BEFORE THE HON'BLE DISTRICT CONSUMER DISPUTES REDRESSAL COMMISSION, GONDIA

Complaint No. : CC/141/2015

Date of filing: 03.12.2015
Date of Order: 17.10.2022

Complainant:

1. Ruplal s/o. Latuji Gautam
   Aged about 67, Occupation-Agricultural
2. Indubai Ruplal Gautam
   Aged about 62, Occupation-Household
3. Nirupa wd/o. Rajeshwar Gautam
   Aged about 23, occupation household

   All R/O. Kindigipar, Post Dongargaon, Gondia, Tahsil and District Gondia

-// **Versus** //-

Opposite Party:

1. Gondia City Hospital Gondia Hospital and Medical Research Center Pvt. Ltd.
   Through Dr. Sanjay Agrawal
   R/o. Bajrang Nagar, Ashok Colony, Gondia
2. Dr. Sanjay Agrawal
   A/a. Major, Occupation-Doctor,
   R/o. Bajrang Nagar, Ashok Colony, Gondia

Quorum :- **Shri. Bhaskar B. Yogi, Hon'ble President**
Ku. Sarita B. Raipure, Hon'ble Member

Present :- Mr. N. S. Popat, Adv. for Complainant
Mr. M. S. Chandwani, Adv. for O. P. 1 & 2

-// ORDER/JUDGEMENT //-

(Passed on dated 17th October, 2022)

Per Shri Bhaskar B. Yogi – Hon'ble President.

1. Present consumer complaint filed Under Section 12 of consumer protection Act, 1986, pertains to medico-legal complaint filed against the opposite-party Hospital and treating Doctor, alleging breach of duty and thereby committed the negligence claiming Rs.20,00,000/- for compensation, costs and mental agony.

Brief facts of the complaint are as under:-

2. The complainant no. 1, complainant no. 2 and complainant no. 3 are father, mother and wife respectively of Late Shri Rajeshwar Gautam. The said Rajeshwar was only son of the complainant no. 1 and 2, who expired in the Hospital of the O. P. No. 2. He was 35 years only at the time of admission in the hospital, who underwent for treatment of O. P. No. 2 at O. P. No. 1 hospital.

3. The Late Shri Rajeshwar Gautam was working as a contributory teacher for mathematics at Rashtriya Higher Secondary School (Arts and Science), Dongargaon (Pardibandh), Gondia. He had completed his B.SC., B.Ed and also studied in Agricultural field and have certificate for Agricultural degree issued by Dr. Panjabrao Deshmukh Agricultural School, Akola in the year 2006. Thus he was highly educated person and his life was also settled. The complainant no. 3 is the wife of the said Rajeshwar Gautam.

4. It is the case of complainant that he (deceased) was having some abdomen pain, vomiting and headache problem, so the complainants and friends have admitted him at O. P. No. 1 hospital on 23.6.2015 at about 11 P.M. for the treatment. He was admitted at O. P. No. 1 after

completing the entire hospital formalities. Thereafter the treatment of Rajeshwar was started by treating doctor i.e. O.P. No. 2. The O.P. No. 2 advised for some tests, which was done immediately on 23.6.2015 at about 11.49 P.M. at Gondia Clinical Laboratory, Gondia by Dr. Mahendra Singh. There is no any serious mismatch in the prescribed limits/quantity of various tests. So everything was normal on 24.6.2015. The blood pressure and pulse rate was also under control/normal on 23.6.2015 and 24.6.2015. The OP No. 2 also told that Rajeshwar will be alright after two three days of treatment.

5. There was no further complaint made by the Rajeshwar on 24.6.2015 to the complainants and during visit to the O.P. No. 2. The treatment was going on; he was talking with complainant and his friends and he was also walking in the hospital. So all were happy to see that health of Rajeshwar was improving and as per advice of the O.P. No. 2 they will discharge him after a day.

6. But late Rajeshwar had later on complaint about his chest pain at about 11.20 P.M. on next day i.e.24.6.2015 to the complainant no. 2 and 3, so they immediately informed the same to available staff nurse, who had given some unknown injection to the Rajeshwar at about 11.25 P.M. and thereafter Rajeshwar got unconscious and his movement was totally unstable, there was no other doctor available at the relevant time. Finally the O. P. No. 2 reached in the hospital at around. 01.00 A.M. on 25.6.2015 and treatment was started but the O. P. No. 2 finally told that the Rajeshwar was expired on 25.6.2015 at about 02.30 AM in the Hospital.

7. The Hospital authority told that they tried to save the life of Rajeshwar, but due to heart attack, the patient was expired. The complainants, relatives and friends were eager to see the Late Rajeshwar, because there was no such problem to the Rajeshwar during

entire day on 24.6.2015. The said Rajeshwar was in ICU for entire day on 24.6.2015 and there was no problem to the said Rajeshwar. Finally the complainants have completed the post death formality. The funeral of the said Rajeshwar was done on 26.6.2015 after reaching the sister of Rajeshwar namely Mineshwari Rahangdale from Ahmedabad. She enquired about the actual problem caught to his brother- late Rajeshwar during treatment from complainants, but they are not sure for the reason of death. Therefore, the Mineshwari had decided to make enquiry from O.P. No. 2, but from the behavior of the O.P. No. 2 and other staff of the O.P. No. 1, it was revealed that something wrong was done by staff of the O.P. No. 1 and due to negligence of the Hospital staff the Rajeshwar was expired. Therefore, Mineshwari had demanded the Indoor medical file of the O.P. No. 1 on 27.6.2015, but the staff officials have refused to supply the same to her. They have made various excuses and tried to avoid delivering the same. The hospital staff had also told that there is no provision to provide Indoor medical treatment report to the relatives. Mineshwari had also tried to meet O.P. No. 2, but he had not given the appointment, so she also told the staff that she will make complaint of the Hospital for not providing the details. She had mounted pressure on the hospital staff and O.P. No. 2, therefore finally on 1.7.2015 at about 6.00 p.m., the O.P. No. 1 and 2 have deliver the alleged duplicate copy of the Indoor medical treatment records of the Late Rajeshwar.

8. The Indoor Medical case Records (herein after refer as 'Records') is falsely prepared by the O.P. as there was no signature of the complainant and patients in the said Records. The hospital staffs have actually obtained the signature of the complainant no. 3 in the Indoor case records, but in the Records supplied there was no signature of the complainant no. 3. The O.P. had prepared fabricated Records to safe guard them self from negligence committed by them. It is pertinent to note that blood pressure and pulse rate of the Late Rajeshwar shown as

normal in the said alleged Records. In the said alleged records it is falsely mentioned that ECG was advised by the O.P. No. 2, but actually there was no such advice given by the O.P. No. 2 to the complainants or patient. It is pertinent to note that O.P. No. 2 had only advised for some tests which were immediately conducted from Gondia Clinical Laboratory, Gondia by Dr. Mahendra Singh, as submitted hereinabove. In the entire Records there is nothing mentioned about whether ECG was done or not. The O.P. No. 2 had not advised for any internal check up. There was no sonography of abdomen or Gastroscopy or plane X-ray of abdomen, which was very important for treatment of abdominal disease. The OPS are negligent in doing their important duty to save the life. The Hospital staff Nurse without giving information regarding chest pain to specialist Doctor had given one unknown injection to Rajeshwar.

9. In the entire Records it is not mentioned about the unknown injection given by staff nurse to the Rajeshwar at about 11.25 P.M. on 24.6.2015. In the Records it is also not mentioned why ECG was not taken when patient had complaint about chest pain. The O.P. had not performed his duty. In the alleged Records it is mentioned that the Rajeshwar expired due to Sudden Cardio respiratory arrest and he expired on 2.30 A.M. on 25.6.2015.

10. It is contentions of the complainant's that normal walking and talking person, could not die especially when he is already in the Hospital. The O.P. No. 1 and 2 did not take care and proper attention towards treatment of Rajeshwar and respectfully submitted, if the condition of Rajeshwar was critical then why proper attention was not taken by O.P. No. 2. The OPs have committed the breach of their duty and thereby committed the negligence. The late Rajeshwar was the only earning member of the family. The complainant no. 3 is aged about 23 years and her husband was expired. The entire family suffered due to

negligence of the OPS. The said Rajeshwar was earning around Rs. 20,000/- per month from salary and tuitions. The work of the Rajeshwar was good and satisfactory in school. The complainants are consumer of the OPS within the meaning of C. P. Act. The complainants are claiming compensation of Rs.19,50,000/- from OP. The complainants have based said calculation on the basis of The Motor Vehicles Act. 1988. The complainants have lost the entire future prospect of life. The late Rajeshwar was the only son of the old aged complainant no. 1 and 2. The complainant no. 3 became widow in her early age of 23 years. All are now required to suffered a lot in future, the demand of the above said compensation of Rs. 19,50,000/ is nominal one. The loss caused to the complainants is more than the claimed amount. The complainant no. 1 and 2 are required to do labour work in the old age for their livelihood. The complainants are also claiming Rs. 25,000/- for mental, physical harassment and for expenses caused to the complainants during treatment and prayed as:-

a. Declare that the OP is deficient in service,

b. Further direct the OPs to pay compensation of Rs. 19,50,000/ to the complainants.

c. Further direct the OP to pay Rs. 25,000/- for the cost of the proceedings

d. also direct the OPs to pay Rs. 25000/- for mental, physical harassment and caused to the complainants on account of deficiency of the OP.

e. grant any other appropriate relief which deems fit to the facts & circumstances of the case in the interest of justice.

11. Complainant's relied upon certain documents filed at pg. no. 12 to 28 mainly death certificate, character certificate, certificate for Agricultural degree issued by Dr. Panjabrao Deshmukh Agricultural School, Akola, teaching certificate issued by National Higher Secondary

School, Indoor case papers of City Hospital along with continuation sheets of treatment and clinical data, blood tests report, electrolytes report, sr. Amylase and sr. Lipase report, rapid test for sr. Creatinine report and lastly death certificate issued by Hospital.

12. The complaint was admitted on 22/12/2015 and notice was issued in accordance with section 13 of CPA, 1986. The Opposite Party appeared and filed their written version on 10/03/2016. They contended that the complaint is filed just to grab the money from opposite party and admitted treatment was given at Hospital suspected and found possibility of Gastritis because of consumption of alcohol or pancreatitis. Various tests were performed along with test of malaria which was found negative. The patient was admitted on 23/06/2015 at about 11:30 p.m. In the evening of 24/06/2015 as patient reported his pain in abdomen was decreased therefore he was advised to take some fluids and juice by mouth in Small quantity. At the time of night around 11:00PM Patient was having abnormal behavior. Patient was having tremor, searching movements and irrelevant talks therefore possibility of ALCOHOL WITHDRAWAL was suspected. His sodium, potassium, calcium and chloride levels were checked which were found in normal range. The test for Malaria was also done which was found negative. Accordingly, for its treatment the O.P. no.1 had given medicines injection aciloc, injection perinorm, injection drotin, intravenous fluid and sucrafil syrup. These types of medicines are used to be prescribed for the patient having such type of disease. At the time of admission ECG of the patient was done by the OP no.1 which was found to be normal. The patient partially relieved from the above symptoms on the next day morning. At the time of morning his blood test was done. In the blood test total leucocytes were raised, serum creatinine was also raised, his serum amylase and serum lipase were raised which confirms diagnosis of PANCREATITIS, Patient was also given the injection

Contramal for relief of pain. The same treatment was continued. And patient was kept nil by mouth.

13. The patient was given injection fulsed 1 ml iv for sedation. The patient was still having abnormal behavior so patient was given INJECTION SERENACE 0.5 ml diluted with 10 ml distilled water after half an hour. The patient was continuously monitored for ECG tracing on monitor and oxygen saturation which were continuously normal. Due to that medicine patient was sleeping but moving intermittently. At about 1:50 AM of 25-06-2015 the patient had sudden cardio respiratory arrest. Opposite Party tried to revive the patient by giving cardiopulmonary resuscitation which was continued till 2:30 AM but the patient cannot be revived. Finally, after all efforts made by the OP he could not be saved hence he was declared dead. There is no any negligence on the part of the OP. There is no deficiency in service provided to the Patient.

14. The Complainant never made any report to the police if they would have find any negligence on the part of the OP this reveals this complaint is filed after thought. If they had any doubt then they would have done Post mortem of the dead body but they did not do so hence it is presumed that the complaint is filed after thought with mala-fide intention to grab money from the OP'S.

15. The OP'S have given treatment to the deceased in accordance with the standards of reasonably competent medical men gives at the time. The O.P. No.2 has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art. The OP is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view. Hence the allegations levelled against the Ops are

baseless without any substance. It is just to grab money from the OPS. Hence, prayed that the present complaint is required to be dismissed.

16. Complainant filed some article written by (1) Dr. Arun Gupta - how to avoid litigation in medical practice, by Dr. Parul Mullica-consent and the Indian medical practitioner. Further relied upon ruling of Hon'ble Supreme Court in case 2009 AIR SCW 3563 between

(i) Nizam Institute of medical science v. Prasanth S. Dhananka and ors. Dated 14/05/2009.

(ii) Samira Kohli v. Prabha Manchanda and anr. decided on 16/01/2008, Indian Medical Council (professional conduct etiquette and ethics) regulation 2002. Article about serenace injection 1ml from https://www.1mg.com/drugs/serenace-injection-1ml-341592.

Schedule for compensation for third party fatal accident injury cases claim under the motor vehicle act.

Also relied upon Regulations mentioned in Indian Medical Council Professional Conduct, Etiquette and Ethics) Regulations, 2002 (Published in Part III, Section 4 of the Gazette of India, dated 6th April, 2002)

1.3 Maintenance of medical records:

1.3.1, 1.3.2., 1.3.3, 1.3.4

CHAPTER 2

2. DUTIES OF PHYSICIANS TO THEIR PATIENTS

2.1 Obligations to the Sick

2.1.1, 2.1.2, 2.2, 2.3. 2.4. The Patient must not be neglected A physician is free to choose whom he will serve. He should however, respond to any request for his assistance in an emergency Once having undertaken a case, the physician should not neglect the patient, nor should he withdraw from the case without giving adequate notice to the patient and his family Provisionally or fully registered medical

practitioner shall not willfully commit an act of negligence that may deprive his patient or patients from necessary medical care.

17. The O.P. relied upon the rulings of Hon'ble Supreme Court-Bombay Hospital & Medical Research centre vs. Asha Jaiswal & ors. Decided on 30/11/2021 and also file certain articles and medical texts viz:

1. Extract of Harrison's Principal of Internal medicine 17th Edition published by MCGraw Hill –Medical

ETIOLOGY AND PATHOGENESIS

TABLE 307-1 CAUSES OF ACUTE PANCREATITIS

Common Causes

- Gallstones (including microlithiasis)
- Alcohol (acute and chronic alcoholism)

APPROACH TO THE PATIENT:

Abdominal Pain

…… Nausea, vomiting, and abdominal distention due to gastric and intestinal hypo motility and chemical peritonitis are also frequent complaints.

Physical examination frequently reveals a distressed and anxious patient. Low-grade fever, tachycardia, and hypotension are fairly common. Shock is not unusual and may result from

(1) hypovolemia secondary to exudation of blood and plasma proteins into the retro peritoneal space (a "retroperitoneal burn");

(2) increased formation and release of kininpeptides, which cause vasodilation and increased vascular permeability; and

(3) Systemic effects of proteolytic and lipolytic enzymes released into the circulation. Jaundice occurs infrequently; when present, it usually is due to edema of the head of the pancreas with compression of the intrapancreatic portion of the common bile duct.

LABORATORY DATA

The diagnosis of acute pancreatitis is usually established by the detection of an increased level of serum amylase. Values threefold or more above normal virtually clinch the diagnosis if overt salivary gland disease and gut perforation or infarctions are excluded. However, there appears to be no definite correlation between the severity of pancreatitis and the degree of serum amylase elevation. After 48-72 h, even with continuing evidence of pancreatitis, total serum amylase values tend to return to normal. However, pancreatic isoamylase and lipase levels

RISK FACTORS THAT ADVERSELY AFFECT SURVIVAL IN ACUTE PANCREATITIS

Severe Acute Pancreatitis

1. Associated with organ failure and/or local complications such as necrosis

2. Clinical manifestations

a. Obesity BMI > 30

b. Hemoconcentration (hematocrit > 44%)

c. Age > 70 3. Organ failure

a. Shock

b. Pulmonary insufficiency (Po <60)

c. Renal failure (CR> 20 mg96)

d. Gl bleeding

……However, jaundice is transient, and serum bilirubin levels return to normal in 4-7 days…….

A CT scan can confirm the clinical impression of acute pancreatitis even in the face of normal serum amylase levels. Importantly, *CT is quite helpful in indicating the severity of acute pancreatitis and the risk of morbidity and mortality and in evaluating the complications of acute pancreatitis (see below). Sonography is useful in acute pancreatitis to evaluate the gallbladder. Radiologic studies useful in the diagnosis of acute pancreatitis are discussed in Chap. 306 and listed in Table 306-1.

DIAGNOSIS

Any severe acute pain in the abdomen or back should suggest acute pancreatitis. The diagnosis is usually entertained when a patient with a possible predisposition to pancreatitis presents with severe and constant abdominal pain, nausea, emesis, fever, tachycardia, and abnormal findings on abdominal examination. Laboratory studies frequently reveal leukocytosis, hypocalcemia, and hyperglycemia. The diagnosis is usually confirmed by the finding of a threefold or greater elevated level of serum amylase and/or lipase. Not all the above features have to be present for the diagnosis to be established. Strong indicators include hemoconcentration (hematocrit > 44%) and signs of organ failure (Table 307-2).

The differential diagnosis should include the following disorders: (1) perforated viscus, especially peptic ulcer; (2) acute cholecystitis and biliary colic; (3) acute intestinal obstruction; (4) mesenteric vascular occlusion; (5) renal colic; (6) myocardial infarction; (7) dissecting aortic aneurysm; (8) connective tissue disorders with vasculitis; (9) pneumonia; and (10) diabetic ketoacidosis. A penetrating duodenal ulcer can usually be identified by imaging studies or endoscopy. A perforated duodenal ulcer is readily diagnosed by the presence of free intraperitoneal air. It may be difficult to differentiate acute cholecystitis from acute pancreatitis, since an elevated serum amylase may be found in both disorders. Pain of biliary tract origin is more right-sided or epigastric than periumbilical and is gradual in onset; ileus is usually absent.

Sonography and radionuclide scanning are helpful in establishing the diagnosis of cholelithiasis and cholecystitis. Intestinal obstruction due to mechanical factors can be differentiated from pancreatitis by the history of colicky pain, findings on abdominal examination, and x-rays of the abdomen showing changes characteristic of mechanical obstruction. Acute mesenteric vascular occlusion is usually evident in elderly debilitated patients with brisk leukocytosis, abdominal distention, and bloody diarrhea, in whom paracentesis shows

sanguineous fluid and angiography shows vascular occlusion. Serum as well as peritoneal fluid amylase levels are increased, however, in patients with intestinal infarction. Systemic lupus erythematosus and polyarteritis nodosa may be confused with pancreatitis, especially since pancreatitis may develop as a complication of these diseases. Diabetic ketoacidosis is often accompanied by abdominal pain and elevated total serum amylase levels, thus closely mimicking acute pancreatitis. However, the serum lipase level is not elevated in diabetic ketoacidosis.

COURSE OF THE DISEASE AND COMPLICATIONS

It is important to identify patients with acute pancreatitis who have an increased risk of dying. Multiple factor scoring systems (Ranson, Imrie, Apache II) are difficult to use, show poor predictive powers, and have not been uniformly embraced by clinicians. The key indicators of a severe attack of pancreatitis are listed in Table 307-2 and include age> 70 years, body mass index (BMI) > 30, hematocrit > 44%, and admission C-reactive protein > 150 mg/L.

However, it is organ failure, in which respiratory failure (Po2< 60 mmHg) dominates, that determines outcome in the majority of difficult to manage cases. The presence of shock (systolic blood pressure < 90 mmHg or tachycardia > 130), renal failure [serum creatinine> 177 μmol/L (>2.0 mg/dL)], and gastrointestinal bleeding (>500 ml/24 h) are also key factors. The high mortality rate of such severely ill patients is due in large part to multi organ failure, especially during the first week, and WARRANTS INTENSIVE monitoring and/or a combination of radiologic and surgical means, as discussed in detail below.

The local and systemic complications of acute pancreatitis are listed in Table 307-3. In the first 2-3 weeks after pancreatitis, patients frequently develop an inflammatory mass, which may be due to organized pancreatic necrosis (with or without infection) or a pseudocyst. Pancreatic abscess develops later, i.e., usually after 6 weeks. Systemic

E307-3 COMPLICATIONS OF ACUTE PANCREATITIS

Local

Necrosis, Sterile Infected, Organized Pancreatic fluid collections, Pancreatic abscess, Pancreatic pseudocyst Pain, Rupture, Hemorrhage, Infection, Obstruction of gastrointestinal tract (stomach, duodenum,colon), Pancreatic ascites, Disruption of main pancreatic duct, Leaking pseudocyst, Involvement of contiguous organs by necrotizing pancreatitis Massive intraperitoneal, Hemorrhage, Thrombosis of blood vessels (splenic vein, portal vein) Bowel infarction,Obstructive jaundice

SYSTEMIC

Pulmonary

Pleural effusion, Atelectasis, Mediastinal abscess, Pneumonitis, Adult respiratory distress syndrome Cardiovascular, Hypotension

Hypovolemia, Sudden death, Nonspecific ST-T changes in electrocardiogram simulating myocardial infarction effusion

……..

complications include pulmonary, cardiovascular, hematologic, renal, metabolic, and central nervous system abnormalities. Pancreatitis and hypertriglyceridemia constitute an association in which cause and effect remain incompletely understood. However, several reasonable conclusions can be drawn. First, hypertriglyceridemia can precede and apparently cause pancreatitis. Second, the vast majority (>80%) of patients with acute pancreatitis do not have hypertriglyceridemia. Third, almost all patients with pancreatitis and hypertriglyceridemia have pre existing abnormalities in lipoprotein metabolism. Fourth, many of the patients with this association have persistent hypertriglyceridemia after recovery from pancreatitis and are prone to recurrent episodes of pancreatitis. Fifth, any factor (e.g., drugs or alcohol) that causes an abrupt increase in serum triglycerides to levels >11 mmol/L (1000

mg/dL) can precipitate a bout of pancreatitis that can be associated with significant complications and even become fulminate.

To avert the risk of triggering pancreatitis, a fasting serum triglyceride measurement should be obtained before estrogen replacement therapy is begun in postmenopausal women, Fasting levels < 3.4 mmol/l. (300 mg/dL) pose no risk, whereas levels > 8.5 mmol/L. (750 mg/dL) are associated with a high probability of developing pancreatitis. Finally, patients with a deficiency of apolipoprotein CII have an increased incidence of pancreatitis; apolipoprotein CII activates lipoprotein lipase, which is important in clearing chylomicrons from the bloodstream.

Acute and Chronic Pancreatitis

The two most common causes of acute pancreatitis are biliary tract disease and alcoholism; other causes are listed in Table 307-1. The risk of acute pancreatitis in patients with at least one gallstone <5 mm in diameter is fourfold greater than that in patients with larger stones. However, after a conventional workup, a specific cause is not identified in -30% of patients.

Recurrent Pancreatitis Approximately 25% of patients who have had an attack of acute pancreatitis have a recurrence. The two most common etiologic factors are alcohol and cholelithiasis. In patients with recurrent pancreatitis without an obvious cause the differential diagnosis should encompass occult biliary tract disease including microlithiasis, hypertri glyceridemia, drugs, pancreatic cancer, sphincter of Oddi dysfunction, pancreas divisum, cystic fibrosis, and pancreatic cancer (Table 307-1).

ACUTE PANCREATITIS

In most patients (85-90%) with acute pancreatitis, the disease is self-limited and subsides spontaneously; usually within 3-7 days after treatment is instituted Conventional measures include (1) analgesics for

pain, (2) IV fluids and colloids to maintain normal intravascular volume, and (3) no oral alimentation.

This finding probably explains why drugs to block pancreatic secretion in acute pancreatitis have failed to have any therapeutic benefit. For this and other reasons, anticholinergic drugs are not indicated in acute pancreatitis. In addition to nasogastric suction and anticholinergic drugs, other therapies designed to "rest the pancreas" by inhibiting pancreatic secretion have not changed the course of the disease.

…… It has been demonstrated that CCK-stimulated pancreatic secretion is almost abolished in four different experimental models of acute pancreatitis. This finding probably explains why drugs to block pancreatic secretion in acute pancreatitis have failed to have any therapeutic benefit. For this and other reasons, anticholinergic drugs are not indicated in acute pancreatitis. In addition to nasogastric suction and anticholinergic drugs, other therapies designed to "rest the pancreas" by inhibiting pancreatic secretion have not changed the course of the disease.

THE ALCOHOL WITHDRAWAL SYNDROME

Once the brain has been repeatedly exposed to high doses of alcohol, any sudden decrease in intake can produce withdrawal symptoms, many of which are the opposite of those produced by intoxication. Features include tremor of the hands (shakes or jitters); agitation and anxiety; autonomic nervous system over activity including an increase in pulse, respiratory rate, and body temperature; and insomnia, sometimes accompanied by frightening dreams. Because alcohol has a short half-life, these withdrawal symptoms generally begin within 5-10 h of decreasing ethanol intake, peak in intensity on day 2 or 3, and improve by day 4 or 5. Anxiety, insomnia, and mild levels of autonomic dysfunction may persist to some degree for 4-6 months as a

protracted abstinence syndrome, which may contribute to the tendency to return to drinking.

At some point in their lives, between 2 and 5% of alcoholics experience withdrawal seizures, often within 48h of stopping drinking. These rare events usually involve a single generalized seizure, and electroencephalographic abnormalities generally return to normal within several days.

The term delirium tremens (DTS) refers to an uncommon state of intense acute withdrawal that includes delirium (mental confusion, agitation, and fluctuating levels of consciousness) associated with a tremor and autonomic over activity (eg, marked increases in pulse, blood pressure, and respirations). Fortunately, this serious and potentially life-threatening complication of alcohol withdrawal is seen in <5% of alcohol-dependent individuals; the chance of DTs during any single withdrawal is <1%, DTs are most likely to develop in patients with concomitant severe medical disorders and can usually be avoided by identifying and treating the underlying medical conditions.

ALCOHOL-RELATED CONDITIONS

ACUTE INTOXICATION The first priority is to assess vital signs and manage respiratory depression, cardiac arrhythmia, or blood pressure in stability, if present. The possibility of intoxication with other drugs should be considered, and blood and urine samples are obtained to screen for opioids or other CNS depressants such as benzodiazepines or barbiturates. Other medical conditions that must be considered include hypoglycemia, hepatic failure, or diabetic ketoacidosis.

Patients who are medically stable should be placed in a quiet environment. If recumbent, patients should lie on their side to minimize the risk of aspiration when the intoxicated person is aggressive or violent, hospital procedures should be followed, including planning for the possibility of a show of force with an intervention team. In the context of aggressiveness, patients should be reminded in a clear and

nonthreatening way that the staff wants to help them to feel better and to avoid problems. If the aggressive behavior continues, relatively low doses of a short-acting benzodiazepine such as lorazepam (e.g., 1-2 mg PO or IV) may be used and can be repeated as needed, but care must be taken so that the addition of this second CNS depressant does not destabilize vital signs or worsen confusion. An alternative approach is to use an antipsychotic medication (e.g., 0.5-5 mg of haloperidol PO or IM every 48 h if needed), but this has the potential danger of lowering the seizure threshold. Two other medications useful for agitation are ziprasi done (10 mg IM every 2n as needed, up to 40 mg) and olanzapine 125-10 mg IM repeated at 2 h and 6 h, if needed). If aggression escalates, the patient might require a short-term admission to a locked ward, where medications can be used more safely and vital signs more closely monitored.

WITHDRAWAL The first step is to perform a thorough physical examination in all alcoholics who are considering stopping drinking, including a search for evidence of liver failure, gastrointestinal bleeding, cardiac arrhythmia, infection, and glucose or electrolyte imbalance.

The second step is to offer reassurance that the acute withdrawal is short lived and to offer adequate nutrition and rest. All patients should be given oral multiple B vitamins, including 50-100 mg of thiamine daily for a week or more. Because most alcoholics who enter withdrawal are either normally hydrated or mildly over hydrated, IV fluids should be avoided unless there is evidence of significant recent bleeding, vomiting, or diarrhea, Medications can usually be administered orally. The third step in treatment is to recognize that most withdrawal symptoms are caused by the rapid removal of a CNS depressant, in this case, alcohol. The symptoms can be controlled by administering any drug of this class in doses that decrease the agitation, and gradually taper the dose over 3-5 days While most CNS depressants are effective, benzodiazepines (Chap 386) have the highest margin of safety and

lowest cost and are therefore, the preferred class of drugs Benzodiazepines with short half lives are especially useful for patients with serious liver impairment or evidence of preexisting encephalopathy or brain damage. However, short acting benzodiazepines such as lorazepam can produce rapidly changing drug blood levels and must be given every 4 h to avoid abrupt fluctuations that may increase the risk for seizures. Therefore, most clinicians use drugs with longer half-lives, such as diazepam or chlordiazepoxide, administering enough drug on day 1 to alleviate most of the symptoms of withdrawal (eg: the tremor and elevated pulse) and then gradually decreasing the dose over a period of 3-5 days. The approach is flexible; the dose is increased if signs of withdrawal escalate, and the medication is withheld if -the patient is sleeping or shows signs of increasing orthostatic hypotension. The average patient requires 25-50 mg of chlordiazepoxide or 10 mg of diazepam given PO every 4-6 h on the first day.

Treatment of the patient with DTS can be challenging and the condition is likely to run a course of 3-5 days regardless of the therapy employed. The focus of care is to identify and correct medical problems and to control behavior and prevent injuries. Many clinicians recommend the use of high doses of a benzodiazepine (as much as 800 mg/d of chlordiazepoxide has been reported), a treatment that will decrease agitation and raise the seizure threshold but probably does little to improve the confusion. Other clinicians recommend the use of antipsychotic medications, such as haloperidol, 2 prasidone, or olanzapine as discussed above, although these drugs have not been directly evaluated for DTS. Antipsychotics are less likely to exacerbate confusion but may increase the risk of seizures; they have no place in the treatment of mild withdrawal symptoms.

Generalized withdrawal seizures rarely require aggressive pharmacologic Intervention beyond that given to the usual patient undergoing withdrawal, i.e, and adequate doses of benzodiazepines.

There is little evidence that anticonvulsants such as phenytoin or gabapentin are effective in drug withdrawal seizures, and the risk of seizures has usually passed by the time effective drug levels are reached. The rare patient with status epilepticus must be treated aggressively (Chap. 363).

While alcohol withdrawal is often treated in a hospital, efforts at reducing costs have resulted in the development of outpatient detoxification for relatively mild abstinence syndromes. This is appropriate for patients in good physical condition who demonstrate mild signs of withdrawal despite low blood alcohol concentrations and for those without prior history of DTS or withdrawal seizures. Such individuals still require a careful physical examination, appropriate blood tests, and vitamin supplementation. Benzodiazepines can be given in a 1- to 2-day supply to be administered to the patient by a spouse or other family member four times a day. Patients are asked to return daily for evaluation of vital signs and to come to the emergency room if signs and symptoms of withdrawal escalate.

2. Extract from National Library of medicine case Report Nihon Holgaky Zasshi. 1990 Jun; 44 (3) 245-7

3. Extract of pancreatitis as the cause of sudden Death in Alcoholies By borgen B. Dalgaarp

4. Extract (abstract) & forensic med Pathol 2001Sep 26(5): 267-70

5. Extract of India Journal for the Practicing Doctor.

6. Extract of Pharmacology for Medical Graduate ELSEVIER (no documents filed only mentioned in list of documents)

Lastly filed color photo copy of all documents available with them like -consent form, Indoor case paper, continuation sheet of treatment and clinical data and various report.

18. Before discussion on merit, we have to note few events took place till date, the complaint was filed on 03/12/2015, admitted on

22/12/2015, Opposite parties filed written version on 27/01/2016, complainant filed an application for appointment of the expert/ independent Court commissioner to verify the medical records of the diseased file in the proceedings and declare the opinion - which was allowed by Hon'ble forum vide order dated 30/12/2016 after hearing the complainant when Opposite Party failed to file reply. Thereafter, due to absence of quorum and no expert report submitted by the Dean of Government Hospital matter was adjourned on various dates as per daily Order sheets.

The complainant filed an application seeking fresh notice calling Dean of Government Hospital to submit report as per order dated 30/12/2016. On 06/09/2019, Since no report submitted direction was given to the complainant to submit expert committee details of Mumbai or Nagpur since complainant alleged that the complaint is filed against Doctor and the Dean of Government Hospital ie K.T.S HOSPITAL (at relevant time) Avoided to submit any adverse report, even not bothered to reply various notices issued from Hon'ble forum.

On 25/09/2019 the complainant filed application for appointment of Director of Government Medical College & Hospital Nagpur to submit its report on the basis of documents filed before the forum. Thereafter Hon'ble forum received one letter signed by (Dr. Avinash Gawande) Medical Superintendent, Government Medical College and Hospital, Nagpur demanding certain documents i.e medical test reports the contents of the letter are quoted for ready reference as below:-

“वरील संदर्भाकिंत पत्राच्या अनुषंगाने राजेश्वर गौतम विरुध्द गोंदिया सिटी हॉस्पीटल याप्रकरणी चौकशी करण्याकरीता मा. वैद्यकीय अधिक्षक यांच्या अध्यक्षतेखाली चौकशी समितीची स्थापना करण्यात आली. सदर चौकशी समितीची सभा दिनांक २४/०६/२०२० ला १२.३० वाजता आयोजीत करण्यात आली. सदर सभेमध्ये चौकशी समितीने प्राप्त झालेल्या सर्व कागदपत्राचे अवलोकन केले असता खालीलप्रमाणे कागदपत्राची त्रुटी आढळुन आली.

1) रुग्णाचे Acute Pancreatitis करीता उपचार सुरु असल्याचे दिसुन येते. परंतु त्याच्या निदाना करीता Serum Lipase आणि Serum Amylase या रक्त चाचणीचे कुठलही अहवाल कागदपत्रासोबत जोडलेले दिसुन येत नाही.

2) रुग्णाच्या छातीत दुखत असल्याची तक्रार असल्यामुळे रुग्णाचे झालेले सर्व E.C.G. किवा इतर चाचण्यांचे अहवाल आढळले नाही.

3) रुग्णांचे मृत्युनंतर शवविच्छेदन झाले असल्यास त्याचा शवविच्छेदन अहवाल पाठविण्यात यावा.

वरील सर्व कागदपत्रांची पुर्तता चौकशी समितीला करण्यात यावी. ज्याशिवाय समितीला आपले मत देणे शक्य होणार नाही."

Complainant filed pursis dated 12/10/2021 informing that he does not have any other documents as received from opposite-party are already submitted to the Nagpur Government Hospital. Hence matter proceeded for filing evidence affidavits and written arguments with citation if any, of the parties and both Ld. Advocate argued the case on the basis of the documents, literature and rulings of Hon'ble Supreme Court and prayed accordingly as per their pleadings.

Under such circumstances we proceeded and kept the matter reserve for orders on 30/08/2022 & 15/09/2022 and since certain literature sought by the commission from complainants adjourned till today. Since Hon'ble President is also given additional charge of Bhandara District Commission the order could not be dictated and complainant was directed to bring certain literature to assist the commission on the issue involved in this complaint, but he failed to bring the medical text, literature etc. Hence today the order has been dictated and pronounced based upon the records available with us.

19. Perused the available record and heard the arguments of LD advocates on length in various dates. Our findings with reasons on following issues are as under:-

Sr. No.	Issues	Our Findings
1.	Whether there is a lapse in taking informed consent (Procedural lapses)?	IN AFFIRMATIVE
2.	Whether O. P. fail to provide proper diagnosis and treatment given by opposite-party is as per standard protocol - (Medical negligence)?	IN AFFIRMATIVE
3.	Whether opposite-party is qualified and has sufficient knowledge, experience and followed standard protocol for treatment?	As per certificate more than 20 years experience but fail to follow standard protocol
4.	What order?	As per final Order

-// FINDINGS WITH REASONS //-

ISSUE NO. 1

21. The opposite party no. 2 the treating doctor has admitted that he failed to take informed consent (signature of patient and his relatives not taken) and as per document consent letter filed by opposite-party at pg. no. Nil (complainant failed to comply our directions dated 13/01/2022 for pagination of complete compilation) doc no. 7 & 8 filed by opposite-party along with application dated 31/03/2022 place of signature are blank.

Informed consent:

The concept of "informed consent" has come to the fora in recent years and many actions have been brought by patients who alleged that they did not understand the nature of the medical procedure to which they gave consent. All information must be explained in comprehensible non-medical terms preferably in local language about the: (i) diagnosis; (ii) nature of treatment; (iii) risks involved; (iv) prospects of success; (v) prognosis if the procedure in not performed; and (vi) alternative methods of treatment.

The three important components of such consent are information, voluntariness and capacity (Dr. Jagdish Singh and Vishwa Bhushan (1999). "Medical Negligence and Compensation", Bharat Law Publications, Jaipur).

The Hon'ble Apex Court in AIR 2008 SUPREME COURT 1385, Samira Kohli v. Dr. Prabha Manchanda & Anr, has summarized the principles relating to consent in the following words:

"Para 32. We may now summarize principles relating to consent as follows:

(i) A doctor has to seek and secure the consent of the patient before commencing a 'treatment' (the term 'treatment' includes surgery also). The consent so obtained should be real and valid, which means that: the patient should have the capacity and competence to consent; his consent should be voluntary; and his consent should be on the basis of adequate information concerning the nature of the treatment procedure, so that he knows what is consenting to.

(ii) The 'adequate information' to be furnished by the doctor (or a member of his team) who treats the patient, should enable the patient to make a balanced judgment as to whether he should submit himself to the particular treatment as to whether he should submit himself to the particular treatment or not. This means that the Doctor should disclose (a) nature and procedure of the treatment and its purpose, benefits and effect; (b) alternatives if any available; (c) an outline of the substantial risks; and (d) adverse consequences of refusing treatment. But there is no need to explain remote or theoretical risks involved, which may frighten or confuse a patient and result in refusal of consent for the necessary treatment. Similarly, there is no need to explain the remote or theoretical risks of refusal to take treatment which may persuade a patient to undergo a fanciful or unnecessary treatment. A balance should be achieved between the need for disclosing necessary and adequate information and at the same time avoid the possibility of the patient

being deterred from agreeing to a necessary treatment or offering to undergo an unnecessary treatment.

(iii) Consent given only for a diagnostic procedure, cannot be considered as consent for therapeutic treatment. Consent given for a specific treatment procedure will not be valid for conducting some other treatment procedure. The fact that the unauthorized additional surgery is beneficial to the patient, or that it would save considerable time and expense to the patient, or would relieve the patient from pain and suffering in future, are not grounds of defence in an action in tort for negligence or assault and battery. The only exception to this rule is where the additional procedure though unauthorized, is necessary in order to save the life or preserve the health of the patient and it would be unreasonable to delay such unauthorized procedure until patient regains consciousness and takes a decision.

(iv) There can be a common consent for diagnostic and operative procedures where they are contemplated. There can also be a common consent for a particular surgical procedure and an additional or further procedure that may become necessary during the course of surgery.

(v) The nature and extent of information to be furnished by the doctor to the patient to secure the consent need not be of the stringent and high degree mentioned in Canterbury but should be of the extent which is accepted as normal and proper by a body of medical men skilled and experienced in the particular field. It will depend upon the physical and mental condition of the patient, the nature of treatment, and the risk and consequences attached to the treatment."

22. We certainly consider that there is deficiency in service in not obtaining the informed or even simple consent of the deceased who was conscious, mentally alert and was in a position to give it nor obtained from the complainant's No. 1 to 3. As per contentions of the complainants "consent" was obtained from the complainant no.3 i.e.

wife of the deceased as mentioned in Para no.7 Pg. no. 4 of complaint but complainant no. 3 fail to affirm said statement on affidavit of evidence being the complainant no.1 has filed the affidavit at pg. no. 76. Therefore the allegations cannot be substantiated. But at the same time Opposite party admitted during arguments that it is procedural lapses on their part and confirmed from document at pg. no. nil Doc 8 filed by OP along with application dated 31.03.2022.

There is no proof to show that the rationale for performing treatment and attendant risk involved were communicated to the patient prior to the treatment.

23. Therefore, drawing inspiration from the landmark judgment (supra), we conclude that there has been deficiency in service by the treating doctor in not obtaining the informed consent from the patient. Accordingly, we hereby award Rs. 1,00,000 as compensation to be paid by the opposite parties to the complainants on procedure lapses. Hence Issue No. 1 is answered in Affirmative.

ISSUE NO. 2 & 3

24. Coming to issue no. 2 from the report at pg. no. nil Doc 11 filed by the OP along with application dated 31.03.2022 the Sr. Amylase was 258.0 mg/dl (normal values –less than 85 U/L) and Sr. Lipase was 301.06 U/L (normal values – up to 60 U/L) report dated 24.06.2015 and Sr. Creatinine was 1.98 mg/dl (normal values – 0.4-1.4 mg/dl) was noted and the treatment given was for Acute Pancreatitis, Alcoholic Gastric, chronic Alcoholic. Doc-8 OP document along with application dated 31.03.2022.

Since the complainant failed to bring any literature, we perused below website for understanding the requirements at the time of

admission and what diagnosis and management would be require to be given.

http://www.tropicalgastro.com/articles/34/3/recurrent-acute-pancreatitis.html

Recurrent acute pancreatitis: an approach to diagnosis and management

Article written by –

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Acute pancreatitis (AP) is a common clinical problem in gastrointestinal practice. It is diagnosed in the presence of acute onset of upper abdominal pain, elevated amylase and/or lipase levels, and imaging evidence of pancreatic and peripancreatic inflammation.

AP is either interstitial or necrotizing. Acute interstitial pancreatitis is seen in 70%–80% of patients and runs a mild course. In contrast, acute necrotizing pancreatitis—a severe form of the disease—is present in 20%–30% of patients and associated with a mortality rate of up to 40%. Others and we have shown that the extent of pancreatic necrosis correlates with organ failure and mortality.

The cause of AP is evident after standard investigations in about 70%–80% of patients during or after the first attack. Gallstones are the cause of AP in about 45%, alcohol intake in 20%–25%, post-endoscopic retrograde cholangio pancreatography (ERCP) in 5%–7%, and miscellaneous in about 5% of cases. Thus, the cause is not evident in 20%–25% of patients after standard initial evaluation and such patients are labelled as having idiopathic AP (Figure 1). The standard initial evaluation includes a detailed history and physical examination, and investigations such as liver function tests (LFTs), lipid profile, serum calcium and imaging.

Phase I investigations: Phase I investigations should be carried out after the first episode of AP (Table 7). These include serum biochemistry and an abdominal USG. LFTs have a very important role during first 48 hours after onset of pancreatitis. Abnormal LFT may indicate biliary aetiology for AP. It has been shown that alamin aminotransferase (ALT) >3 times the upper limit of normal (ULN) and bilirubin level >3 mg/dL predict biliary pancreatitis with a high degree of accuracy. In a study, ALT level >150 IU/L had a sensitivity of 96% for predicting biliary aetiology for AP.[63] One should strongly suspect microlithiasis as the cause of pancreatitis in presence of abnormal LFT and absence of gallstones on imaging. Serum calcium and triglyceride (TG) levels must be obtained after the subsidence of acute episode because they may not be elevated during the acute episode. If a patient have had a CECT scan of the abdomen during the acute episode, it need not be repeated at this stage. If the aetiology of pancreatitis is unclear after initial evaluation and phase I investigations, the patient is labelled as having idiopathic pancreatitis (Figure 4) and one should then proceed to phase II investigations (Table 7).

Summary

Approximately 20%–30% of patients with AP do not have a detectable cause after initial evaluation. These patients have a high risk of recurrence of pancreatitis. Patients with IRAP must be thoroughly evaluated to find out the aetiology. Microlithiasis is not a common cause of IRAP at least among Indian patients. The role of PD is better understood now and it is believed to be a cofactor; the main factor being associated genetic mutations. The role of SOD as a cause of IRAP remains controversial especially that of type II and type III and there is still not much clarity about the differential role of biliary and pancreatic SOD. Malignancy should be ruled out in any patient with idiopathic pancreatitis who is >50 years of age. Early CP can present initially as RAP. The work-up of patients with IRAP includes a detailed history and

investigations. **LFT, serum calcium, serum TG, abdominal USG and CECT scan are the standard phase I investigations**.
EUS, MRCP and possibly ERCP are indicated in phase II, if the work-up is negative after phase I tests. EUS should be done usually 6–8 weeks after an acute episode and is considered as an extremely useful modality. Phase III tests are not required often outside of research setting.

In present complaint, Reports available on records ECG (pg. 60 Dt. 23.06.2015), CBC (pg. 57, dated 23.06.2015), Electrolytes (Pg. 56), Sr. amylase & Sr. Lipase (pg. 58) SR. Creatinine (pg. 59) are of dt.24.06.2015

Thus the treating Doctor though have more than 20 years of experience of medical practice fail to prescribe LFT, Serum TG, Serum Calcium, abdominal USG and CECT Scan Test which are standard investigation for proper diagnosis & treatment of Pancreatitis. Hence Issue No. 2 is also answered In Affirmative and hold that treating doctor is qualified but failed to follow standard protocol.

From records it is clear that investigation of phase I has not been carried out and due this proper diagnosis of Late Rajeshwar Gautam is not properly done which amounts to deficiency in service.

The Nagpur Hospital Committee also suggested that in absence of proper reports what treatment was given and whether opposite-party has committed any deficiency is not possible for them to submit report. Thus it is clearly established that the opposite party no. 2 has committed deficiency in service & O. P. No. 1 is vicariously liable for the act of O. P. No. 2. Hence complaint must be allowed with compensation of Rs. 8,00,000/- only being just & proper, which includes mental agony and harassment. (Total compensation Rs. 1,00,000/- + Rs. 8,00,000/- as per Issue No. 1 + 2). No legal cost allowed since complainant fails to

comply our order dated 13-01-2022 and also no medical text made available for perusal of the commission.

Hence following order.

-// Final Order //-

1. The opposite party No. 1 & 2 are jointly & severally liable to pay Rs. 9,00,000/- (Total compensation Rs. 1,00,000/- + Rs. 8,00,000/- as per Issue No. 1 + 2)in total for procedure lapses and for deficiency in service to be paid within four weeks from the date of receipt of this order to the complainant 1, 2 & 3 equally. If fails to comply, penal interest @ 10% p.a. would be applicable after four weeks till realization.

2. Certified free copy of this order be provided to the parties as per Regulation 21.

3. Additional sets of complaint be returned to the complainant and original complaint along with documents be confined to record room

Pronounced on 17th October, 2022.

[KU. SARITA B. RAIPURE]
HON'BLE MEMBER

[MR. BHASKAR B. YOGI]
HON'BLE PRESIDENT

S.D.