NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION
NEW DELHI

FIRST APPEAL NO. 402 OF 2023

(Against the Order dated 09/03/2023 in Complaint No. 38/2016 of the State Commission Uttar Pradesh)

1. OPAL HOSPITAL & 2 ORS.
HAVING ITS OFFICE AT N 10/60-2, KARJARMATA, DW ROAD,VARANASI
VARANSI
2. DR. PRAMOD KUMAR RAI
ADULT MBBS, MS, FRCS(I),PHD.(LASER SURGERY) S/O H.B RAI,.N 10/60-2, KARKAMATTA DLW ROAD
VARANSI
3. DR SMT SMRITA RAI
ADULT W/O DR. M.G. RAI N10/60-2,KARKARMATTA, DLW ROAD,
VARANASI ....Appellant(s)

Versus

1. DAMYANTI SINGH
AGED ABOUT 63 YEARS, W/O SHRI JAGDISHWAR SINGH, S/O HOUSE NUMBER 18, VARUNA VIHAR COLONY, SIKRAUL
VARANASI ....Respondent(s)

FIRST APPEAL NO. 502 OF 2023

(Against the Order dated 09/03/2023 in Complaint No. 38/2016 of the State Commission Uttar Pradesh)

1. DAMYANTI SINGH
W/O SHRI JAGDISHWAR SINGH R/O JOUSE NUMBER18, VARUNA VIHAR COLONY, SIKRAUL,
VARANSI ....Appellant(s)

Versus

1. OPAL HOSPITAL, A MULTISPECIALTY HOSPITAL & 2 ORS.
OFFICE AT: N 10/60-2, KAKRMATTA DLW ROAD
VARANASI
2. DR PRAMOD KUMAR RAI
R/O N 10/60-2, KAKARMATTA, DLW ROAD, VARANASI
3. DR SUNITA RAI
R/O N 10/60-2, KAKARMATTA DLW ROAD,
VARANSI ....Respondent(s)

BEFORE:

HON'BLE MR. JUSTICE RAM SURAT RAM MAURYA,PRESIDING MEMBER
HON'BLE MR. BHARATKUMAR PANDYA,MEMBER

FOR THE APPELLANT : MS. NAMRATA CHANDORKAR, ADVOCATE
MR. RITESH KHARE, ADVOCATE
MR. ADITYA RANA, ADVOCATE

FOR THE RESPONDENT : MR. AKSHYA RINGE, ADVOCATE
MR. AJEYO SHARMA, ADVOCATE
MS. AKANSHA MEHRA, ADVOCATE
MS. MEGHA MUKHERJEE, ADVOCATE
MS. NIKA TIWARI, ADVOCATE

Dated : 14 October 2024

ORDER

1. Heard Ms. Namrata Chandorkar, Advocate, for the hospital and doctors and Mr. Akshya Ringe, Advocate, for Smt. Damyanti Singh.

2. The office has submitted report that FA/502/2023 has been filed with delay of 24 days. The appellant has filed IA/5850/2023 for condoning the delay in filing the appeal. In this IA, the appellant has stated that certified copy of the impugned order was received on 13.03.2023. Thereafter, the appellant collected the papers and handed over the counsel on 20.03.2023 for filing the appeal. The appeal was filed on 02.05.2023. For the reasons given in the IA and as cross appeal has already been filed, we condoned the delay in filing the appeal. IA/5850/2023 is allowed.

3. Opal Hospital, Dr. Pramod Kumar Rai and Dr.(Smt.) Smrita Rai (the opposite parties) have filed FA/402/2023 and Smt. Damyanti Singh (the complainant) has filed FA/502/2023 from the order of Uttar Pradesh State Consumer Disputes Redressal Commission, dated 09.03.2023 passed in CC/38/2016, allowing the complaint and directing Opal Hospital and others (the OPs) to pay Rs.15/- lacs as compensation, Rs.10/- as doctor's fees and other medical expenses, Rs. One lac for extra nourishment, Rs.60/- lacs, for permanent burning, sensation, pain, suffering, disfigurement of right leg, physical and mental agony and litigation cost with interest @10% per annum from 01.01.2019 till the date of payment to the complainant.

4. Smt. Damyanti Singh filed CC/38/2016 for directing Opal Hospital, Dr. Pramod Kumar Rai and Dr.(Smt.) Smrita Rai to pay (i) Rs.15/- lacs as compensation, for loss of her services to the family and estate, due to permanent disability of her right leg; (ii) Rs.10/- as expenses incurred in paying doctor's fees and other medical and traveling expenses; (iii) Rs. One lac towards extra nourishment; (iv) Rs.10/- lacs, for physical and mental agony due to permanent burning, sensation, pain, suffering, disfigurement of right leg, litigation costs; (v) Rs.5/- lacs, as expenses for engaging an attendant; (vi) litigation cost; with interest on these amounts; and (vii) any other relief, which is deemed fit and proper in the facts and circumstances of the case. The complainant stated that Smt. Damyanti Singh (the patient) was wife of Shri Jagdishwar Singh, a retired District Judge and belonged to higher income group in the society. She was keeping good health throughout of her life except minor hypothyroidism for few years back. She suffered from abdomen pain in First week of February, 2014 and consulted Dr. D.N. Singh, who advised for ultrasound of abdomen and pelvis bone. Ultrasound was done on 12.02.2014 at Sigra Diagnostic, which showed 'Cholecystitis with echogenic gall bladder sludge. Small left renal concretion". The patient

showed ultrasound report to Dr. Pramod Kumar Rai (OP-2) on 13.02.2014, who after examining the report and medical history, advised certain tests and medication. All the test reports were received by 14.02.2014. Dr. Pramod Kumar Rai (OP-2) admitted the patient in Opal Hospital (the hospital) on 15.02.2014 in early morning, for laparoscopic cholecystomy. The patient was taken to operation theatre on 15.02.2004 at 9:00 hours by Dr. Pramod Kumar Rai, Dr.(Mrs.) Smrita Rai (OP-2 and 3) and 3-4 staffs of OP-1. Dr. Pramod Kumar Rai instructed Dr.(Mrs.) Smrita Rai to give anaesthesia to the patient and went out. Dr.(Mrs.) Smrita Rai asked the patient to be in supine position and thereafter inserted a needle in spine of the patient. The patient felt current like shock sensation in her right leg. Dr.(Mrs.) Smrita Rai immediately took out the needle and inserted the needle again in the spine of the patient. The patient again felt current like shock sensation in her right leg. Dr.(Mrs.) Smrita Rai immediately took out the needle and instructed the medical staff present in the hospital theatre to caught hold the patient. Two staffs caught hold from each side and a third staff caught hold the head of the patient. Dr.(Mrs.) Smrita Rai inserted the needle third time in the spine of the patient. The patient again felt current like shock in her right leg but anaesthetic medicine was injected at this time. Thereafter, Dr. Pramod Kumar Rai conducted surgery. After regaining consciousness, the patient tried to move her right leg but was unable to do so although other body parts were working normally. Dr. Pramod Kumar Rai came for check-up the patient at about 15:00 hours, then the patient and her husband informed him that there was no movement in right leg of the patient. Dr. Pramod Kumar Rai took it very casually and stated that it was only an effect of anaesthetic drug, which would be subsided in next 48 hours. Dr.(Mrs.) Smrita Rai did not came to check-up the patient to examine the post-operative effect of anaesthesia. Lack of sensation in right leg of the patient continued even on 16.02.2014, which was informed to Dr. Pramod Kumar Rai and other attending doctors of the hospital but they did not give any heed. Lack of sensation in right leg of the patient continued even till 17.02.2014. Then the patient and her husband worried as 48 hours had expired after regaining consciousness and requested Dr. Pramod Kumar Rai to call a neurologist but the request was again ignored. After removal of catheter on 17.02.2014, the patient tried to rise up from the bed for going to toilet herself. While getting down from the bed, she realized no power and sensation in her right leg, which was virtually paralyzed. The husband of the patient immediately informed Dr. Pramod Kumar Rai, then he very reluctantly called Dr. Kaushal Agrawal, an Orthopaedic Surgeon in night and not any neurologist of anaesthetist. The husband of the patient requested for entire medical record of the patient on 18.02.2014 at 11:00 hours as maintained in the hospital and after perusal, it found that there was no report of anaesthetist in the record. When he inquired about it, Dr. Pramod Kumar Rai stated that anaesthetist had not given her report so far, she would be asked to submit her report. The report of anaesthetist has not been attached in the treatment record even on 19.02.2014. The husband of the patient again examined medical record of the patient on 20.02.2014. By that time anaesthetist report (signed and dated on 15.02.2014) was kept in the treatment record. The husband of the patient immediately met with Dr.(Mrs.) Smrita Rai and inquired as to why she had given report in back date which contained an interpolation in size of needle and incorrect fact that needle was pricked 2 times, while actually it was pricked three times and at third attempt the anaesthetic drug was injected. She replied that in normal course, anaesthesia report, if required, only then it is prepared. However, she did not reply about interpolation in size of needle and incorrect fact that needle was pricked 2 times, while actually it was pricked three times. The husband of the patient, at his own level, requested Dr. Rakesh Singh, Neurosurgeon and Dr. D.K. Singh, Anaesthetist, to examine the patient on 18.02.2014.

After examining the patient, Dr. Rakesh Singh observed as "(a) Patient not able to walk on 17Th unable to put right foot properly on ground. (b) O/E not able to dorsiflex right foot. (c) Slight movement on fingers present, sensation on foot absent. (d) Case discussed with orthopaedic surgeon and treatment given as per advice. Advice: Do not walk without accompanying person to avoid fall". Dr. Pramod Kumar Rai advised for MRI of Lumbosacral spine on 18.02.2014, which was got done at Arihant Diagnostic Centre. The MRI report made impression as "MRI features of focal increased, Intramedullary signal intensity in the conus meddullar is on T2 weighted images at D12-L1 level as described above. Early Lumbar Spondylosis with mild anterior subluxation of L4 over L5 vertebral body with annular bulge L4/5 I.V. Disc with attendant B/L facet joint arthrosis with hypertrophied ligamentum flavum leading to thecal sac indentation with mild B/l neural foramina encroachment". From MRI report it is evident that the damage to the spinal cord has been done while injecting anaesthetic drug and the damage caused is so severe that cannot be reverted back to normal functioning of right leg. The patient was discharged on 19.02.2014 in the late evening for the reasons best known to OP-2. However, the patient was again admitted on 20.02.2014 in the hospital under OP-2 and Dr. P.B. Singh as there was no sensation and power in right leg of the patient. The patient remained under treatment till 27.02.2018. However, lack of sensation in right leg continued and the patient was discharge in that condition on 27.02.2014. The patient went for follow up on 29.03.2014 and was referred to Dr. Kaushal Agrawal, Orthopaedic Surgeon, who observed as "Full right foot drop post spinal. Pain in calf. Tender, mild. The patient then got examined in Sir Sunder Lal Hospital, IMS, BHU on 01.05.2014. The doctor made impression as " Partial disc desiccation at multiple levels with no significant radiculopathy. Syrinx formation at D12-L1 level as described above. The Senscry and Motor NCS report conducted at Department of neurology, BHU dated 01.05.2014 showed as "SNCS Reduced SNAP potential was seen over right sural nerve in comparison to left sural nerve. MNCS CMAP amplitude was not recorded over right CPN. EPS is suggestive of sensory, motor axonal neuropathy of right lower limb". The patient thereafter got examined in Max Heathcare, New Delhi on 09.05.2014, wherein Dr. Amit Batra reported as "Right lower leg (distal 7 Prox) (Post Spinal). Advised NW/EMG right lower limb. Physiotherapy and medication. Thereafter, the patient got examined in Primus Super Specialty Hospital, Delhi by Dr. Kaushal Kishore Mishra on 14.06.2014, 14.08.2014 and 09.05.2015. The patient got examined in Sir Sunder Lal Hospital, IMS, BHU on various dates and on advice of Dr. Saurabh Singh got her MRI-MID-DORSOL-LUMBAOSACRAL SPINE at Nobal Star Diagnostic and Interventional Centre on 07.08.2014. The report made following impression "Syrinx changes in spinal cord at D12-Conus Medullary Region Predominantly Right side. Mild difuse disc bulge with disc protusion at L4-L5, Annular Bulge at L3-L4 Predominantly para-Posterio-Central, Resulting compressing over the epidural sac, thecal sac, existing nerve roots with maintained spinal canal dimension & narrowing at L3-L5 Suggested mild propapsed Intervertibral disc with polyradiculopathy". The NCV Report dated 06.08.2014 reported: Test Performed : MNCV RTPTN, CPN, LT PTN, CPN; Test: Left lower limb nerves are normal, Right CPN nerves are mild discharge. Right CPN nerves are neuropathy. Kindly correlate clinically. The NCV Report dated 07.08.2014 reported: Test Performed: MNCV : RT PTN, RT CPN, LT PTN, LT CPN; Test: Left lower limb & Right PTN nerves are normal, Right lower limb CPN nerves are mild discharge. Right lower limb CPN nerves are neuropathy. Kindly correlate clinically. The patient is still going through treatment. Dr.(Mrs) Smrita Rai (OP-3) Anaesthetist was grossly negligent and deficient in administering spinal anaesthesia to the patient on

15.02.2014 i.e.(i) Anaesthetist made three attempts in administering anaesthetic drug, ignoring current like shock sensation in the right leg of the patient. If spinal needle causes pain, she should have avoided injection to prevent nerve damage. (ii) The Anaesthetist intentionally and deliberately avoided to follow up the patient to know the after effects of the loss, caused on account of incorrect and wrong administration of anaesthesia. No radiological means to establish the interspace that was used either by anaesthetist or by the surgeon just after the operation. (iii) It was apparent from the post-operative records that atraumatic needle was inserted in upper lumbar interspace, which ought to have been avoided. (iv) On account of wrong and incorrect administration of anaesthesia post-operative complications developed which were not attended to promptly by the surgeon and anaesthetist. (v) The anaesthesia report was prepared and signed after 19.02.2014 in back date. (vi) There is interpolation in size of needle in the anaesthesia report. (vii) The anaesthesia report is on a separate sheet and not on regular case sheet paper. (viii) Dr.(Mrs) Smrita Rai (OP-3), Anaesthetist did not apply reasonable degree of skill and care with reasonable competence while treating the applicant and did not apply professional skill that she possessed, while administering anaesthesia to the patient. (ix) There has been no coordination between the doctor i.e. OP-2 and his associates and also between the doctors and nursing staff, which resulted in mismanagement. The OPs failed to provide timely medication to the patients in exercise of reasonable care and caution, which is required to be done by the doctor, although the patient complained loss of sensation and power in her right leg to the doctor on 15.02.2014. Due to gross negligence of the OPs, the condition of the patient was deteriorated and she had to take treatment and physiotherapy in various hospital and from various doctor, expending nearly Rs.5/- lacs during this period. The patient is unable to walk freely as she was walking before surgery by OP-2. The patient suffers from permanent disability and unable to serve her family. On these allegations the complaint was filed on 09.02.2016.

5. Opal Hospital, Dr. Pramod Kumar Rai and Dr.(Smt.) Smrita Rai (the opposite parties) filed their joint written reply stating that the hospital was a reputed hospital with super speciality services and has been successfully catering medical services to the patient for last several years. The hospital is a well-equipped with highly qualified and experienced doctors and para-medical staff. Dr. Pramod Kumar Rai (OP-2) is MBBS, MS, FRCS(I), Ph.D. (Laser Surgery) and is in field of surgery since 1995. Dr.(Mrs) Smrita Rai (OP-3) did M.B.B.S. and specialised in the field of anaesthesia and successfully completed DM Anaesthesia from Avadhesh Pratap Singh University, Rewa in 1997 and is a qualified and experienced anaesthetist. Smt. Damyanti Singh, aged about 58 years (the patient) visited the hospital on 13.02.2014 with complaint of pain in abdomen and back. At that time, she had ultrasound report dated 12.02.2014, which showed 'Cholecystitis with echogenic gall bladder sludge. Small left renal concretion". She was examined by Dr. Pramod Kumar Rai (OP-2), who suggested for surgery with method chole. OP-2 advised for certain tests and medicines and asked her to come with test reports and previous medical record. The patient again visited on 14.02.2014 along with test reports. From the test report, she was found fit for surgery and was suggested to admit in the hospital on 15.02.2014 in morning for surgery. The patient was admitted in the hospital on 15.02.2014 in morning, for laparoscopic cholecystomy. The patient was taken to operation theatre on 15.02.2004 at 9:00 hours for surgery by Dr. Pramod Kumar Rai (the surgeon), Dr.(Mrs.) Smrita Rai (the anaesthetist) and medical staffs of OP-1. The OPs denied that Dr. Pramod Kumar Rai instructed Dr.(Mrs.) Smrita Rai to give anaesthesia to the patient and went out and Dr.(Mrs.) Smrita Rai asked the patient to be in

supine position or three attempts were made for injecting the anaesthetic drug. In fact spinal anaesthesia cannot be given in supine position. The injection of anaesthesia was given in sitting position in two pricks. OP-2 advised the patient to set relaxed in blow down position with head down. It is blind procedure, so more than one prick may be required even by most expert hand. The patient did not realise current like shock sensation in her right leg nor she was caught hold by medical staff. Optimum effect was obtained and Dr. Pramod Kumar Rai conducted surgery smoothly, which was uneventful. After surgery, all vitals i.e. pulse, B.P., respiration, oxygen saturation, consciousness of the patient was re-examined. Oxygen saturation was 100% without any external support. Then the patient was shifted to ward. The patient was carefully attended by nursing staff throughout and by the doctors during visiting time. Post-operative care was smooth. The patient or their attendant did not make any complaint either on 15.02.2014 or on 16.02.2014 to OP-2 and 3 or to nursing staff. On 17.02.2014, the catheter of the patient was removed and she was allowed to go toilet. While getting down from the bed, the patient realized difficulty in walking through her right leg and made complaint in this respect. She was immediately examined by Dr. Pramod Kumar Rai, who called Dr. Kaushal Agrawal, an Orthopaedic & Spine Surgeon to resolve the problem of the patient. Dr. Kaushal Agrawal examined the patient and found loss of sensation in particular area and foot drop, which was noted in B.H.T. on 17.02.2014. Dr. Kaushal Agrawal did not find complete loss of sensation and movement in right limb of the patient. This was diminished sensation and weakness in L4, L5, S1, S2. Dr. Kaushal Agrawal advised for Inj. ‘Solumedral 250 mg IV, 8 hourly and first dose of Solumedral was given on 17.02.2014 at 14:30 hours and second dose was given at 22:00 hours. After giving first dose of Solumedral (corticosteroid), there was very good response and the patient able to value on her legs. However, Mr. Jagdishwar Singh, the husband of the patient stopped medication as given by the OPs and called Dr. Rakesh Singh, Neurosurgeon and Dr. Sushil Jaiswal, Anaesthetist, to examine the patient on 18.02.2014. After examining the patient, Dr. Rakesh Singh advised to continue same treatment as advised by Dr. Kaushal Agrawal. Dr. Pramod Kumar Rai (OP-2) advised for MRI of lumbo-sacral spine on 18.02.2014, which was done. MRI report dated 18.02.2014 showed “focal increased intra medullary signal intensity in conus medullaris with early lumbar sponylosis with mild anterior subluxation of L4 L5 vertebral body with annular bulge L4/L5 disc with B/s facet joint arthrosis with hypertrophied ligamentum flavum leading to thecal sac indentation with mild neural foramina encroachment”. From MRI report no one can say that lesion is because of spinal anaesthesia and cannot be reversed back. There was good response in right leg. The patient could put heal on ground but no response in toe. The patient was feeling better and asked for discharge and she was discharged on 19.02.2014 in morning. On 19.02.2014, she was on oral medication and physiotherapy of the foot, which could be done comfortably at her house. The report of anaesthetist was on the record and attached with the case sheet. Anaesthesia report was also written in full in B.H.T. There is no interpolation in respect of needle, which was a writing error. If it would have been prepared later on, then there would have no mistake. OP-3 used two pricks, which was noted in the report of anaesthetist as well as B.H.T. The patient developed drug induced nausea and vomiting on 20.02.2014 in morning. As per advice of Prof. P.B. Singh, the patient was again admitted in the hospital for IV medication on 20.02.2014. Dr. Pramod Rai and Mr. Jagdishwar Singh discussed the case with Prof. P.B. Singh, Consultant Urologist, Max Hospital as a friend and well-wisher. He discussed with his colleagues Orthopaedican, Neurologist and Anaesthetics and advised to give Inj. Solumedral (corticosteroid) for 3 days again and then discharge on oral tablets,

which was given. On 22.02.2014, the patient felt better and there was no nausea and vomiting. Power in right foot and toe improved. Sensation was also improving significantly. On 24.02.2014, the patient was seen by Dr. R.P. Singh, Neurosurgeon. He examined and found that the patient was putting heal on ground and started walking. He added some more medicine (Neuro-Tonics). The patient was also seen by Dr. Avinash Singh, Neurologist, who advised to continue same medicines. The patient was discharged on 27.02.2014 in stable condition. All the allegations contrary to it are denied. The OPs did not commit any negligence and treated the patient as per medical protocol.

6. The complainant filed Replication, Affidavits of Evidence of Smt. Damyanti Singh and Jagdishwar Singh and documentary evidence. The opposite parties filed Affidavit of Evidence of Dr.Pramod Kumar Rai and documentary evidence. The complainant filed an application for obtaining an expert opinion from a Medical Board consisting Anaesthetist, Neurologist and Orthopaedics. State Commission referred the matter to Sanjay Gandhi Post Graduate Institute of Medical Sciences, Lucknow for expert opinion. Medical Board of SGPGIMS submitted its Report dated 19.12.2018, stating that no negligence was committed by the Anaesthetist and neurological complications following spinal anaesthesia is 1/10000 whereas the incidence of severe neurological complications following spinal anaesthesia is reported to be 0.5/10000. Both the parties filed their written arguments.

7. State Commission, after hearing the parties, by the impugned judgment found that a common rule in the field of anaesthesia is that if you prick the spinal first time and the patient suffers an electric shock then it must be aborted but in the present case, it is admitted that OP-3 pricked twice. Expert Opinion of SPPGI did not mention as to how many times the anaesthetic needle can be pricked, if first prick fails and further did not say about puncturing of spinal nerve during the spinal anaesthesia. Expert did not consider the current like sensation felt by the patient. There was no separate consent for anaesthesia. The consent form in not in prescribed proforma. The consent form does not specifically mention all the risks to the patient regarding operation or any other tests, which may be performed. Surgery was performed on 15.02.2014 and on very next day, Dr. Kaushal Agarwal noted regarding weakness of right foot, unable to walk on own. Due to defective spinal anaesthesia and lack of knowledge regarding anaesthesia resulted in the pity situation of the patient, which resulted in 60% disability in the patient. Foot drop is a neurological disorder, which occurs following natural childbirth and spinal anaesthesia due to direct needle trauma or local anaesthetic toxicity. As the patient suffers 60% disability as such compensation of Rs. One lac per percent is payable. On these findings the complaint was allowed and order as stated above was passed. Hence these appeals have been filed. The complainant is aggrieved from the interest having been awarded from 01.01.2019, which is neither correlate with the date of injury or the date of filing the complaint.

8. We have considered the arguments of the parties and examined the record. It is own case of the complaint that the patient suffered from abdomen pain in First week of February, 2014 and consulted Dr. D.N. Singh, who advised for ultrasound of abdomen and pelvis bone. Ultrasound was done on 12.02.2014 at Sigra Diagnostic, which showed ‘Cholecystitis with echogenic gall bladder sludge. Small left renal concretion”. The patient showed ultrasound report to Dr. Pramod Kumar Rai (OP-2) on 13.02.2014, who after examining the report and medical history, advised certain tests and medication. All the test reports were received by 14.02.2014. Dr. Pramod Kumar Rai (OP-2) admitted the patient in Opal Hospital (the

hospital) on 15.02.2014 in early morning, for laparoscopic cholecystomy. The patient came to the hospital for laparoscopic cholecystomy and the husband of the patient has signed the 'Consent Form' which is a composite form for operation and anaesthesia. The complainant did not raise any issue in respect of the consent that 'informed consent' was not obtained. But State Commission has recorded adverse findings in this respect without there being any issue between the parties in respect.

9. Supreme Court in **Samira Kohli v. Dr. Prabha Manchanda, (2008) 2 SCC 1,** summarised 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 he 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 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 unauthorised 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 unauthorised, is necessary in order to save the life or preserve the health of the patient and it would be unreasonable to delay such unauthorised 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* [464 F 2d 772 : 150 US App DC 263 (1972)] 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.

10. Supreme Court in **M.A. Biviji v. Sunita, (2024) 2 SCC 242,** held that to hold a medical practitioner liable for negligence, a higher threshold limit must be met. This is to ensure that these doctors are focused on deciding the best course of treatment as per their assessment rather than being concerned about possible persecution or harassment that they may be subjected to in high-risk medical situations. Therefore, to safeguard these medical practitioners and to ensure that they are able to freely discharge their medical duty, a higher proof of burden must be fulfilled by the complainant. The complainant should be able to prove a breach of duty and the subsequent injury being attributable to the aforesaid breach as well, in order to hold a doctor liable for medical negligence. On the other hand, doctors need to establish that they had followed reasonable standards of medical practice.

11. So far as the arguments that no expert evidence has been produced by the complainant is concerned, Supreme Court in **V. Kishan Rao v. Nikhil Super Speciality Hospital, (2010) 5 SCC 513,** held that this Court however makes it clear that before the Consumer Fora if any of the parties wants to adduce expert evidence, the members of the Fora by applying their mind to the facts and circumstances of the case and the materials on record can allow the parties to adduce such evidence if it is appropriate to do so in the facts of the case. The discretion in this matter is left to the members of the Fora especially when retired Judges of the Supreme Court and the High Courts are appointed to head the National Commission and the State Commissions respectively. Therefore, these questions are to be judged on the facts of each case and there cannot be a mechanical or straitjacket approach that each and every case must be referred to experts for evidence. When the Fora finds that expert evidence is required, the Fora must keep in mind that an expert witness in a given case normally discharges two functions. The first duty of the expert is to explain the technical issues as clearly as possible so that it can be understood by a common man. The other function is to assist the Fora in deciding whether the acts or omissions of the medical practitioners or the hospital constitute negligence. In doing so, the expert can throw considerable light on the current state of knowledge in medical science at the time when the patient was treated. In most of the cases the question whether a medical practitioner or the hospital is negligent or not is a mixed question of fact and law and the Fora is not bound in every case to accept the opinion of the expert witness. Although in many cases the opinion of the expert witness may assist the Fora to decide the controversy one way or the other.

12. Although, expert opinion is not necessary in every case but expert opinion requires its evaluation cautiously in corroboration of other evidence on record and standard medical literature. State Commission ignored Expert Opinion of SPPGI on the grounds that it did not mention as to how many times the anaesthetic needle can be pricked, if first prick fails and further did not say about puncturing of spinal nerve during the spinal anaesthesia. Expert did not consider the current like sensation felt by the patient.

13. In the present case, the patient was admitted in the hospital for laparoscopy cholecystectomy. There is no allegation that any negligence has been committed during surgery of the gall bladder or post-surgery, there is any complication in this respect. The allegations against Dr.(Smt.) Smrita Rai (OP-3) Anaesthetist are as (i) anaesthesia had been

administered in supine condition (ii) the needle was prinked three times, while in first attempt itself and in all attempts the patient experienced shock like sensation in her right leg but ignoring it the third attempt was made forcefully in which the patient was caught hold by the medical staffs and the needle was inserted by OP-3 and anaesthetic medicine was administered. The opposite parties in their written reply has denied the allegation that needle was inserted in supine condition and instead three attempts, only two attempts were made and there was no complaint regarding shock sensation in right leg by the patient.

14. The spinal anaesthesia cannot be administered in supine condition which is impossibility. Thus the allegation of the complaint in this respect is not liable to be believed. Similarly, the allegation that the patient experienced shock sensation in her right leg in sprinkling the needle has also been denied. The opposite parties stated that the patient was asked to set relaxed in blow down position with head down and in second attempt the anaesthesia has been administered without any help of the other medical staff and there was no complaint about shock sensation in right leg by the patient. OP-3 is an experienced qualified anaesthetist. There is no reason to disbelieve the statement of the OPs in this respect. Similarly presence of OP-3 in operation theatre on 15.02.2014, administering anaesthesia by her are admitted as such there is no reason to disbelieve the records of pre-surgery assessment of the patient and monitoring the patient during surgery prepared by the OP-3.

15. The next question has to be examined whether the complication has been caused due to giving anaesthesia in any wrong or negligent manner. In this respect the earliest evidence is on record is MRI report dated 18.02.2014 which reads as follows: -

“MR scan reveals focal increased intramedullary signal intensity in the conus medullaris on T2 weighted images at D12-L1 level showing iso to hypointense signal intensity on T1 weighted images with mild cord swelling.

Mild anterior subluxation of L4 over L5 vertebral body with attendant disc desiccation with annular bulge L4/5 I.V disc with B/L facet joint arthrosis with hypertrophied ligamentum flavum leading to thecal sac indentation with mild B/D neural foramina encroachment.

Lumbar vertebrae shows early degenerative changes in the form of smaller marginal osteophytes at few level, however the vertebral bodies are well preserved in height and shows normal marrow signal intensity.

Rests of the I.V discs are normal height, configuration and signal intensity.

Cauda equine are normal. Rests of the neural foramina and nerve roots are unremarkable. No evidence of any nerve root impingement/compression.

No evidence of primary lumbar canal stenosis. Anteroposterior canal diameter as follows:

L1: 13.5mm, L2: 13.4mm. L3: 13.1mm, L4: 12.7 mm, L5: 13.3 mm, L4/5: 10.2mm.

Neural arches and rest of the facet joints are unremarkable.

Pre and paravertebral soft tissues shows normal signal intensity. No evidence of paravertebral abscess/granulation.

IMPRESSSION:

MRI FEATURES OF FOCAL INCREASED INTRAMEDULLARY SIGNAL INTENSITY IN THE CONUS MEDULLARIS ON T2 WEIGHTED IMAGES AT D12-L1 LEVEL AS DESCRIBED ABOVE, SUGGESTIVE OF? NO SPECIFIC MYELITIS.

EARLY LUMBAR SPONDYLOSIS WITH MILD ANTERIOR SUBLUXATION OF L4 OVER L5 VERTEBRAL BODY WITH ANNULAR BULGE L4/5 I.V DISC WITH ATENDANT B/D FACET JOINT ARTHROSIS WITH HYPERTROPHIED LIGAMENTUM FLAVUM LEADING TO THECAL SAC INDENTATION WITH MILD B/L NEURAL FORMAIA ENCHOACHMENT."

16. Second MRI was done on 01.05.2014 and the report of the same reads as under:

"PARTIAL DISC DESICCATION NOTED AT L3-L4 AND L4-L5 WITH MILD CONCENTRIC DISC BULGE AT L4-L5 LEVEL WITH MILD HYPERTROPHY OF LIGAMENTUM. PROTRUDED DISC AS CUASING THECAL SAC INDENTATION LIGAMENTUM. PROTRUDED DISC IS CAUSING THECAL SAC INDENTATION WITHOUTL ANYE/O COMPRESSION OVER TRAVERSING NERVE ROOTS.

D12-L1 LEVEL SHOWS PRESENCE OF SYRINX FORMATION APPPROX 2CM IN LENGTH.

Rest of the related intervertebral disc show normal dimensions and intensity patterns. Rest of the levels show no bulge is seen with normal calibre of the lateral recesses.

Anterior and posterior longitudinal ligaments are unremarkable.

The bony spinal canal shows normal dimensions with no significant thecal sac stenosis at any level.

The intervertebral alignment and overall spinal curvature is maintained.

No abnormality is noted in the pre/paravertebral soft tissues. The epidural space is maintained.

MR pyelography also shows similar features.

IMPRESSION:

PARTIAL DISC DESICCATION AT MULTIPLE LEVELS WITH NO SIGNIFICANT PADICULOPATHY.

SYRINX FORMATION AT D-12-L1 LEVEL AS DESCRIBED ABOVE."

17. Overall, the MRI findings suggest that the patient has early-stage degenerative changes in her lumbar spine. The mild subluxation, annular bulge, facet joint arthrosis, and

ligamentum flavum hypertrophy are all contributing to potential nerve compression. **MRI features of focal increased intramedullary signal intensity in the conus medullaris on T2 weighted images at D12-L1 level** are often indicative of a pathological process within the spinal cord. Given these MRI findings, **nonspecific myelitis** is a highly probable diagnosis. This condition involves inflammation of the spinal cord without a clearly identifiable cause. The increased signal intensity on T2-weighted imaging is often a hallmark of inflammation within the spinal cord. The expert of SPPGI has not accepted the allegation of the complainant that these complications developed due to wrong manner of needle prinks. In the absence of any contradictory expert opinion or any standard medical literature, it is not possible to find that OP-3 has committed any medical negligence in administering anaesthesia.

18. So far as post-operative care is concerned, from medical record it appears that after removal of catheter on 17.02.2014 while the patient wished to go toilet, she realized difficulty in walking and made complaint in respect of lack of sensation and power in her right leg. She was immediately examined by Dr. Pramod Kumar Rai, who called Dr. Kaushal Agrawal, an Orthopaedic & Spine Surgeon to resolve the problem of the patient. Dr. Kaushal Agrawal examined the patient and found loss of sensation in particular area and foot drop, which was noted in B.H.T. on 17.02.2014. Dr. Kaushal Agrawal did not find complete loss of sensation and movement in right limb of the patient. This was diminished sensation and weakness in L4, L5, S1, S2. Dr. Kaushal Agrawal advised for Inj. 'Solumedral 250 mg IV, 8 hourly and first dose of Solumedral was given on 17.02.2014 at 14:30 hours and second dose was given at 22:00 hours. After giving first dose of Solumedral (corticosteroid), there was very good response and the patient able to value on her legs. However, Mr. Jagdishwar Singh, the husband of the patient stopped medication as given by the OPs and called Dr. Rakesh Singh, Neurosurgeon and Dr. Sushil Jaiswal, Anaesthetist, to examine the patient on 18.02.2014. After examining the patient, Dr. Rakesh Singh advised to continue same treatment as advised by Dr. Kaushal Agrawal. Dr. Pramod Kumar Rai (OP-2) advised for MRI of lumbo-sacral spine on 18.02.2014, which was done. MRI report dated 18.02.2014 showed "focal increased intra medullary signal intensity in conus medullaris with early lumbar sponylosis with mild anterior subluxation of L4 L5 vertebral body with annular bulge L4/L5 disc with B/s facet joint arthrosis with hypertrophied ligamentum flavum leading to thecal sac indentation with mild neural foramina encroachment". From MRI report no one can say that lesion is because of spinal anaesthesia and cannot be reversed back. There was good response in right leg. The patient could put heal on ground but no response in toe. The patient was feeling better and asked for discharge and she was discharged on 19.02.2014 in morning.

19. In view of the aforesaid discussion, the findings of State Commission that the opposite parties had committed negligence in administering anaesthesia is illegal and liable to be set aside. The appeal filed by the opposite parties is liable to be allowed and the appeal filed by the complainant is liable to be dismissed.

ORDER

In view of aforesaid discussions, FA/402/2023 is allowed. The order of State Commission dated 09.03.2023 passed in CC/38/2016 is set aside. CC/38/2016 is dismissed. FA/502/2023 is dismissed.

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RAM SURAT RAM MAURYA
PRESIDING MEMBER

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BHARATKUMAR PANDYA
MEMBER