Date of Filing: 01.12.2022
Date of Order: 23.10.2024

BEFORE THE DISTRICT CONSUMER DISPUTES REDRESSAL COMMISSION-III, HYDERABAD

Present

SRI M. RAM GOPAL REDDY, PRESIDENT
SRI R. NARAYAN REDDY, MEMBER
SMT. MADHAVI SASANAKOTA, MEMBER

Wednesday, the 23rd day of October, 2024

**C.C. No.767 of 2022**

Between:

A. Rajesh, S/o. Late A. Sathyanarayana,
Aged about 48 years, Indian, Occ: Artist,
R/o. H.No.77/2RT, Opp: GHMC Park,
Vijayanagar Colony, Masab Tank,
Hyderabad – 500057. ....Complainant

AND

1. Vasavi Medical & Research Centre,
   6-1-91, Beside Vasavi Seva Kendram,
   Lakdikapul, Hyderabad – 500004,
   Rep. by its Medical Superintendent.

2. Dr. R. Sreekanth Reddy,
   Senior Interventional Cardiologist,
   Vasavi Hospitals,
   6-1-91, Beside Vasavi Seva Kendram,
   Lakdikapul, Hyderabad – 500004.

3. Dr. R. Viswanath,
   Cardiologist, Vasavi Hospitals,
   6-1-91, Beside Vasavi Seva Kendram,
   Lakdikapul, Hyderabad – 500004. ....Opp. Parties

Counsel for the Complainant: Sri V. Gouri Sankara Rao, Advocate
Counsel for Opposite Parties 1 to 3: Sri Talaat Sajjad, Advocates.

**ORDER**

**(PER HON'BLE SMT. MADHAVI SASANAKOTA, MEMBER ON BEHALF OF THE BENCH)**

I. This complaint is filed by the Complainant under Section 35 of Consumer Protection Act, 2019 praying to direct opposite parties:

   a. To pay compensation of Rs.50,00,000/- along with interest @ 15% p.a., till the date of realization.
   b. To pay costs of Rs.3,00,000/- and pass any such order/orders as the Hon'ble Commission may deems fit and proper under the circumstances of the case.

II. Brief Facts of the Complaint:

1. Brief facts of the complaint as made out by the Complainant are that the mother of the Complainant, aged about 75 years having suffering from breathlessness, increased chest discomfort on exertion visited the Opposite party no.1 hospital on 12.11.2020 upon the advice of their family Physician Dr. Vijay Kumar Soni for routine Angiogram Test, as a part of routine health screening. She had no history of critical ailments like Blood Pressure, Diabetes and Heart related diseases and did not undergo any treatment for the said ailments at any earlier point of time. The Complainant accompanied his mother to the Hospital and she was admitted in Opposite party no.1 Hospital on 12.11.2020 where it was planned to perform Angiogram in the evening of the same day. But no tests were done on 12.11.2020 and the procedure was postponed to next day i.e., 13.11.2020 due to lack of the technical staff to conduct cardiac procedure. On 13.11.2020 the patient had breakfast and tea at 09.15 am and was speaking with her family happily before getting into operation theatre. The Opposite party no.2 & 3 attended upon the mother of the Complainant for performing Angiogram. After one hour, the Opposite party no.2 & 3 called upon the Complainant and informed that the patient was diagnosed with “two heart blocks” as per Angiogram status and advised to get stent application at the same time to avoid repetition of the procedure for better outcome, but didn’t inform any risks and complications involved in the stent application but assured better life of the patient after stent application. The Complainant and other attendants have consulted their family physician Dr. Vijay Kumar Soni and accepted for application of stent upon the mother of the Complainant. At around 11.30 am and 12.00noon, the Complainant and other attendants were informed that the patient has developed complications during surgery and chances of survival are less and they are trying their level best to save her. The Complainant and other attendants shocked to hear the same and having left with no other alternative, requested the Opposite party no.2 & 3 to save their mother. Around 01.45 pm on 13.11.2020, the Opposite Parties declared that the mother of the complainant died due to sudden cardiac arrest.
2. When the Complainant questioned the Opposite Parties as to why his mother who was very active till she got into the Operation theatre

has died all of a sudden, the Opposite Parties informed that after CAG, his mother was diagnosed to have two vessel disease i.e., LAD and LCX and that the patient underwent PTCA to LCX and that she had sudden Cardio Respiratory Arrest and that inspite of intubation and temporary pace maker and CPR, the patient could not be saved and was declared dead at 01.45 pm. The Opposite Parties except a copy of Death Summary, have not furnished any medical records and any copy of Case Sheet to the Complainant. The Complainant had paid an amount of Rs.2,23,872/- to the Opposite Parties towards charges as per the Hospital Bill dt.13.11.2020. It is averred that the Opposite parties declared that the mother of the Complainant is fit in all respects and can withstand the procedure and assured that there are no risks involved, as it is very common now-a-days to perform the procedure of stenting for 2 vessel disease. Reposing confidence upon the representations of the Opposite Parties, the Complainant accepted for application of stent also, though informed in the middle of the procedure. Complainant submitted that he is suspecting gross negligence and deficiency in the service of the Opposite Parties in application of stenting (CAG+PTCA) and failure to properly manage the complications as a result of which his mother died. It is further submitted that on 22.05.2021, when the Complainant requested the Opposite Parties to furnish total treatment record (Case Sheet), the Opposite party no.1 on 27.05.2021 gave a reply stating that the Case Sheet is the property of the Hospital and cannot be furnished to any person without any orders from the competent authority, despite knowing that the Complainant is the son of the patient who had admitted his mother in the Opposite party no.1 hospital and attended her all through till her death in the said hospital and averred that he is entitled to demand the copy of Case Sheet and other medical records.

3. When Opposite parties did not respond to his plea, the Complainant got issued a Legal Notice on 09.09.2021 demanding the Opposite party no.1 to furnish medical records including Case Sheet, Death Summary, and the profiles of the Doctors who have attended on the patient, within a week. Whereas, on 28.09.2021 the Opposite party no.1 got issued a reply Legal Notice stating that even as per MCI Regulations 2002, they are no obligated to furnish the demanded documents and that they have already furnished the copy of Death

Summary. Finally, on 28.10.2022 the Complainant got issued another Legal Notice demanding the Opposite party no.1 to furnish the Degrees and Registration numbers of Opposite party no.2 & 3 along with the details of Cath Lab license of the Opposite party no.1 hospital but despite service of the notice, as is evident from Postal Track Consignment, the Opposite party no.1 has not chosen to give any reply. Complainant averred that Opposite Parties' nonperforming CAG + PTCA properly, and failing in managing the complications arouse out of it, not only amounts to gross negligence but also amounts to deficiency in service. It is further averred that had the Opposite Parties not performed PTCA, the mother of the Complainant would have survived for several more years.

III. Written version of the Opposite party no.1, 2 & 3:

1. The Opposite party no.1, 2 and 3 admitted to the extent of Complainant approaching the hospital for his mother's angiogram procedure and denied all other allegations alleged towards Opposite party no.1, 2 & 3 and put the Complainant to strict proof of the same. It is submitted that the allegations made by the Complainant are with his own assumptions and presumptions without being proper knowledge with regard to medical procedure according to medical science and literature. It is submitted that the Opposite parties after thorough investigation according to standard protocol, pre-diagnosis test and considering the patient's condition, fitness and upon the consultation and opinion with the other team of doctors opined that the Complainant's mother should undergo the mentioned procedure as advised, and conducted counseling to the Complainant and other attendants and explained all the consequences, risk to the Complainant's mother/patient like existing trauma and post-trauma, monetary involvement and course of action to be taken by the Opposite parties during the treatment and the procedure as to follow during the said surgery and even before and after the said surgery. It is further submitted that the Complainant along with others after having satisfied with the said counseling to the patient and the attendant therein, together agreed for the operation/procedure and with their consensus given full and free consent to the Opposite parties to proceed with the surgery/procedure, thus the Opposite party along with other related doctors posted the Complainant's mother/patient

for procedure of angioplasty/Procedure on the fixed date and carried out the procedure scientifically in accordance with the medical text and literature and following with the complete protocol thereof. The Opposite parties submitted that they have acted acceptable to the medical profession and with due care, skill and diligence carried out the procedure with utmost care to the entire satisfaction and in accordance with the medical text and literature and vehemently denied the allegation of the Complainant that they have not followed the correct therapeutic approach. It is further submitted that despite taking up various investigations and satisfaction before the procedure, the patient might be suffering with some ailments on account of her age factor and not due to the procedure or treatment of these Opposite parties, thus the Opposite parties cannot be made liable for amount of negligence or medical negligence as alleged for no fault of them.

2. Without admitting the adverse allegations of the Complainant, the Opposite parties submitted that the Complainant's mother/Patient was a 75 years female who got admitted in Opposite parties' hospital on 12.11.2020 at 2pm as she was brought to hospital's cardiology department with a complaint of chest pain and breathlessness, and she had significant chest pain and breathlessness for 2 days before admission and she had been having similar but less severe chest pain over three to four months before the day of admission. She had been seen at different health facilities and had been suspected to have a cardiac problem. Since her chest pain was getting worse and she was having breathlessness, she was brought to the Opposite parties' hospital for treatment and was advised admission, further evaluation and treatment and her attendants were explained about the need for the same. It is submitted that the Complainant's mother/patient had a previous history of hypertension and she was on medication to control high blood pressure, and she also had a previous paralysis attack and had been diagnosed to have previous brain STROKE-CVA from which she had recovered only partially. In view of her age of 75 years, history of hypertension, previous paralysis and now chest pain, admission was advised and she was admitted by her attendants to the cardiology area at 2pm. She was assessed by a nurse who examined her pulse rate, blood pressure, temperature, respiratory rate, oxygen saturation and level of consciousness and her medical history, drugs, allergy history, past

medical illness and clinical details were recorded. An intravenous cannula was inserted in her vein, nursing assessment about her physical condition and patient requirement was carried out. Blood was taken by venous puncture for blood investigations. ECG was recorded and She was advised bed rest and medication prescribed was administered. She was connected to heart monitor for recording heart rate and heart rhythm. She was initially assessed by ward doctor and her general examination respiratory and cardiovascular examination and systemic examination were carried out and recorded. She was seen by Opposite party no.3 who advised about blood tests and advised 2D Echo and she was seen by Opposite party no.2, Cardiologist who advised medicines to be given and advised attendant regarding evaluation of patient and her blood reports taken elsewhere prior to admission in Opposite parties' hospital were noted by Opposite party no.2 and diagnosed acute coronary syndrome. She was administered Clopidogrel, Aspirin, Atorvastatin, Nikorandil and low molecular weight heparin cleaxne was administered. Her vitals were recorded and monitored by duty doctors of the cardiology department at regular periodic intervals and her condition, blood pressure and symptoms were monitored. She was advised coronary angiography in view of her complaint of chest pain and breathlessness, with a history of hypertension and previous paralytic stroke, and her attendants were explained in detail the need for angiogram to determine if any blocks to circulation in the coronary arteries (cardiac) were causing her chest pain, breathlessness and ECG changes, and the need to identify the cause was explained so as to determine mode of treatment. Informed consent was obtained from the patient's son and consent for coronary angiography in written form was obtained and possible complications were explained and after obtaining high risk consent from her son, decision to undertake coronary angiogram was taken.

3. On 12.11.2022 after 2.30 pm following rounds by duty doctor, she complained of chest pain. She was examined by the duty doctor and ECG was recorded, medication prescribed was administered and her chest pain subsided. In the morning of 13.11.2020 she was kept fasting orally (nil by mouth), her groins and forearms were prepared for procedure of coronary angiography, her blood reports were noted and her blood pressure, pulse rate and ECG recorded and she was taken to the Cardiac Catheterization Room. Opposite

party no.2 conducted Coronary angiography and Opposite party no.3 assisted the procedure along with Cath lab nurse, Cath lab technician, Nursing staff for drug administration and Respiratory Therapist. Coronary angiography revealed evidence of coronary artery disease and the LAD Artery was noted to have 80% lesion and disease in mid LAD. Diagonal has Ostioproximal disease. Left Circumflex Artery has tandem 70% lesion, right coronary artery Anomalous/abnormal origin. In view of disease in Left Anterior Descending artery (LAD) and Left Circumflex Artery, she was diagnosed to have two vessel disease. In view of recurrent chest pain and symptoms, it was advised that she should have angioplasty and stent placement with drug eluting stent to left circumflex and left anterior descending artery. It is submitted that the Complainant and other attendants of the patient were shown the Angiogram and the diagnosis of two vessel disease was explained and the advice of treatment by angioplasty and clearances of obstruction Blood flow was explained. It is further submitted that the symptoms of recurrent chest pain with ECG Abnormality and the risk of developing Myocardiac infarction was explained and in view of the significant nature of the disease it was advised that she should be treated for the disease in the form of angioplasty. In view of recurrent chest pain with ECG abnormality, it was advised that the procedure for her treatment be carried out without significant delay. It is submitted that all the risks involved in the procedure of angioplasty and stent in 75 year old lady with hypertension and previous paralytic stroke were explained to her attendants in detail and the possible complications of bleeding, blood clots, infection, reblockage of stents, recurrence of disease Arrhythmias, Cardiac Dysfunction, drop in blood pressure or elevation in blood pressure, cardio embolic events, sudden arrhythmia leading to possibility of fatality were explained and informed high-risk consent was obtained from her son and the procedure of angioplasty with stent was commenced. The left circumflex artery was treated by passing PTCA coronary wire drug eluting stent was inserted and placed across the disease and expanded at the start of the procedure of angioplasty and during the procedure her blood pressure, oxygen level, heart rate was constantly monitored and heart rhythm was monitored. She received adequate doses of heparin, and blood thinners as per accepted norms and soon after development of stent in left

circumflex artery, it was seen that the patient had speech disturbance and her sensorium became altered. she had become drowsy and was not responding to speech. Her limb movement to instruction were reduced. It was felt that she was developing a further paralytic stroke. Even as she was being assessed for the same complication, her heart rate reduced. The reduction in heart rate, bradycardia was followed by cardiac arrest and respiratory arrest. She did not have any spontaneous breathing. Immediately Cardio Pulmonary Resuscitation was carried out. Endotracheal intubation was carried out by the respiratory therapist. She was ventilated by AMBU Bag and Oxygen, drugs were administered as per protocol. In view of persistent slow heart rate, Brady Cardial Pacemaker was inserted to normalise heart rate. She had a seizure during the course of the resuscitation and it was felt that her pupils were of unequal size both sides left pupil being pinpoint and right pupil 3mm. She was connected to ventilator and cardiac resuscitation was continued with cardiac massage, medication and ventilatory support the resuscitation was carried out for significant duration. Despite all measures, no heart contraction as determined by pulse could be obtained. She was therefore certified as deceased at 1.50 pm on 13th November, 2020 and her attendants were given a detailed summary of the course of clinical even the procedure was carried out by the Opposite party no.2 & 3. The cause of death as explained to her attendant was due to Cardio respiratory arrest, Coronary artery disease, Cerebrovascular stroke and Hypertension. All protocols as outlined by her clinical condition and disease were carried out after full explanation and consent of her son and attending relatives. The patient's condition and medical therapy was conveyed and discussed with the attendants from admission.

4. It is further submitted that Opposite party hospital and its management acted with due standard care and caution towards the Complainant's mother/patient while she was under treatment and also Opposite party no.1 being reputed hospital, maintained all sterilized instruments, infrastructure and standards as required. As such Opposite Party never committed any kind of unscientific things in taking care or during the said surgery towards Complainant's mother/patient and Opposite Parties cannot be made liable for the said inanimate claim. It is submitted that, the allegations and calculations for claim made are vexatious, illusory,

evasive and arbitrary made basing on Complainant's own assumptions and presumptions only. It is denied as false to state that, Opposite Party without proper care and caution, by omissions and commissions has conducted the said surgery etc. It is submitted that the Complainant and other attendants being legitimate persons had given full consent for known complications as stated, after having accepted the advice of the said doctors, and denied the allegation that Opposite party no.2 operated wrong surgery as false and baseless. It is further submitted that the Opposite party no.2 is a qualified person and possessed requisite skill for performing the said procedure under the medical field and he never committed any amount of negligence as alleged during the said surgery, procedure and the treatment towards the patient and he advised for further investigations as per requirements of the said treatment. It is submitted that as per the case sheet proceedings maintained by the Opposite party no.2 endorsed by the concerned doctor it reveals that, the opposite party after having investigated the standard tests which were adopted and recognized by the medical science and method of practice on that day, performed the said treatment. The Opposite party no.2 having several years of experience in the realm of medical fraternity, surgeries and treatment etc., and to provide suitable treatment of an acceptable standard care of the patients, opted the same care on that day when the patient was admitted. It is submitted that sincere efforts were made by the Opposite party no.2 and other doctors concerned to revive the patient but the patient suffered a serious setback which cannot be thrown on the Opposite parties in the absence of material and prime facie evidence. It is submitted that "the treatment/ medication is not like a mathematical equation, where a particular input always gives a particular output. The treatment methodology can vary from doctor to doctor, Hospital to Hospital and cannot adjudge the negligence on one scale", and as such it is evident from the records that the patient had got proper treatment. It is submitted that the cause was severe in nature when the patient was admitted in the Opposite party no.1 Hospital and there is nothing to show from the record that the Opposite parties has committed negligence in treating the Complainant's mother/patient.

IV. <u>FINDINGS & CONCLUSION:</u>

During Enquiry, the Complainant filed his evidence affidavit as PW1 and marked the documents as Ex.A1 to A8. Sri Nageshwar Rao, Representative of Opposite party no.1 hospital and Dr. Sreekanth Reddy, Representative of Vasavi Medical & Research Centre filed their evidence affidavits and got the document marked as Ex.B1 (Death Certificate). Both of them attended Cross Examination and their statements were recorded as RW1 and RW2. Both parties filed their Written Arguments. Heard. The matter was reserved for orders.

V. Based on the facts and material available on the record, the following points have emerged for consideration:

1. Whether there is any unfair trade practice or deficiency of service on the part of the Opposite Parties as claimed under the complaint?
2. Whether the Complainant is entitled for the relief sought? If so, to what extent?

Point No.1:

1. Complainant's mother/patient aged about 75 years having suffering from breathlessness, increased chest discomfort on exertion visited Opposite Party No.1 hospital on 12.11.2020 upon advice of their family Physician Dr. Vijay Kumar Soni for routine Angiogram Test, as a part of routine health screening. She had no history of critical ailments like Blood Pressure, Diabetes and Heart related diseases and did not undergo any treatment for the said ailments at any earlier point of time. On 12.11.2020, the Complainant got her admitted in Opposite party no.1 Hospital where an Angiogram was planned in the evening of the same day. But, no tests were conducted on 12.11.2020, and the procedure was postponed to next day i.e., 13.11.2020 due to lack of the technical staff to conduct cardiac procedure. On 13.11.2020 the patient had breakfast and tea at 09.15 am and was speaking happily with her family happily before getting into operation theatre. The Opposite party no.2 & 3 attended upon the Complainant's mother/patient for performing Angiogram. After one hour, the Opposite party no.2 & 3 called upon the Complainant and informed that the patient is diagnosed with "two heart blocks" as per Angiogram status and advised to get stent application at the same time to avoid repetition of the procedure for better outcome. Opposite parties confirmed that the Complainant's mother/patient is fit in all respects and can withstand the procedure and assured that there are no risks involved, and it is

very common now-a-days to perform the procedure of stenting for 2 vessel disease. Reposing confidence upon the version of the Opposite Parties, and upon consultation with their family physician Dr. Vijay Kumar Soni, the Complainant accepted for application of stent, though informed in the middle of the procedure. Around 11.30 am – 12.00noon, the Complainant was informed that the Complainant's mother/patient has developed complications during surgery and chances of survival are less and they are trying their level best to save her. Though shocked to hear that, having left with no other alternative, the Complainant requested the Opposite party no.2 & 3 to save his mother. Around 01.45 pm on 13.11.2020, the Opposite Parties declared death of the Complainant's mother/patient due to sudden cardiac arrest. The Complainant has cleared the Hospital bill dated 13.11.2020 for an amount of Rs.2,23,872/- on the same day. Complainant suspecting gross negligence and deficiency in the service of the Opposite Parties in application of stenting (CAG+PTCA) and failure to properly manage the complications as a result of which his mother died, questioned the Opposite party no.2 & 3 about the reason for his mother's unexpected event, who was very active till she got into the operation theatre for the procedure. Opposite party no.2 & 3 informed the Complainant that after CAG, as his mother was diagnosed to have two vessel disease i.e., LAD and LCX and when the patient underwent PTCA to LCX, she had sudden Cardio Respiratory Arrest and inspite of intubation and temporary pace maker and CPR, the patient could not be saved and was declared dead. Complainant averred that on 22.05.2021, when he requested the Opposite Parties to furnish total treatment record (Case Sheet), the Opposite party no.2 on 27.05.2021 gave a reply stating that the Case Sheet is the property of the Hospital and cannot be furnished to any person without any orders from the competent authority, despite knowing that the Complainant is the son of the patient who had admitted his mother in the Opposite party no.1 hospital and attended her all through till her death in the said hospital. Though he is entitled to obtain the copy of Case Sheet and other medical records, the Opposite Parties have not issued any medical records or copy of Case Sheet to him except copy of Death Summary. Inspite of Complainant issuing legal notices dated 09.09.2021 and 28.10.2022, the Opposite parties did not furnish the medical

records of the Complainant's mother/patient nor the Degrees and Registration numbers of Opposite party no.2 & 3 along with the details of Cath Lab license of the Opposite Party No.1.

2. Opposite parties denied the allegations of the Complainant as his own assumptions and presumptions due to lack of proper knowledge regarding the medical procedure according to medical science and literature. Opposite parties claimed that after thorough investigation according to standard protocol, pre-diagnosis test and considering the patient's condition, fitness and upon consultation and opinion with the other team of doctors, opined that the Complainant's mother/patient should undergo the mentioned procedure as advised, and conducted counseling to the Complainant and other attendants and explained all the consequences, and risks involved in the said procedure to the Complainant's mother/patient like, existing trauma and post-trauma, monetary involvement and course of action to be taken by the Opposite parties during the treatment and the procedure as to follow during the said surgery and even before and after the said surgery. Having satisfied with the said counseling to the patient and the attendant therein, they agreed for the operation/procedure and given full and free consent to the Opposite parties to proceed with the surgery/procedure, thus the Opposite party along with other related doctors posted the Complainant's mother/patient for procedure of angioplasty/Procedure on the fixed date and carried out the procedure scientifically in accordance with the medical text and literature and following with the complete protocol thereof. Opposite party no.1 & 2 further claimed that they have acted the way acceptable to the medical profession and with due care, skill and diligence carried out the procedure with utmost care to the entire satisfaction and in accordance with the medical text and literature and denied the allegation of the Complainant that they have not followed the correct therapeutic approach. It is further asserted that the Opposite parties cannot be made liable for medical negligence as alleged by the Complainant in view of Opposite parties having taken up various investigations before the procedure, and stated that the patient might be suffering with some ailments on account of her age factor and not due to the procedure or treatment of the Opposite parties. Opposite party hospital and its management confirmed that they have acted with due standard care and caution

towards the Complainant's mother/patient while she was under treatment and also Opposite party no.1 being reputed hospital, maintained all sterilized instruments, infrastructure and standards as required. As such Opposite Party never committed any kind of unscientific things in taking care or during the said surgery towards Complainant's mother/patient and Opposite Parties cannot be made liable for the said inanimate claim. It is further claimed that the Opposite party no.2 doctor is a qualified person possessing requisite skill for performing the subject procedure under the medical field and he never committed any amount of negligence as alleged during the said surgery, procedure and the treatment to the Complainant's mother/patient, who advised for further investigations as per requirements of the said treatment. As per the case sheet proceedings maintained by the Opposite party no.2 endorsed by the concerned doctor it reveals that, the Opposite party after having investigated the standard tests which were adopted and recognized by the medical science and method of practice on that day, performed the said treatment. The Opposite party no.2 having several years of experience in the realm of medical fraternity, surgeries and treatment etc., and to provide suitable treatment of an acceptable standard care of the patients, opted the same care on that day when the patient was admitted and sincere efforts were made by the Opposite party no.2 and other doctors concerned to revive the patient but the patient suffered a serious setback which cannot be thrown on the Opposite parties in the absence of material and prime facie evidence. Opposite parties further claimed that "the treatment/ medication is not like a mathematical equation, where a particular input always gives a particular output. The treatment methodology can vary from doctor to doctor, Hospital to Hospital and cannot adjudge the negligence on one scale", and as such it is evident from the records that the patient had got proper treatment. Moreover, the cause was severe in nature when the patient was admitted in the Opposite party no.1 Hospital and there is nothing to show from the record that the Opposite parties have committed negligence in treating the Complainant's mother/patient.

3. Upon perusal of the material placed on record it is observed that the Complainant's mother/patient when consulted Dr. Vijay Kumar Sony, General Physician for chest pain on 10.11.2020, she was advised for hospital admission at higher centre and referred to

Opposite party no.1 hospital (Ex.A1). Accordingly, on 12.11.2020, the Complainant's mother/patient got admitted in Opposite party no.1 Hospital where an Angiogram was planned. On 13.11.2020 the Opposite party no.2 & 3 attended upon the Complainant's mother/patient for performing Angiogram and diagnosed the patient with "two heart blocks" as per Angiogram status and advised the Complainant to get stent application at the same time to avoid repetition of the procedure for better outcome, and the Complainant in consultation with his family doctor agreed for the said surgery/procedure. Around 01.45 pm on 13.11.2020, the Opposite Parties declared death of the Complainant's mother/patient due to sudden cardiac arrest. Complainant filed Death summary of his mother dated 13.11.2020 (Ex.A2) where the cause of death of his mother is noted as sudden cardiac arrest. Complainant addressed a letter dated 22.05.2021 (Ex.A4) to the Superintendent of the Opposite party no.1 hospital requesting for his mother's complete treatment record (Case sheet), to which the Opposite party no.1 hospital superintendent replied on 27.05.2021(Ex.A5) stating that the contents of the said case sheet are the property of the hospital and hence, cannot be furnished to any person without orders from the competent authority. Aggrieved by the said reply, the Complainant issued legal notice dated 09.09.2021 to the Opposite party no.1 hospital to furnish the details as per the regulations under Sec 20 A R/w Sec.33 (m) of the Indian Medical Council Act 1956 conferred by the Medical Council of India. The said notice further submitted that as per regulation 1.3.2, if any request is made for medical records either by patient/authorised attendant involved, the same may be duly acknowledged and documents shall be issued within the period of 72 hours and, MCI ethics regulations 7.2 clarifies that not giving records amounts to professional misconduct. Upon receiving the said legal notice, the Opposite parties sent reply notice dated 28.09.2021 (Ex.A7) stating that a copy of the death summary and other details with procedure CD was sent to the Complainant along with the reply sent in the first instance to the letter requesting for the Case sheet of the deceased. Whereas, in the said reply letter, the superintendent of the Opposite party no.1 hospital had out rightly denied the Complainant's request to furnish case sheet claiming that it is hospital's property and it cannot be shared to anyone without any orders from the

competent authority. Opposite parties contradicting to their own statement, submitted that they have already furnished the copy of the death summary and other details with procedure CD, which is not true. Further, in the said reply notice it is again stated that the death summary and other details were provided to the Complainant twice, i.e., once during the time of the death discharge and second time along with the reply letter but failed to provide any evidence to prove the same. However, the said reply notice has the mention of clause 7.14 of MCI Act that pertains to the non-disclosure of the secrets of the patient, which is irrelevant to the present case.

4. In the subsequent legal notice dated 28.10.2022 (Ex.A8), the Complainant requested for the details of the degrees and registered numbers of the Opposite party no.2 & 3 and the details of the university from where they have obtained the professional degree and the License of the Cath Lab of Cardiology department, in order to ascertain the professional standards of the Opposite parties, but, despite delivery of the said notice, the Opposite parties failed to provide any reply to the same and even during leading their evidence, the Opposite parties have not chosen to submit those details to prove the professional competency of the Opposite party no.2 & 3 doctors and the availability of the license to the Cath Lab of Cardiology department of the Opposite party no.1 hospital for the reasons better known to them, displays their careless attitude.
5. On 13.08.2024, Mr. Y. Nageswar Rao, In-charge of cardiology department was cross examined on behalf of the Opposite party no.1 where he has admitted that he is a layman so far as the medical issues are involved in the present case, and the facts stated in his evidence affidavit are as per the information given by Opposite party no.2 & 3. He admitted that the nursing in-charge has obtained the signatures of the Complainant on the consent forms Ex.B1 (Pg.1 to 3) and further admitted that inspite of receiving the request letter and legal notices from the Complainant they have not issued any documents to the Complainant, claiming case sheet is the property of the hospital and submitted that he is not aware that according to statutory provisions, decided case-laws and under CP Act, the patient or his/her attendants are entitled to obtain the case sheet and other medical records on payment of user charges. His statement once again contradicts with the submission made by the Opposite parties that the death summary and other details were

provided to the Complainant twice, i.e., once during the time of the death discharge and second time along with the reply letter and proved them wrong.

6. As per the medical literature, Angiogram is a diagnostic procedure that uses imaging to show the blood flow through blood vessels or heart and an interventional cardiologist performs an angiogram. If the procedure is being done on general anesthesia, the patient is advised not to eat or drink anything after midnight and only to have clear liquids for breakfast on the day of the procedure. Coronary angioplasty and stent placement are emergency treatments for heart attack and if a nonemergency procedure is scheduled, the cardiologist has to follow certain preparatory steps like, conducting all the required medical tests to find out other conditions of the patient that may increase the risk of complications, and advise to adjust or stop taking certain medicines before angioplasty, not to eat or drink several hours before the procedure, and to take approved medicines with small sips of water on the morning of the procedure. Medical literature further reveals that Ischemic complications of percutaneous coronary intervention (PCI) are infrequent but prognostically important. Whereas, in the instant case, as admitted by the Complainant in his evidence affidavit, his mother took breakfast and tea before the said procedure which evidences that the Opposite parties neither given any instructions in this regard nor prepared the patient for further procedure, if required. In the absence of Opposite parties' denial on the same, it is evident that the Complainant's mother/Patient had breakfast before the procedure and as such, she was not prepared for any further medical procedures other than the angiogram. As per the evidence affidavit of the Opposite party no.2, he has explained to the Complainant and other attendants all the consequences and risks involved and the course of action to be taken by them during the procedure. If such is the case, it is evident that knowing that the Complainant's mother/patient is not prepared for the any further procedure, if required, other than angiogram, he has proceeded for further procedure of angioplasty and stenting. Further, the Opposite party no.2 has submitted that after the Complainant has given full and free consent, he along with other related doctors posted the Complainant's mother/patient for procedure of angioplasty/procedure on the fixed date and accrued out the

procedure scientifically in accordance with the medical text and literature and following with the complete protocol thereof. However, the Opposite party no.2 has forgot the fact that the angioplasty/procedure was not posted to a fixed date as he mentioned but carried out the additional procedure as an extension of angiogram without any specific preparation of the patient, just to avoid carrying out the procedure once again. Additionally, Opposite party no.2 admitted that in view of the age of the Complainant's mother/patient, H/o Hypertension, previous paralysis and now chest pain she was admitted and assessed by a nurse and blood was taken for blood investigations. ECG was recorded and prescribed medication was administered. She was connected to heart monitor for recording heart rate and heart rhythm. She was initially assessed by ward doctor and her general examination, respiratory and cardiovascular examination and systemic examination were carried out and recorded. Later she was seen by Opposite party no.3 who advised about blood tests and 2D ECHO and was seen by Opposite party no.2 who advised medicines to be given and advised attendant regarding evaluation of the patient. But there are no reports filed to that extent to substantiate that the said tests were duly conducted on the Complainant's mother/patient before commencing the procedure and the patient is fit for undergoing the said procedure and any additional procedures also at one go, if needed, having diagnosed the acute coronary syndrome by the Opposite party no.2. Moreover, the ER Assessment form that is appeared to be filled by the Opposite party no.3 is without his signature.

7. In addition to these observations there are few more observations that proves that the Case sheet is not properly maintained and the necessary precautions were not duly carried out by the Opposite parties before conducting the dual procedure of Angiogram and Angioplasty with stenting on an elderly patient who is a K/C/O of HTN and K/C/O CVA.

    - After the duty nurse handed over the case to the morning duty staff at 08.00am on 13.11.2020 (Ex.B1 – Pg.24), no further monitoring of the patient was recorded. However, the insertions in Doctor's Progress notes in Ex.B1 at Pg.32, 'Plan CAG' and at Pg.36 'Status of the patient and risk of the procedure explained to attendant in detail' are appearing to

be inserted at a later date as they are not matching the original flow of the record and is neither matching with the hand writing of the Opposite party no.2 as it appears in his evidence affidavit and cross examination.

- The notes in Doctor's Progress notes in Ex.B1 at Pg.34 and Pg.35, though appears to be written by one Dr. Praveen, but both the hand writings are distinctly different evidencing that said case sheet is not an original one. Further, the final pages of the said document Pg37 to 39 has no record of the time and the said notes was not signed by the treated doctor.
- From the DMO's handing & taking over sheet (Ex.B1 – Pg.41) it is evident that when the case sheet was handed over from the Afternoon shift DMO to Night shift DMO on 12.11.2020, the night shift DMO recorded that there were no investigations done and no reports obtained and there is no change in the medication. Whereas, as per the Nurse's progress note (Ex.B1 – Pg.23), the patient was admitted in Opposite party no.1 hospital around 2pm and tests for Sr. electrolytes, blood urea viral markers were done and Reports were collected at 4pm. The two contradicting recordings of the case sheet evidences that there is no proper procedure adopted in treating the Complainant's mother/patient by the Opposite parties. Since no such reports were furnished by the Opposite parties along with the case sheet, it adds strength to this conclusion. Generally, whenever such a critical procedure is taken up for an elderly person who is a (K/C/O HTN and Old CVA) known case of Hypertension and Stroke that is referred to as a Cerebral Vascular Accident - a condition of an interruption in the flow of blood to the cells in the brain, much care is needed and all necessary pre-operative tests need to be conducted properly to understand the capacity of the patient to withstand the said procedure as the Opposite parties themselves admitted that all the possible risks and consequences are explained to the Complainant and other attendants. The Opposite parties failed to prove the precautions they have taken during the procedure of Angiogram followed by subsequent Angioplasty with stenting, which was not an emergency condition to attend therein.

- On 13.11.2020 at 09.30am it was recorded in the Doctor's Progress Notes that CAG – Coronary Angiogram was conducted. It is further recorded that the Patient's attendants were explained about 2VD, Plannrd PTCA/DES to LCX/LAD/D1 and full explanation about all risks explained, LCA engaged, suddenly patient developed dysphoria, CVA – followed by bradycardia, (a state with abnormal heart rhythm), CPR commenced, Endotracheal intubation done by respiratory therapist, CPR continued but no cardiac output, PR, HR or BP developed, patient developed CVA/brainstem CVA and subsequently developed Cardiac arrest and patient certified dead at 01.50pm and Cause of death is recorded as CVA – Cardio respiratory arrest. But the said Report is not signed by either of the treating doctors, Opposite party no.2 & 3.
- In the In-patient and family education form, (Ex.B1-pg29), the information recorded related to the patient's diagnosis, procedure undertaken, plan, consent obtained, development of sudden complication, action taken and death occurred as a final result, were not recorded properly and the language used lack basic standard which shows that the same is not recorded by any qualified doctor much less the treating doctors Opposite party no.2 and 3. Further, neither of the signatures i.e., of the Complainant, Opposite party no.1 & 2 are matching with their original ones as per evidence affidavits. It is once again evident from the said document that the Case sheet is not properly maintained during the entire procedure but was prepared as per the convenience of the Opposite parties when the said complaint is filed in this commission.
- During the cross examination of RW2, it is admitted that they have carried out CATH profile, ECG and 2D ECHO, which reports were filed before this commission, and after going through the said reports, he decided to perform Angiogram on the patient. Further, he also admitted that he has gone through all the documents filed by the Opposite parties before this commission but, contrary to his statement, none of those reports were placed on record before this commission. He has submitted that after performing Coronary Angiogram for

which she was primarily posted to conduct the said procedure and not to directly/simultaneously apply stunt, the said angiogram revealed two vessels diseases 85% lesion in LAD and 80 to 85% lesion in LCX. RCA abnormal origin and the same was informed to the patient attendants and advised adhoc angioplasty since she is very symptomatic. This evidences that the patient was not primarily prepared for the subsequent possible procedure, if needed, after the predefined angiogram procedure.

- The Opposite parties claimed that they have shown the Angiogram to the Complainant and other attendants of the patient and the diagnosis of two vessel disease was explained and advised treatment by angioplasty but, the said angiogram report is not filed which is crucial to prove their contention.

8. With the given observations, it is evident that the Opposite parties have acted hastily and negligently in treating the Complainant's mother/patient with multiple procedures at one go knowing very well that she is not prepared for the subsequent procedure of Angioplasty with stenting except for the Angiogram which was originally planned. It is also proved that they have not followed proper protocol in conducting the said procedures as there are no sufficient reports submitted to substantiate that they have followed the standard protocol. Additionally, the Opposite party no.1 hospital did not follow due procedure in issuing the case sheet and necessary documents to the Complainant inspite of receiving multiple requests which amounts to deficiency in service.
9. Considering the age of the Complainant's mother/patient, and in the absence of detailed calculation from Complainant to calculate the compensation prayed for her death, the prayer is partly allowed trusting that the death of the Complainant's mother/patient is a great loss to the family. Thus, point no.1 is answered in favour of the Complainant.

Point No.2:

In the result, the complaint is allowed in part and the Opposite party no.1, 2 & 3 are held jointly and severally liable to pay the Complainant

1. Rs.10,00,000/- (Rupees Ten lakhs only) towards compensation for the mental agony caused and
2. Rs.10,000/- (Rupees Ten Thousand only) towards costs.

Time for compliance is 45 days from the date of this order.

Typed to my dictation and pronounced in the open court on this the 23rd day of October, 2024.

| Sd/- | Sd/- | Sd/- |
|---|---|---|
| MEMBER | MEMBER | PRESIDENT |

**APPENDIX OF EVIDENCE**
**WITNESSES EXAMINED**

**For Complainant:**

PW1 - A. Rajesh.

**For Opposite Parties:**

DW1: Sri Nageshwar Rao, Representative of Opposite Party No.1.

DW2: Dr. Sreekanth Reddy, Representative of Vasavi Medical & Research Centre.

**DOCUMENTS MARKED**

**For Complainant:**

Ex.A1 : is the copy of Prescription, dt.10.11.2020.
Ex.A2 : is the copy of Death Summary, dt.13.11.2020.
Ex.A3 : is the copy of O.P.No.1 Hospital Bill, dt.13.11.2020 for Rs.2,23,872/-.
Ex.A4 : is the copy of Representation to O.P.No.1 Hospital dt.22.05.2021.
Ex.A5 : is the copy of Reply letter, dt.27.05.2021.
Ex.A6 : is the copy of Legal Notice, dt.09.09.2021.
Ex.A7 : is the copy of Reply legal notice, dt.28.09.2021.
Ex.A8 : is the copy of Postal tracking record.

**For Opposite Parties :**

Ex.B1 : is the Death Certificate.

| Sd/- | Sd/- | Sd/- |
|---|---|---|
| MEMBER | MEMBER | PRESIDENT |

KPS

//CERTIFIED TRUE FREE COPY//