Mahaboob Basha C vs Dr. Mansoor Ahmed J on 14 July, 2025

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SC/29/CC/13/2016

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BEFORE THE KARNATAKA STATE CONSUMER DISPUTES REDRESSAL COMMISSION, BENGALURU (PRINCIPAL BENCH)

DATED THIS THE 14th DAY OF JULY, 2025

PRESENT

HON'BLE Mr JUSTICE T G SHIVASHANKAREGOWDA: PRESIDENT

Mrs DIVYASHREE M:LADY MEMBER

,

SC/29/CC/13/2016

Mr C Mahaboob Basha
S/o Late Mohammed Shariff
Aged about 63 years
R/at D No.157, W.No.XXVIII
Behind Dalwala Mosque
Cowl Bazaar, Ballary-583 102

(By Mr S Dorai Babu, Advocate) Complainant

-Versus-

1. Dr Mansoor Ahmed
Consultant ENT Surgeon
Department of ENT
VIMS
Ballary-583 104

(Mr J M Umesha Murthy, Advocate for OP1)

2. St. Mary's Hospital
Rep. by Chief Medical Officer
OPD Road, Cantonment

Ballary-583 104
Karnataka State

(Mr P D' Souza, Advocate for OP2) Opposite Parties

:ORDER:

ORAL PER:Mr JUSTICE T G SHIVASHANKAREGOWDA: PRESIDENT This Complaint is filed u/s 12 of CP Act, 1986.

2. The brief facts of the case pleaded in the complaint is, that one Mrs Ayesha Bee (the deceased) is the wife of the Complainant and OP1 is the Consultant ENT Surgeon working at VIMS, Ballary. On 13.08.2015, the Complainant took his Wife, the deceased to OP1 at 8.15 pm with a complaint of Throat infection from the previous day. OP1, after examining her, advised them to admit her for treatment, as in-patient at St. Mary's Hospital (OP2). Accordingly, the deceased was admitted to St. Mary's Hospital. After admission at OP2 hospital, treatment was provided to the deceased over night. After treatment, the deceased started feeling little bit better and relieved from pain. In the late night hours, OP1 had suggested that the deceased should undergo MRI test at 'Anjana MRI Scan Centre' and issued an appropriate format, dully filled up. Inspite of such prescription, at the early hours of 14.08.2015, OP1 had visited the deceased, informed the attendants that the Patient has to be operated upon, without KSCDRC SC/29/CC/13/2016 any further delay, irrespective of the MRI Scanning. The Complainant was not present along with the patient during the said period. Because of the hurried action of OP1, the deceased was taken to the Operation Theatre and an emergency 'Tracheostomy' was done by OP1 at 10.30 am on 14.08.2015. By 10.45 am the patient was declared dead. It is further alleged that, OP1 without due consultation with the concerned Surgeon, he has conducted a 'botched-up- operation' on the Patient, which is nothing but sheer Medical Negligence on the part of OP1. The Deceased was earning Rs.10 lakhs p.a, being the founder of President of an Educational Society functioning in the name & style as 'Peace Educational Minority Welfare Society'. Therefore, he is liable to pay compensation of Rs.25 lakhs.

3. On service of Notice, OPs entered appearance and filed their respective Versions.

4 (a). OP1 in his Version, contends that, on 13.08.2015, he has been consulted for the ailment affecting the deceased. Before coming to him, the deceased had contacted Senior ENT Surgeon who had diagnosed her ailment as Ludwig KSCDRC SC/29/CC/13/2016 Angina (infection in one space of neck) and advised to undergo Surgery, which was declined and she had insisted for Out-Patient treatment. The deceased was prescribed an Injection and the same was administered, which could be seen in the Prescription Slip and the Case Sheet maintained by the Complainant. Surgery is advised, only when the condition of the patient is precarious. It was noticed after thorough clinical

examination and also Blood Investigation Report that, the deceased was facing difficulty in breathing, swallowing and opening the mouth.

4(b) Initially, the infection was confined to one space of neck and has subsequently, spread to the entire spaces of neck and thereafter into the chest. The ailment was blocking the air way and her condition was indeed critical and there was a possibility of her breathing her last, at any time. Hence, it was absolutely necessary to admit and treat her vigorously as the air way was getting compressed. MRI scanning was advised during Clinical consultation and not in the late hours. The Complainant had urged to take the deceased to VIMS Hospital, Ballary, but, OP1 insisted and KSCDRC SC/29/CC/13/2016 pleaded on religious ground, for admitting her in St. Mary's Hospital, which was proximate to his residence. 4(c). After admission of the deceased to OP2 hospital, utmost care was taken, medical line of management was started, appropriate treatment was given and the same are recorded in the Case Sheet. In order to save the life of the patient, with an intention to secure the air way, the patient was advised to undergo Tracheostomy. But, the attendant present did not agree and insisted for MRI first. Having regard to the seriousness of the patient, the ailment eventually resulted in her death. Blood Oxygen level had dipped to 78%. The complainant was informed that patient cannot be taken for MRI in a critical condition and it was necessary to secure air way by doing Tracheostomy. Only after blood investigation, it was noticed that the Deceased was suffering from Diabetes.

4(d). Over Telephone, the matter was discussed with the Physician, who advised for fasting and postprandial Blood Sugar level for first treatment. Surgery was not done in haste manner, but only with an intention to save the life of KSCDRC SC/29/CC/13/2016 patient. No negligence or breach of duty is caused during the period of treatment. No ingredient towards actionable negligence was made available in the averments made in the Complaint.

4(e). The Hon'ble Apex Court in Jacob Mathew's case discussed meaning of negligence by Medical Professionals. No medical negligence is attributed, as standard procedure of treatment was followed.

4(f). The judgment of the Hon'ble Apex Court in Bolams case is also referred to in this case contending that OP1 is not guilty of negligence and he has acted in accordance with a practice accepted as proper by responsible body of medical men skilled in that particular art and hence, sought for Dismissal of the Complaint.

5. OP2 in his Version contended that, there is no negligence on the part of the Hospital and there is no allegation made against the Hospital authorities, OP2 is nota necessary party to the Complaint and sought for Dismissal of the Complaint.

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6. On behalf of the Complainant, he has examined himself as CW1 and marked 9 documents as Ex C1 to C9. On behalf of OPs, OP1and Superior of OP2 Hospital, Sr. Celine have filed their respective Affidavit Evidences.

7. We have heard the arguments of Mr S Dorai Babu, the learned Advocate for Complainant, Mr J M Umesha Murthy, the learned Advocate for OP1 and Mr P D Souza, the learned Advocate for OP2. On behalf of Complainant and OPs1 & 2, separate Written Arguments are filed. We have perused the same.

8. The points that arise for our consideration are -

i. Whether OP1 has committed a Medical Negligence resulting in death of the deceased?

ii. Whether Complainant is entitled to the relief as prayed for in the Complaint?

:REASONS :

Point No.(i):

9. There is no dispute as to the deceased Ayesha Bee is the wife of the Complainant. On 13.08.2015 at 8.15 pm, the KSCDRC SC/29/CC/13/2016 deceased was taken to OP1, with complaint of throat infection from the previous day. After examination, OP1 advised her for hospitalisation. Accordingly, the deceased was admitted to OP2 Hospital, where she was given treatment. Initially, treatment was given for primary relief to the deceased. OP1 had advised MRI scan to be taken on the next day morning, so that he can decide further course of treatment. Further, on perusal of the records, it is observed that, on 14.08.2015 at 10.30 am, OP1 received information from the attending Nurse about the condition of the deceased, has deteriorated and Blood oxygen level had dipped to 78% and with the consent of the Complainant, Tracheostomy was carried out, without MRI. We also notice that, MRI report has nothing to do with conducting of the Tracheostomy. By 10.40 am on 14.08.2015, the Pulse of the patient, as well as Oxygen level was dipping, which has not recovered and the Patient died at 10.45 am on 14.08.2015.

10. Now on the basis of this, the specific allegation against OP1 that, he has conducted Tracheostomy without consent of the Complainant, without consultation with the Physician and other Surgeons and carrying out the Tracheostomy, KSCDRC SC/29/CC/13/2016 amounts to medical negligence. The OP1 contended that he has promptly attended the patient, he is an expert in the field of ENT; he has explained the consequences of the patient and also to the attendant. In the case sheet, the consent of patient was obtained to carry out tracheostomy to create air way to the patient as she was suffering breathless, which is fatal to the patient. Accordingly, he has conducted tracheostomy. There was no complication on account of tracheostomy, but on account of other complications, such as, pulse and level of Oxygen in the blood was decreasing and it has not come upto the mark and consequently the patient had collapsed.

11. In the Affidavit Evidence of Complainant, he alleged the averments, as made in the Complaint, whereas, in the Affidavit Evidence of OP1, he defended on his actions taken in treating the patient. In view of the same, we have to consider, what is the Medical Negligence? Whether OP1 has followed the standard procedure contemplate to treat a patient of this nature or not;

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12. The Hon'ble National Consumer Disputes Redressal Commission, New Delhi in the case of "Kanchan Singh Vs. Maa Sharda Hospital & anr", held that if an emergency operation was conducted by competent surgeon to save the patient, it is not amounts to medical negligence. The Hon'ble NCDRC at Para 12 of the judgement referred to the judgement of Apex Court in the case of "Jacob Mathew Vs State of Punjab & anr", for better appreciation, we extract the Para 12, as hereunder:

> "Simply because a patient has not favorably responded to a treatment given by a physician or surgery has failed, the doctor cannot be held liable and result was a failure".

13. It is proper to refer literature regarding treatment of this nature. OP2 along with his Written Arguments, submitted the 7th Edition, Volume-I, Scott Borwn's Otorhinolaryngology, Head and Neck Surgery. The text speaks of 'deep neck space Abscesses' that 'these include parapharyngeal or lateral pharyngeal retropharyngeal and submandibular space abscesses and although less common than in the past, partially because of better oral care and KSCDRC SC/29/CC/13/2016 antibiotic treatment, may still present as life-threatening infection'.

14. In the same text, the ailment regarding Ludwig's angina at Key points it is specially mentioned, 'Ludwig's angina' Ludwig's angina has a high incidence of airway compromise and tracheostomy should be considered early.

15. The text also deals with the complication.

The complications after tracheostomy fall in to the following categories.

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      Immediate

-     anaesthetic complications
-     haemorrhage
      thyroid veins
      juglar veins
      arteries
-     air emoblism
-     apnoea
-     cardic arrest
-     local damage
      thyroid cartilage
      cricoid carilage
      recurrent laryngeal nerve

      Intermediate
-     Displacment of the tube
-     Surgical emphysema
-     Pneumothorax/pneumomediastinum
-     Infection; perichondritis
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- Tube obstruction by secretion or crusts
- Tracheal necrosis
- Tracheoarterial fistula

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- Tracheo - oesophageal fistula
- Dysphagia

Long term
- stenosis
- decannulation problems
- tracheocutaneous fistula
- disfiguring scar

'Complication rates quoted in the literature range between 4 and 31 percent for percutaneous tracheostomy and between 6 and 66 percent for surgical tracheostomy. Most of these complications should be avoidable in the majority of cases. Meticulous attention to the details of the technique reduces the complication rate to almost zero in elective non-complicated cases carried out by an experienced team. However, the complication rates are two to five times more common in emergency cases. It is important to emphasize that the most crucial members of this team are usually the nurses who will be responsible for the management of the patient in the first 48 hours'.

16. In another literature- OTOLARYNGOLOGY - Volume III Head and Neck, 3rdEdition, where Clinical Mani-festations regarding Ludwig's Angina is explained as -

'Ludwig's angina or from pharyngeal swelling in lateral pharyngeal and retropharyngeal space abscesses. Dyspnoea is a late finding, indicating impending airway obstruction and steps should be taken to secure the airway immediately'.] The clinical complications of Ludwig's angina is also explained as-

Complication 'Ludwig's original description reported a 50 per cent mortality rate, whereas Patterson's recent report had KSCDRC SC/29/CC/13/2016 a 0 percent mortality rate. The major cause of death in Ludwig's angina is acute airway obstruction, and the most effective means of preventing it include careful monitoring of the patient with intervention at the earliest sign of airway compromise'. The infection was also discussed and the complications on account of the infection in the said literature are as follows:

> 'Formerly, complications of lateral pharyngeal space infection were fairly common; at present they are much rarer but are still occasionally reported. Airway compromise is possible secondary to encroachment by pharyngeal edema, and should move to secure the airway at the first sign of respiratory distress. Internal jugular vein

> thrombosis occasionally occurs and may result in septic emboli with pulmonary emboli, pneumonia, emphysema, bacterial endocarditic, or uncontrolled septicaemia. Under these circumstances, ligation of the internal jugular vein may be indicated. Mediastinitis may also occur as a complication of lateral pharyngeal space infection from spread along the carotid sheath and it carries an extremely high mortality rate'.

17. Cummings Otolaryngology - Head & Neck Surgery, 5th Edition, Volume One - the physical examination has been described and also mode of Treatment. The text speaks of treatment on medical management cell particularly Airway Management, which reads as follows:

> The initial management of any patient with a known or suspected deep neck infection is securing a safe airway. Loss of airway has traditionally been the major source of mortality from deep neck infection. Airway complications KSCDRC SC/29/CC/13/2016 should be anticipated in all cases of deep neck infection and especially infections involving the floor of the mouth, the parapharyngeal space, and the retropharyngeal space. Fiberoptic evaluation of the upper airway at the time of initial evaluation often identifies an evolving airway complications before it occurs. Pulse oximetry monitoring is helpful if interpreted in the proper context, but a normal oximetry should not provide false security in a patient who appears to be in airway distress. Patients with airway compromise should not be transported out of an intensive care suite for prolonged radiographic testing until the airway is secure.
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> The text also deals with selected complication of Deep Neck infection under head note Mediastinitis it has been discussed.
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> Mediastinitis Mediastinitis is a relatively rare complication of deep neck infection with a mortality rate of 30% to 40% caused by spread of infection along the retropharyngeal and prevertebral planes of the neck into the upper mediastinum. Presentation includes diffuse neck edema, dysnea, pleuritic pain with deep breathing, tachycardia, hypoxia and pleural effusion or mediastinal widening on chest radiograph. Thoracic CT scan with intervenous contract often reveals the presence of fluid collection, air-fluid levels or stranding or infiltration of the mediastinal fat. Broad-spectrum intravenous antibiotics are necessary due to a high frequency of multiple pathogens including gram-positive, gram negative, aerobic and anaerobic species. If limited to the anterior superior mediastinum, transcervical drainage via a bilateral cervictomy with blunt dissection along the prevertebral plane often provides sufficient access for drainage, irrigation and placement of soft rubber drains. Thoracotomy should be strongly considered in cases that extend beyond the upper mediastinum or that involve more than one mediastinal compartment. In a meta-analysis of 69 patients with mediastinitis from cervical abscess, the mortality rare was 19% among patients who underwent both cervical and thoracic drainage and 47% among those who underwent cervical drainable alone.

KSCDRC SC/29/CC/13/2016 The above 3 medical literatures explains the ailment, need of treatment procedure for such patient in an emergency.

18. We have carefully evaluated Ex C-1 to C-9, which consists of the Prescription Slips issued by OP1 on 13.08.2015, which refers to admission of patient to OP2 Hospital and patient was admitted with a complaint of pain in the neck over 4-5 days. Ex-C2 is the MRI scan report issued on 13.08.2015. The neck and chest MRI scan has been suggested by OP1. Ex-C3 is the Case Sheet explains the admission of the deceased to OP2 hospital on 13.08.2015 at 10 pm. The patient was said to be discharged on 14.08.2015 at 10.45 am the patient was declared dead by OP1.

19. The case sheet point out the nursing care forwarded to and nursing staff informed the OP1 about the condition of the patient. Ex-C2 also contains Operation Report which stands supported to the contention taken by OP1 about admission and reasons for patient to undergo tracheostomy. The Nursing Daily Record point out the patient was followed KSCDRC SC/29/CC/13/2016 up regularly from 13.08.2015 at 10 pm to 14.08.2015 at 10.45 am. This goes to show that patient was regularly followed up by nursing staff. The interval of timings clearly explains the patient was regularly monitored on an hourly basis.

20. On behalf of the Complainant, except the In-patient record and Out-patient Slip, there is no other material that the patient of this nature when brought before an ENT Surgeon for treatment, what is the treatment protocol required to be followed? What has been followed by OP1? What is expected of ? & what is not followed?. As we referred to the text supra, the complications and the risk of the person with an ailment of this nature required the expert to follow standard procedure required to be adopted by a prudent ENT surgeon.

21. This has been discussed by the Hon'ble NCDRC in the case of "Kanchan Singh Vs Maa Sharda Hospital & anr", wherein, referring to the "Jacob Mathew Vs State of Punjab & anr" case by Hon'ble Apex Court, it has been held that - KSCDRC SC/29/CC/13/2016 "A mere deviation from normal professional practice is not necessarily evidence of negligence. At times, the professional is confronted with making a choice between the devil and the deep sea and he has to choose the lesser evil".

The Hon'ble NCDRC held that "So long as it can be found that the procedure which was in fact adopted was one which was acceptable to medical science as on that date, the medical practitioner cannot be held negligent merely because he chose to follow one procedure and not another and the result was a failure".

22. We have carefully perused the complications, expected treatment that a prudent ENT surgeon has to provide. As discussed in the literature, we do not find any material on record to show that OP1 has deviated from the standard procedure and which is prescribed by the medical text. Mere operating to make the air went by conducting Tracheostomy will not come in the purview of the negligence, as pleaded by the Complainant.

23. Medical Science clearly point out that in such case of complications, the primary duty on the part of ENT Surgeon is to make airway which could be done only by operating the patient by Tracheostomy which the OP1 as performed. We do not find any procedural irregularity or negligence on the part of OP1. The allegations that, he has not consulted with KSCDRC SC/29/CC/13/2016 any Physician is not a ground to alleged medical negligence against OP1.

24. As rightly contended by OP2, there is no allegation made against Hospital and there is no allegation that nursing care was carrying any deficiency. Hence, we are of the considered view that, on the basis of evidence placed before us by the Complainant, we have not persuaded to accept that OP1 has committed any medical negligence in treating the patient. Accordingly, we answer point No.(i) in the negative.

Point No.(ii):

25. The Complainant is seeking compensation of Rs.25 Lakhs, on the ground that the deceased was managing an Institution and earning Rs.10 lakhs p.a. In this regard, the School records and Audit reports are also placed before us. Since, while answering Point No.(i), we have come to a conclusion that there is no medical negligence on the part of OP1, there is no necessity to go in detail about quantum of KSCDRC SC/29/CC/13/2016 compensation. Accordingly, we answer point No.(ii) in the negative.

26. In view of our discussion above, we hold that Complaint is misconceived and proceed to pass the following :-

ORDER Complaint is Dismissed with no order as to costs.

Supply free copy to the parties concerned, immediately.

(Justice T G Shivashankare Gowda) President (Divyashree M) Lady Member *s KSCDRC