an unfortunate post procedural complication, the occurrence of which was totally out of the control of the treating team of doctors. On the other hand, upon occurrence of the unfortunate stroke event, the team of doctors including 2nd opposite party had given their best & sincere efforts by immediately responding with necessary emergency medical protocols and administered all the requisite medications towards treating the patient for her recovery. Under such circumstances, it is proved without any iota of doubt that the opposite parties have neither committed any deficiency in service nor indulged in unfair trade practice as wrongfully alleged by the complainant. With respect to the averments made in para 48 of the complaint., it is contended that since there is absolutely no medical negligence, deficiency of service or unfair trade practice committed/carried out by the opposite parties there is no cause of action that had arisen against the op's and in favour of the complainant to file the present complaint before this Hon'ble forum. The averment made by the complainant that the in para 49 of the complaint that the patient was managing her physical discomfort of limbs with the help of maid & pain killers only indicates the physical condition of the patient. However, on the other hand her medical condition can only be evidenced through the previous medical history, tests reports & nature of existing illness. While so, the fact that the patient had recurrent minor strokes in different territories of the

brain as witnessed in the OPD document dated 24.11.2017 and the CT& MRI brain reports would ipso facto prove that the patient's clinical condition was not as simple as portrayed by the complainant but the patient was rather having a complicated and clinically worsening recurrent intra cranial stenotic arterial disease as documented in the CT angiogram & DSA reports. With respect to the averment made by the complainant in para 50 of the complaint, it is submitted that the medical advise of undergoing physhotherapy & other therapies were advised based on the medical protocols as evidenced in the literatures in due consideration of the her age & other clinical factors. With respect to the averments in para 51 of the complaint it is contended that there is no cause of action/ grounds whatsoever in favour of the complainant to impose such claim against the opposite parties and it is further submitted that the said claim made by him is nothing but a malafide attempt to extract money from the opposite parties based on false, deceitful & misleading grounds. With respect to para 52 of the complaint it is strictly contended the complainant in their legal notice dated 30.01.2018 having made an exorbitant and baseless claim of Rs. 1,00,00,000/- based on flimsy & baseless grounds had all of a sudden reduced the claim amount to Rs.19,85,000/- without furnishing any justifiable reasons. This clearly goes to show that the claim of the complainant itself lacks bonafideness and that the same merely sterns out of greed to attain unlawful monetary benefits at the cost of the opposite parties. Given the facts and circumstances presented above, it is apparently evident that the patient's medical condition was diagnosed precisely based on which the best possible treatment had been rightfully advised after explicitly explaining the patient. Complainant & their sons about the pros & cons including the benefits, risks & complications associated with the said procedure during the multiple counseling sessions. Further to it, the said procedure was uneventfully & successfully carried out by the 2nd opposite party in pursuant to the written consent given by the patient,

complainant & their son. Consequently, it is medically proven that the said stroke suffered by the patient was purely an unfortunate event/medical complication that happened during the post procedural observation period in the neuro critical care ICU, which is also been clearly mentioned & informed to the patient, complainant & their son to be a material inherent risk prior to the consent given by them. It is also further evidenced through the relevant medical records that the team of doctors had clearly carried out all the sincere& best possible efforts in the best interest of the patient have in no way committed any medical negligence, unfair trade practice or deficiency of services as wrongfully alleged by the complainant. Hence, the opposite parties pray for dismissal of the complaint with exemplary cost.

4. In order to prove the case, proof affidavits have been filed by both parties as their evidence and Ex.A1 to Ex.A5 & Ex.B1 to Ex.B9 were marked. Written argument of both sides filed. Oral argument of 2nd opposite party heard. As per memo filed by both, written arguments treated as oral argument on the side of the complainant and 1st opposite party.

As per CMP.No.36/2019,

1) Expert's opinion of Regional Medical Board, Rajiv Gandhi Government General Hospital, Chennai, Madras Medical College is marked as Ex.C1..

2) Order in Ref.No.TNMC/T.No.693/2021 dated 15.11.2022, Tamil Nadu Medical Council, Chennai is marked as Ex.C2.

5. **<u>At this juncture, the point for consideration before this Commission are:-</u>**

i) Whether there is any specific allegation of medical negligence in the complaint?

ii) Whether the conduct of the doctors of the opposite parties fell below that of the standards of a reasonably competent practitioner in his field.

iii) The burden of proof lies with the complainant or opposite party?

6. <u>Point No.1 to 3 :-</u> Heard both sides. Considered all the documents available on records.

6.1 The complainant's counsel contended that the written consent was obtained from him without explaining the post operative complications. The counsel for complainant further contended that the 2nd opposite party did not possess requisite skill to perform the procedure done to the complainant's wife and to prove the same the complainant moved CMP No 145/2022 to cross examine the 2nd opposite party for the reasons best known to the 2nd opposite party. The 2nd opposite party abstained himself from appearing for cross examination, failed to file any documentary evidence to prove that he is competent to perform the procedure done to the complainant's wife, nor submitted himself for cross examination. The counsel for complainant further contended that the Medical Board constituted to examine the procedure done to complainant's wife had not gone into the competency of the doctors who were involved in the treatment given to complainant's wife, especially the 2nd opposite party. Even assuming that there was no negligence in the procedure adhered, during the course of treatment and the treatment given to the patient, the doctor who performed the procedure should have competent skill and qualifications to do the same. The Medical Board has miserably failed to look into the qualifications and competency of the 2nd opposite party. Hence the Commission should not rely on the opinion of the Medical Board (Ex.C1). The counsel further contended that the Tamilnadu Medical Council also while disposing the complaint of the complainant, failed to record the qualifications of the 2nd Opposite party, even though the Tamilnadu Medical Council has recorded the qualifications , experience and competency of Dr.Sridhar, who was with 1st opposite party. Therefore, the Tamilnadu Medical Council deliberately omitted

to record the qualifications and experience of Dr.Satheesh Grahadurai who is the 2nd opposite party herein. Hence the decision of Tamilnadu Medical Council (Ex.C2) also should also not be relied on by this commission. The counsel for complainant further contended that the opposite party failed to obtain informed consent from the complainant or the attenders of the patient. Such act of opposite party amounts to medical negligence besides unfair trade practice.

6.2 On the other hand the counsel for opposite parties contended that the Medical Board constituted by Rajiv Gandhi General Hospital Chennai, to examine the procedure done to the patient, has opined that there was no evidence of medical negligence on the part of opposite parties. The counsel for opposite parties further contended that the OPD consultation records dated 24.11.2017 and CT and MRI reports would evidence that the patient, Indirani, the wife of the complainant, had the history of one week repeated attacks of left, upper and lower limb weakness and the same was due to Recurrent TIA. Hence 2nd opposite party Doctor had advised for Intracranial Stenting procedure to the patient. The Tamilnadu Medical Council, after considering the Opinion rendered by the Medical Board constituted by Rajiv Gandhi General Hospital (Ex-C1), had rendered it's decision in favour of the Opposite parties. The decision of Tamilnadu Medical Council is marked as Ex.C2. Both, Ex-C1 and C2 are experts opinions rendered by experts and this Commission should consider the same in favour of the Opposite parties, while adjudicating the present complaint.

6.3 The counsel for opposite party relied on following authorities in support of his contention.

i) Dr.Harish Kumar Khurana Vs Joginder Singh & others reported in http:/indiankanoon.org/doc/96761433/- by Hon'ble Apex Court

ii) Dr.C.P.Sreekumar M.S(Ortho) Vs S.Ramanujam reported in http:/indiankanoon.org/doc/1858788/ by Hon'ble Apex Court.

iii) Martin F.D'Souza Vs Mohd. Ishfaq reported in http:/indiankanoon.org/doc/1092676/ by Hon'ble Apex Court.

iv) State of Rajasthan & Another Vs Mohammed Ikbal & Ors (AIR 1999Raj 169)

ANALYSIS

6.4 The expert opinion dt.11.09.2020 received from the Regional Medical Board Rajiv Gandhi Government General Hospital is marked as Ex.C1 and the order passed by the Tamil Nadu Medical Council in response to the complaint made by the complainant is marked as Ex.C2. A perusal of Ex.C1 & Ex.C2 prove that the complainant's wife had discomfort on 09.11.2017 and on 10.11.2017, the complainant's wife consulted her family Dr.Srikanth, who diagnosed symptoms of seizure and advised for various tests and clinical examination. The results of those tests and examinations revealed that the complainant's wife was having neurological issues and complainant's wife was admitted in the 1st opposite party hospital on 28.11.2017 with above ailments. According to Ex.C2 the health of complainant's wife conditions required consultation and treatment from Neurologist specialist and the patient was referred to 1st opposite party. The discharge summary reveals that the 2nd opposite party performed Intracranial Stenting procedure on the patient.

6.5 The relevant portions of Ex.C2 viz. paras 11 to 14 are reproduced here below for ready reference:

11. *"The case was placed before the Disciplinary Committee on 14th September 2022 and the Complainant and Respondents appeared before the Disciplinary Committee and deposed. The Complainant reiterated his complaints. The Respondents maintained their line of arguments as in their earlier replies.*

12. *The disciplinary Committee considered the case. The complainant alleges that both the respondents are responsible for inflicting paralytic stroke on his wife.P.Indira Kumari and made her permanently incapacitated for life time. He also questioned the Academic qualifications, their eligibility to conduct the surgery of the brain and their academic dishonesty in adopting high sounding designations*

13. *Neurosurgery is a branch of surgery that treats conditions and diseases of the brain and nervous system. Radiology is a medical speciality that helps diagnose and treat conditions and disease using various radiology techniques. Endovascular neurosurgery is a speciality within neurosurgery. It uses catheters and radiology to diagnose and treat various conditions and diseases of the central nervous system. The central nervous system is madeup of the brain and the spinal cord. This medical speciality is also called neurointerventional surgery. Interventional neurology is a sub speciality within radiology. It also involves catheters and radiology to diagnose and treat neurological conditions and diseases. The term Endovascualr means " inside a blood vessel". Endovascular neurosurgery uses tools that pass through the blood vessels to diagnose and treat disease and conditions rather than using open surgery. The surgeon often uses radiology images to help him or her to see the part of the body involved in the procedure. These types of procedures are called minimally invasive. This is because they generally need only a tiny incision, instead of a larger incision necessary for open surgery. Healthcare providers who specialize in Endovascular neurosurgery need training in both neurosurgery and radiology. The 2nd respondent is a qualified and trained physician.*

14. *Elective Stenting is an alternative therapeutic method for the prevention of secondary ischemic stroke in stroke patients with MCA stenosis, and seems to be a potentially effective but also hazardous therapeutic technique in patients*

with recurrent TIAs. Sometimes they can cause intracranial hemorrhages (bleeding in the brain) when they are put it, which can in turn also cause a stroke."

6.6 Ex.C2 reveals that the complainant had questioned the academic qualification and the 2nd opposite party's competency to perform the surgery/ procedure. In Ex.C2, the disciplinary committee nowhere discussed about the qualification and the competency of the doctors including the 2nd opposite party who had treated the patient when the patient was with the 1st opposite party Hospital.

6.7 However, in para 5 it is stated that *"the complaint is made against Dr.Sridhar and Dr.Sathish Graghadurai. Dr.Sridhar had completed his graduation in MBBS from Madras Medical College in December 1982 and have been certified as a Diplomate of National Board of Examination for the practice of Neuro-Surgery in May 1990 (DNB – Neuro Surgery) and a qualified Neuro Surgeon, possessing requisite knowledge, skill, competence, experience and expertise to practice Neuro-Surgery".* There is no such recording about the 2nd opposite party, Dr.Sathish Graghadurai and other team members. Dr. Sridhar has stated that he has neither recommended nor performed the Intracranial Stenting Procedure on the patient. Therefore, it is proved that the patient was refered by Dr.Srikanth, the family Physician of the patient to get treatment from Dr.Sridhar of the 1st opposite party hospital, and the said Dr.Sridhar neither recommended nor performed the Intracranial Stenting Procedure on the patient. The 2nd opposite party, Dr.Satheesh Grahadurai for the reasons best known to him, has performed Intracranial Stenting procedure on the patient.

6.8 A complete reading of Ex.C2 would show that the Disciplinary Committee has not recorded the names of the team of doctors except the names Dr.Satheesh Grahadurai & Dr.Sridhar. A complete reading Ex.C2 would further prove that

Dr.Satheesh Grahadurai / 2nd opposite party herein has not stated where he had completed his MBBS and where he studied Radiology or how he was competent to perform Endo Vascular Neuro procedures. However, in para 8 of Ex.C2 the Disciplinary Committee of Tamil Nadu Medical Council, was silent on the allegation that the said Dr.Satheesh Grahadurai has not having registration with the Tamil Nadu Medical Council to practice Neuro-surgery. Therefore, Dr.Satheesh Grahadurai, the 2nd opposite party herein is duty bound to prove that whether he is competent to perform Endovascular Neuro - surgery and why he has not registered his competent educational qualifications with the Tamil Nadu Medical Council to practice Endovascular Neuro surgery / procedures.

6.9 The complainant has preferred in CMP No.145/2022 to cross examination the 2nd opposite party. But, for the reasons best known to the 2nd opposite party, the 2nd opposite party abstained himself for cross examination. Inspite of this Commission directed him to appear for cross examination. Instead, the 2nd opposite party preferred RP No.4/2023 against the said order of this Commission, directing him to appear for cross examination. But the said RP No 4 of 2024 was dismissed by hon'ble SCDRC. Thus, though this Commission has provided ample opportunities to the 2nd opposite party to prove his competency, the 2nd opposite party willfully disobeyed the order passed by this Commission and abstained to appear for cross examination for the reasons best known to him. If the 2nd opposite party has acquired the requisite qualification to perform Intracranial Stenting procedure on the patient, namely Mrs.Indirakumari Leeladhara Rao, the 2nd opposite party could have appeared for cross examination. Thus, the 2nd opposite party had acted in violation of the Hippocratic Oath taken by the doctors. As soon as doctor and patient establish a confidential relationship, the doctor has responsibility to provide most logical

treatment plan to the patient. This is the element of duty. Further, the doctor himself should have concluded that whether he was competent to undertake the treatment. In the present case, the 2nd opposite party has neither filed any documentary evidence to prove that he had competent skills to perform Intracranial Stenting procedure, nor appeared before this Commission for cross examination to enable the complainant to controvert the competency of the 2nd opposite party. Therefore, it is presumed that the 2nd opposite party did not possess minimum skill and competency to perform the intracranial stenting procedure. Both, the Medical Board Constituted by Rajiv Gandhi General Hospital and The Tamilnadu Medical Council had not deliberated the qualifications and competency of 2nd opposite party in their respective opinion / decisions. Therefore, there is merit in the contention of the complainant's Counsel that the complainant's wife, the patient suffered stroke which is a direct result of negligence and incompetency of the 2nd opposite party.

6.10 Ex.B2 is the discharge summary. Even in the discharge summary, the 2nd opposite party is stated as Neuro Intravention and Neuro-Radiology senior consultant. But the 2nd opposite party failed to prove, when he acquired the requisite competency, and where he acquired the requisite competency as a senior consultant Neuro Intervention and Neuro-Radiology. The 2nd opposite party had also not explained why he has not registered himself as Neuro surgeon with the Tamil Nadu Medical Council. Therefore it is proved that there is negligence on the part of the 2nd opposite party and the 1st opposite party had engaged the 2nd opposite party as a consultant for Neuro Intervention and Neuro-Radiology without scrutinizing and / or verifying the qualification and competency of the 2nd opposite party. By such act, the 1st opposite party has also indulged in unfair trade practice.

6.11 The Counsel for Opposite party contended that the OPD consultation records dated 24.11.2017 and CT & MRI reports of the complainant's wife would evidence that the patient had history of one week repeated attacks of left upper, lower limbs weaknes and recurrent TIA based on which the 2nd Opposite party preferred to perform Intracranial Stenting Procedure to the patient on 1.12.2017. But the Opposite parties neither filed the OPD consultation records dated 24.11.2017 nor the CT or MRI reports taken prior to 1.12.2017. Ex-B7, the progress notes evidence that at 6.25 PM on 30.11.2017, the team of doctors ordered to shift the patient to operation Theatre with a plan to perform the procedure at 12.00 AM on 01.12.2017. There is no iota of evidence to prove that the patient had recurrent TIA prior to 01.12.2017. Therefore, burden of proof lies upon the opposite parties to prove that the patient was advised to undergo the Intracranial Stenting procedure because of her of medical conditions and also the competency of the 2nd opposite party to perform the said procedure.

6.12 Ex-B7 is progress notes relating to the patient from 29.11.2017. A reading of progress note dated 29.11.2017 does not disclose any symptom of Recurrent TIA as alleged by opposite parties. But, reveals that the patient had a single occurrence of giddiness before a week from 29.11.2017. The patient was referred for MRI and Angio (DSA) on 29.11.2017. MRI and DSA (angio) reveal that there was >90 stenosis and it is this finding made the 2nd opposite party to do Intracranial stenting procedure on the patient. Therefore the contention of the opposite parties that the patient had Recurrent TIA is not recorded in the progress notes (Ex.B7) till 1.12.2017 and hence, there is no merit in that contention.

6.13 As for as consent .is concerned, a perusal of entire evidence of opposite parties Ex-B1 to B9, a general consent was obtained by the opposite parties at 1022 AM

on 29.11.2017 that is on the date of admission which is part of Ex-B2. A special consent was obtained on 11.40 AM on 29.11.2017 for DSA which is part of Ex-B3. In Ex-B2, consent obtained for Anesthesia for DSA at 11.40AM on 29.11.2017 is also filed by the opposite parties. A perusal of the alleged consent for Anesthesia would prove that the opposite parties obtained signature in a blank form without even mentioning the name of the patient. The alleged consent form for Anesthesia does not reveal which type of anesthesia was administered to the patient. Such act of opposite parties also amounts to deficiency in service.

6.14 A high risk consent for Right Middle Cereberal Artery stenting is marked as Ex-B4. But, there are a lot of discrepancies especially in the recording of timings in the progress notes at 5.45 PM on 30.11.2017 in the alleged consent. A perusal of Ex-B4 would reveal that the staff of opposite parties obtained signature in a blank ruled paper. When the opposite party obtained other consent in a printed form, it is the opposite parties who should explain why the high risk consent was obtained in progress note sheets. Whether Ex.B4 was obtained at 5.45 PM on 30.11.2017 or at 10.15 Am of 1.12.2017. The style in which Ex.B4 is written would expose the purpose for which Ex.B4 had been prepared. Ex.B4 is also marked as part and parcel of Ex-B7. Ex-B4, the alleged high risk consent and all the consent form are not duly filled. Therefore, Ex.B4 cannot be treated as a consent in the eye of settle proposition.

6.15 A reading of Ex.B7, Progress notes would also prove that there are repugnancies in recording the timing of each procedure. The alleged Intracranial stenting procedure was not performed between 10.20 AM and 3.20 PM on 1.12.2017. The opposite parties manipulated the medical records by interpolating certain procedures to cover up their misdeeds. A reading of Ex-B7 clearly proves such interpolations.

6.16 According to 2nd opposite party, the patient developed weakness at 8.15 PM on 1.12.2017 and the patient was referred to Neurologist Opinion which would prove that the 2nd opposite party is not competent to do any Endovascular Neuro procedures on any patient. At this juncture, it is pertinent to note the facts in Ex.C2 wherein, Dr.Sridhar a neurologist has stated that the patient was neither referred for Intracranial Procedure by him. Even though the patient was referred to Dr.Sridhar, the 2nd opposite party for the reasons best known to him preferred to perform Intracranial Procedure on the patient, without basic clinical investigation, when the said Dr.K.Sridhar did not prefer intracranial stenting procedure.

7.1 A three judge Bench of the Apex Court in **Dr Laxman Balkrishna Joshi v Dr Trimbak Bapu Godbole(AIR 1969 SC 128)** stipulated that the standard to be applied by a medical practitioner must be of a “reasonable degree of care”:

> *“11. The duties which a doctor owes to his patient are clear. A person who holds himself out ready to give medical advice and treatment impliedly undertakes that he is possessed of skill and knowledge for the purpose. Such a person when consulted by a patient owes him certain duties viz. a duty of care in deciding whether to undertake the case, a duty of care in deciding what treatment to give or a duty of care in the administration of that treatment. A breach of any of those duties gives a right of action for negligence to the patient. The practitioner must bring to his task a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. Neither the very highest nor a very low degree of care and competence judged in the light of the particular circumstances of each case is what the law requires (cf. Halsbury's Laws of England 3rd Edn. Vol. 26 p. 17).”*

7.2 **In Jacob Mathew v State of Punjab((2005) 6 SCC 1) ,** a three judge Bench of the Apex Court upheld the standard of the ordinary competent medical practitioner exercising an ordinary degree of professional skill, as enunciated in Bolam (supra). The Apex Court held that the standard of care must be in accordance with *"general and approved practice":*

> *"24. The classical statement of law in Bolam has been widely accepted as decisive of the standard of care required both of professional men generally and medical practitioners in particular. It has been invariably cited with approval before the courts in India and applied as a touchstone to test the pleas of medical negligence. In tort, it is enough for the defendant to show that the standard of care and the skill attained was that of the ordinary competent medical practitioner exercising an ordinary degree of professional skill. The fact that a defendant charged with negligence acted in accord with the general and approved practice is enough to clear him of the charge. Two things are pertinent to be noted. Firstly, the standard of care, when assessing the practice as adopted, is judged in the light of knowledge available at the time (of the incident), and not at the date of trial. Secondly, when the charge of negligence arises out of failure to use some particular equipment, the charge would fail if the equipment was not generally available at that point of time on which it is suggested as should have been used."*

7.3 **A three judge Bench of the Apex Court in State of Punjab v Shiv Ram((2005) 7 SCC 1) and in Nizam's Institute of Medical Sciences v Prasanth S Dhananka ((2009) 6 SCC 1)** affirmed the judgement in Jacob Matthew.

7.4 **A two judge bench of the Apex Court in Martin F D'Souza v Mohd. Ishfaq((2009) 3 SCC 1)** held thus:

"37. The standard of care has to be judged in the light of knowledge available at the time of the incident and not at the date of the trial. Also, where the charge of negligence is of failure to use some particular equipment, the charge would fail if the equipment was not generally available at that point of time."

7.5 **A two judge Bench of the Apex Court in Kusum Sharma (2010 (3) SCC 480)** laid down guidelines to govern cases of medical negligence. Justice Dalveer Bhandari, speaking for the Court, held:

"89. On scrutiny of the leading cases of medical negligence both in our country and other countries specially the United Kingdom, some basic principles emerge in dealing with the cases of medical negligence. While deciding whether the medical professional is guilty of medical negligence following well-known principles must be kept in view:

I. Negligence is the breach of a duty exercised by omission to do something which a reasonable man, guided by those considerations which ordinarily regulate the conduct of human affairs, would do, or doing something which a prudent and reasonable man would not do.

II. Negligence is an essential ingredient of the offence. The negligence to be established by the prosecution must be culpable or gross and not the negligence merely based upon an error of judgment.

III. The medical professional is expected to bring a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. Neither the very highest nor a very low degree of care and competence

judged in the light of the particular circumstances of each case is what the law requires.

IV. *A medical practitioner would be liable only where his conduct fell below that of the standards of a reasonably competent practitioner in his field.*

V. *In the realm of diagnosis and treatment there is scope for genuine difference of opinion and one professional doctor is clearly not negligent merely because his conclusion differs from that of other professional doctor.*

VI. *The medical professional is often called upon to adopt a procedure which involves higher element of risk, but which he honestly believes as providing greater chances of success for the patient rather than a procedure involving lesser risk but higher chances of failure. Just because a professional looking to the gravity of illness has taken higher element of risk to redeem the patient out of his/her suffering which did not yield the desired result may not amount to negligence.*

VII. *Negligence cannot be attributed to a doctor so long as he performs his duties with reasonable skill and competence. Merely because the doctor chooses one course of action in preference to the other one available, he would not be liable if the course of action chosen by him was acceptable to the medical profession.*

VIII. It would not be conducive to the efficiency of the medical profession if no doctor could administer medicine without a halter round his neck.

IX. It is our bounden duty and obligation of the civil society to ensure that the medical professionals are not unnecessarily harassed or humiliated so that they can perform their professional duties without fear and apprehension.

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

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

90. In our considered view, the aforementioned principles must be kept in view while deciding the cases of medical negligence. We should not be understood to have held that doctors can never be prosecuted for medical negligence. As long as the doctors have performed their duties and exercised an ordinary degree of professional skill and competence, they cannot be held guilty of medical negligence. It is imperative that the doctors must be able to perform their professional duties with free mind."

8. In the practice of medicine, there could be varying approaches to treatment. There can be a genuine difference of opinion. However, while adopting a course of treatment, the medical professional must ensure that it is not unreasonable. The threshold to prove unreasonableness is set with due regard to the risks associated with medical treatment and the conditions under which medical professionals function. This is to avoid a situation where doctors resort to 'defensive medicine' to avoid claims of negligence, often to the detriment of the patient. Hence, in a specific case where unreasonableness in professional conduct has been proven with regard to the circumstances of that case, a professional cannot escape liability for medical evidence merely by relying on a body of professional opinion.

9. In the above facts and circumstances, a careful consideration of the rival submissions, Exhibits available on record, it is proved that there is negligence on the part of the 2nd opposite party and the 1st opposite party had engaged the 2nd opposite party as a consultant for Neuro-Intervention and Neuro-Radiology without scrutinizing and/or verifying the qualifications and competency of the 2nd opposite party. The Disciplinary Committee of the Tamilnadu Medical Council has held that the 2nd opposite party is not an Endovascular Neurosurgeon, but trained physician. Still the 2nd opposite party has performed intracranial stenting Procedure on the patient. The 2nd opposite party failed to prove his competency when several opportunities were provided to him. Thus, the conduct of the Opposite parties fell below that of the standards of a reasonably competent practitioner in the field. By such act, the opposite parties had indulged in unfair trade practice with incompetent skills. Since the 2nd opposite party has failed to prove his competency including educational qualification besides registration details with National/State Medical Council, even after providing sufficient opportunities, this is a fit case to invoke proviso to Section 39(1) (d) read with Section 39(1) (g) to restrain the 2nd opposite party from practicing Endovascular-

Neuro procedures on any patient . Therefore both Opposite parties are jointly and severally liable to compensate the complainant.

10. In the present complaint the complainant has claimed that he has spent Rs.6,36,176/- towards hospital expenses and filed any documentary evidence to prove the that he has spent Rs.6,36,176/-. Further the complainant has not averred that he has incurring any recurring/continuing expenditure in the treatment of her wife. The complainant has proved alleged losses averred in para 51 of the complaint by filing documents (Ex.A1) in support of such allegation of loss.

11. It is now well settled by a catena of decisions of the Apex Court that the contribution made by a non-working spouse to the welfare of the family has an economic equivalent.

12. In Lata Wadhwa v State of Bihar ((2001) 8 SCC 197), a three judge Bench of the Apex Court computed damages to be paid to dependents of deceased persons. The Court took into consideration the multifarious services rendered to the home by a home-maker and held the estimate arrived at Rs.12,000/- per annum to be grossly low. It was enhanced to Rs 36,000 per annum for the age group of 34 to 59 years.

13. In Malay Kumar Ganguly v Sukumar Mukherjee, ((2009) 3 SCC 663) Justice S B Sinha held thus:

> *"172. Loss of wife to a husband may always be truly compensated by way of mandatory compensation. How one would do it has been baffling the court for a long time. For compensating a husband for loss of his wife, therefore, the courts consider the loss of income to the family. It may not be difficult to do when she had been earning. Even otherwise a wife's contribution to the family in terms of money can always be worked out. Every housewife makes a contribution to his family. It is capable of being measured on monetary terms although emotional aspect of it*

cannot be. It depends upon her educational qualification, her own upbringing, status, husband's income, etc."

Thus, in computing compensation payable on the death of a home-maker spouse who is not employed, the Court must bear in mind that the contribution is significant and capable of being measured in monetary terms.

14. In assessing the amount of compensation, this Commission is inclined to follow the principle which has been laid down by the Apex Court in **Malay Kumar Ganguly Vs. Sukumar Mukherjee, ((2009) 3 SCC 663),** a case involving medical negligence.

15. In the present case though the patient, the complainant's wife is not an earning member, the complainant has lost his affectionate companion at the advanced age of 80 plus. This commission cannot ignore the mental agony and sufferings being suffered by the complainant and his family members. Such loss cannot be valued in terms of money. However the Commission assesses the compensation as Rs.10,00,000/-.towards the mental agony and sufferings inflicted upon the complainant and his family members because of the deficiency in service and unfair Trade Practice of the opposite parties.

16. In the result, this complaint is partly allowed. The opposite parties 1 & 2 are jointly and severally directed

i) To pay Rs.16,36,176/- (Rupees Sixteen Lakh Thirty Six Thousand One Hundred and Seventy Six only) towards compensation for mental agony, deficiency in service and unfair trade practice including the sum of Rs.6,36,176/- spent by the complainant towards the treatment charges.

ii) Further, to pay a sum of Rs.25,000/- (Rupees Twenty Five Thousand only) towards cost of proceedings to the complainants within two months from the date of receipt of copy of this order.

iii) The 1st opposite party is directed to discontinue unfair trade the practice of appointing specialists medical practitioners without verifying whether such specialists have enrolled with National / State Medical Council/ Commissions.

iv) The 2nd opposite party is hereby restrained from practicing Endovascular-Neuro procedures with immediate effect, till such time the 2nd opposite party prove that he is competent to perform Endovascular-Neuro procedures by registering himself with respective National/State Medical Council.

Failing which, the above said amounts (Rs.16,36,176/- + 25,000/- = 16,61,176/-) shall carry interest @ 9% p.a. from the date of order till the date of realization.

Dictated by the President to the Steno-typist, transcribed and computerized by her, corrected by the President and pronounced by us in the open Commission on this 29th day of April 2024.

Sd/- **Sd/-** **Sd/-**
MEMBER-II **MEMBER-I** **PRESIDENT**

List of document(s) filed by the complainant(s):-

Sl.No.	Marked as	Date	Details	Remarks
1.	Ex.A1	09.12.2017	In-patient final bill for Rs.6,36,176/-	Xerox
2.	Ex.A2	09.12.2017	Discharge summary.	Xerox
3.	Ex.A3	30.01.2018	Legal notice.	Xerox
4.	Ex.A4	27.02.2018	Reply notice.	Xerox
5.	Ex.A5	---	Authorization letter.	Xerox

List of documents filed by the opposite party(s):-

Sl.No.	Marked as	Date	Details	Remarks
1.	Ex.B1	---	OP registration documents containing history and Evaluation / Diagnosis.	Xerox
2.	Ex.B2	---	In patient admission documents containing discharge summary.	Xerox
3.	Ex.B3	---	DSA (Cerebral Angiogram) consent and clinical reports.	Xerox

4.	Ex.B4	---	Counseling documents containing the discussion towards planning of procedure (Intra Cranial Stenting).	Xerox
5.	Ex.B5	---	Anaesthesia & Intracranial Stenting Procedure – counseling and consent documents (intra cranial stenting – report).	Xerox
6.	Ex.B6	---	DSA Angio & Intracranial stenting-procedure DVD.	Xerox
7.	Ex.B7	---	Progress Notes-post procedure clinical status & occurrence of major storke, tests and protocols followed.	Xerox
8.	Ex.B8	---	CT , MRI reports – done in the hospital after the occurrence of the storke.	Xerox
9.	Ex.B9	---	Literature susbstantiating the possibility of occurrence of major storke in the Intra cranial stenting procedure (minimally invasive) and the criteria / underlying clinical conditions with > 70% stenosis (High Grade) for which the procedure is medically advised over medical management.	Xerox

Ex.C1 : Expert's opinion of Regional Medical Board, Rajiv Gandhi Government General Hospital, Chennai, Madras Medical.

Ex.C2 : Order in Ref.No.TNMC/T.No.693/2021 dated 15.11.2022, Tamil Nadu Medical Council, Chennai**.**

Sd/-
MEMBER-II

Sd/-
MEMBER-I

Sd/-
PRESIDENT