# NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION
# NEW DELHI

## FIRST APPEAL NO. 189 OF 2011

(Against the Order dated 02/04/2011 in Complaint No. 3/2007 of the State Commission Chhattisgarh)

1. UMA DEVI AGRAWAL
R/O DARRI ROAD KORBA
KORBA
CHATTISGARH .....Appellant(s)

Versus

1. SUYASH HOSPITAL & ORS.
BADHAI PARA,
RAIPUR
CHATTISGARH
2. DR NITIN GOEL
M.D.F.N.N. (URO) UROLOGIST SUYASH HOSPITAL
BADHAI PARA
RAIPUR
CHATTISGARH
3. DR VIVEK KESHARWANI
M.S. SURGERY SUYASH HOSPITAL BADHAI PARA
RAIPUR
CHATTISGARH .....Respondent(s)

**BEFORE:**

**HON'BLE MR. JUSTICE A. P. SAHI,PRESIDENT**

FOR THE APPELLANT : MOHD. ANIS UR REHMAN, ADVOCATE
FOR THE RESPONDENT : MR. VAIBHAV AGNIHOTRI, ADVOCATE WITH
MR. GANDHARV GARG, ADVOCATE
MS. GARIMA KHANNA, ADVOCATE

**Dated : 12 October 2023**

## ORDER

**1.** This is an appeal against an Order of the State Commission dated 02.04.2011 in respect of a medical negligence claim where the husband of the complainant, late Mr. D. K. Agrawal, who was suffering from Benign Prostatic Hypertrophy (in short, ‘a prostate problem’) consulted the respondent no. 2, Dr. Nitin Goel at his hospital, namely, Suyash Hospital, Raipur (C.G.) and he was advised surgery that was conducted on 04.11.2006 at the said hospital. On 08.11.2006, he was discharged from the hospital with a specific direction to follow the treatment by reporting at the hospital after 07 days.

**2.** The case, as disclosed, is that the patient developed some problems and he telephonically sought some advice but due to a hemorrhage, he got himself admitted in a local hospital, namely Paliwal Nursing Home, Korba, Chhattisgarh. On being contacted on

phone, he was advised by Dr. Goel to reach Raipur immediately. The distance from Korba to Raipur is almost 225 kilometers. It is also alleged by the opposite parties that the relatives of Mr. Agrawal had informed that he had taken a ride on a scooter for 20 to 25 kilometers a couple of days before he was admitted on 24.11.2006 at Paliwal Nursing Home, Korba..

**3.** The patient went to Bilaspur to consult Dr. Neeraj Sharma, who also advised him to go to Raipur. He was however admitted in Dr. Bhargava's Nursing Home where he stayed overnight and then on 25.11.2006 at 10.00 a.m. he was brought to Suyash Hospital, Raipur again under the treatment of Dr. Nitin Goel.

**4.** The case of the hospital and the doctor is that all due precautions were taken and since there was a clotting due to hemorrhage, surgery was undertaken and post-surgery at about 11.30 p.m. at night, he complained of respiratory problems. The events that followed led to the patient becoming unconscious and he ultimately died at about 12.00 a.m. immediately after midnight.

**5.** The complainant approached the State Consumer Disputes Redressal Commission whereafter assessing the entire evidence and on perusal of the papers, the State Commission dismissed the complaint vide its Order dated 02.04.2011 against which the present appeal has been filed.

**6.** The allegations before the State Commission primarily focussed on the negligence about the pre-operative investigations not having been carried out as a result whereof there was no protocol observed by the opposite parties for the assessment of the patient and his condition prior to the patient being shifted to the operation theatre.

**7.** It is alleged in the complaint that at about 9.00 p.m., post surgery, there was a sudden movement and a talk between the doctors and the staff of the hospital about the patient being admitted in an ICU but since there was no such facility available in the said nursing home, the treatment was carried out with the existing facilities. However, the allegations are that after the patient died, a death certificate which came to be issued later on indicates some correction on the timing of death. It was alleged by the complainant that there was gross negligence on the part of opposite parties and with no facility of cardiologist, the patient died without having been attended to at the pre-operative stage by following the protocols.

**8.** It is noteworthy that a medical board was constituted by the State Commission and the said report of the medical board indicated that the preoperative medical fitness checkup was not done on an assessment of the documents that were produced. The said report dated 23.08.2010 is extracted hereinunder:

To,

The President,

Chhattisgarh State Consumer Disputes Redressal Commission,

Pandri, Raipur (C.G.)

**Throu.-** Proper channel

**Sub.** – Regarding opinion on the medical negligence of the patient late D. K. Agrawal.

**Ref.**- Your letter no. 827 dated 18/05/10 & letter no. 1007 dated 24/06/10 (to the Dean)

The following documents were received –

1. An order from the Dean, Pt. J.N.M. Medical College, Raipur (C.G.) No. 9200 dated 07/08/2010
2. A photocopy of the statement of Smt. Uma Devi Agrawal w/o late D. K. Agrawal to the consumer forum
3. A photocopy of the statements of Dr. Nitin Goel (operating surgeon), Dr. Vivek Keshwarwani (surgeon), Dr. Jayesh Parmar (anaesthetist) and Dr. Neeraj Sharma (surgeon, Bilaspur)
4. A photocopy of the hospital records including admission record dated 25/11/2006
5. A photocopy of the examination done in the OPD at 9.30 AM on 25/11/2006
6. A photocopy of the discharge ticket dated 08/11/2006
7. A photocopy of the referral cum discharge ticket dated 24/11/2006 issued from Korba Hospital & Stone Clinic
8. A photocopy of Preanaesthetic check up (PAC)
9. A photocopy of the progress chart, intake/output chart
10. A photocopy of various blood reports from Clinical Path, Lab
11. A photocopy of the death certificates issued by the operating surgeon
12. A photocopy of the blood cross match form

As per the order of the Dean dated 07/08/2010, a committee of the doctors was constituted to go into the matter and form an opinion. The committee comprised thus (the names were suggested by the heads of the departments concerned)-

1. Dr. Gambhir Singh, Associate Professor (Surgery) – President
2. Dr. Naveen Kumar Tirkey, Assistant Professor (Medicine) – Member

We the doctors named above have gone through the above documents (01-02) and on the basis of the facts mentioned in them have analysed the case thus -

As per the records made available to us, the patient late D.K. Agrawal, 57 yrs old male, was a case of Benign Prostatic Hyperplasia (BPH) with bladder outlet obstruction (BOO). He was operated upon by Dr. Nitin Goel on 04/11/2006 at Suyash hospital, Raipur. The procedure done was TURP. He was subsequently discharged on 08/11/2006 in a stable condition with clear instructions to report after seven days for follow up. The patient didn't turn up after seven days.

Later he developed bleeding per urethra and was subsequently admitted on 24/11/2006 at Korba hospital and stone clinic, Korba for management. Dr. Nitin Goel was telephonically contacted the same day. The patient was then shifted to Bilaspur and seen by Dr. Neeraj Sharma who detected features of chronic blood loss and advised him to consult a urologist at Apollo Hospitals, Bilaspur. Dr. Nitin Goel was again

contacted the same day. As reported, the condition of the patient was not suitable for a long distance travel from Bilaspur to Raipur. Instead, the patient got admitted at Dr. Bhargava's nursing home where he was transfused one unit of blood. The records are not sufficient to evaluate the march of events. The patient was brought to Suyash hospital next day on 25/11/2006. The records reveal that the patient was in poor general condition with features of chronic blood loss. The treatment of the patient as per the records submitted appears clinically appropriate to the condition of the patient. There was suspicion of clot retention for which a surgery was planned. Postoperatively, the patient remains table till 11.30 PM when he suddenly developed ventricular arrthythmias & respiratory problem. Physician and anaesthetist were consulted. The patient was put on life support system. The patient could not be revived and was declared dead at 0:15 AM 26/11/2006.

**Opinion-**

1. It appears that the patient had failed to follow the post operative instructions. When the complication developed, he was showing to various doctors before coming to Dr. Nitin Goel.
2. Dr. Nitin Goel's line of treatment was a standard one and appropriate in the given context.
3. As mentioned it were the respiratory distress and ventricular arrthythmias which culminated into the death of the patient. The preoperative medical fitness check up, ECGs and chest x rays were imperative in this context, which it appears were not done. Complete medical history and examination were required in the case.

**9.** The complainant before the State Commission as also the learned counsel in this appeal have heavily relied upon the said report. Learned counsel for the appellant contends that the said report has been erroneously appreciated by the State Commission for coming to the conclusion that all pre-operative steps have been taken and the records clearly indicate the same.

**10.** At this stage, the finding recorded by the State Commission needs mention that is as follows:

> 12. Treatment papers and the statement of treating Doctors, show that in the O.T. & in the room to which the patient was shifted from the operation theatre, the patient was directly put to ECG and monitor was attached to him and condition of his heart was continuously monitored, so it cannot be said that before, during or after the operation, his ECG was not taken. He was always on monitor and ECG was always being recorded.
>
> 13. Dr. Niteen Goel has stated that ECG of the patient was taken at the time of first operation about 15 days back, which was brought by him at the time of second operation and before giving anesthesia to the patient he was attached to the ECG monitor and then again the ECG was taken and he was found normal. This statement shows that by attaching the patient directly with the monitor his Cardio Vascular System was checked and ECG was found normal before the second operation and same was the position before the first operation also, when specific ECG was taken by

Dr. Bisen, so it cannot be said that any of the Doctor has committed deficiency in service in examining the heart of the patient, his Cardio Vascular System and respiratory system, before operation. Probably the notes recorded by Dr. Jayesh Parmar have escaped from the sight of Committee of experts.

14. As per the opinion of experts as well as the treatment papers, it appears that after operation, during night of 25.11.06, at about 11.35 p.m. all of a sudden the patient started making complaints of respiratory distress. At that time his pulse was 100/min, which was normal, Blood Pressure was 120/90 and the monitor was showing VPCS i.e. Ventricular Premature Contractions and then immediately Physician was consulted and then anesthetist started treatment of the patient. It has been stated by Dr. Jayesh Parmar as well as Dr. Niteen Goel and Dr. Vivek Kesharwani that Dr. Jayesh Parmar, Anesthetist is critical care expert and they had also consulted Dr. R. S. Bisen, Physician and then treated the patient for Ventricular Premature Contractions. Immediately Oxygen was given to him and inj. Intra Venous Lignocaine 60 mg (3ml) dilute was given slowly and I.V. Deriphyllin, I.V. Hydrocorti sone 100 mg state and Nebulisation with levoline 1 amp state were also given in their presence and Physician Dr. Bisen was continuously consulted, but even then at about 11.45 p.m. the condition of the patient became unsatisfactory. He became irritable of state, feeling much difficulty in respiration, pulse rate became 120/min and irregular, Oxygen saturation was 85%, blood pressure was 110/70 and from the chest occasional rhonchi sound was heard. Ventricular Premature Contraction were of begimini in nature and therefore 100% Oxygen was given through mask of bains circuit and injection Cardavone 200 mg. I.V. was given slowly, but even then the patent became unconscious, pulse became feeble and fast, blood pressure became unrecordable and crepts sound were heard from the chest along with bilateral wheeze. The monitor was showing ventricular tachycardia, which was also treated along with continuous supply of Oxygen. Cardiac massage was also given but the ventricular tachycardia continued and D.C. Shock 200 J was given and other medicines, as prescribed, were also given. The general condition of the patient became very poor and his pulse and Blood Pressure became not recordable again and D.C. shock 360 J was given along with other life saving treatment. Oxygen ventilation and cardiac massage adrenaline was given. Injection Advealnie and Injection Lignocaine etc. were also given but the condition had not improved, heart sounds have stopped coming out and the ECG was showing flat line. Thereafter, at 00.15 a.m. of the night, the patient was declared dead, when his condition could not be revived.

**11.** Apart from assailing the aforesaid findings of the State Commission, learned counsel for the appellant has advanced his submissions contending that in the absence of ICU facility and also without calling a Cardio Vascular Consultant, the hospital negligently treated the patient as a result whereof the patient died. It is, therefore, submitted that the findings recorded by the State Commission are contrary to record and based on an erroneous interpretation of the documents that clearly prove the negligence on the part of the opposite parties.

**12.** It was vehemently contended that the cardiac arrest of the patient was a consequence of the negligence as alleged and it was not in the ordinary course of understanding of medical science where cardiac arrest takes place on account of general health conditions. It is urged

that in the present case, the cardiac arrest resulted only because of the negligence which was established on record.

It was also urged that a judicial review of a medical expert reports ought not to have been attempted by the State Commission. The logic given by the State Commission is not as per record in as much as, The medical expert report talks of some essential preoperative steps that were not taken, and not of what was done when the patient was being brought to the operation theatre. The gap that was crucial that establishes negligence was clearly pointed out at point no. 3 in the expert opinion, but the State Commission took a view contrary to the findings of the medical expert body which is without any material to support the same.

**13.** On the other hand, learned counsel for the respondents urged that every step for pre-operative assessment was undertaken. The patient had not followed the advice for check up after 07 days of the original surgery and had undertaken a scooter ride, which might have caused the hemorrhage, which got aggravated on account of the negligence of the patient himself, who did not take any immediate advice and it is only after visiting three hospitals that he arrived on 25.11.2006 at the hospital, namely, Suyash Hospital.

**14.** Learned counsel then took pains to explain the respective steps that were taken with the aid of the hospital documents and the treatment papers after admission that have been filed on record and registers the timewise treatment that was offered to the deceased patient.

**15.** Learned counsel contends that right from the examination of the chest, recording of the ECG, blood pressure, pulse rate as well as the cardiac Vascular status, function of the heart, were all recorded to be normal and it is only thereafter that the patient was shifted to the operation theatre. Not only this, the continuous monitoring of the ECG is also recorded and that continued throughout the surgery and even thereafter. It is submitted that post surgery, the patient came out of the operation theatre in a normal condition after the removal of clot, which was successful and it is late at night that the physical condition of the patient deteriorated from about 10.00 p.m. onwards resulting in his death after almost 2 hours.

**16.** It is urged that the main contention of the complainant that pre-operative assessments were not observed according to the protocol is absolutely incorrect and even after the operation, the line of treatment as envisaged was a standard one in the opinion recorded by the medical board. It is, therefore, submitted that there is no evidence much less a suspicion or a doubt about the pre-operative care taken by the opposite parties before performing the operation. He submits that no negligence was established. Hence, the complaint was rightly dismissed by the State Commission after the assessment of the error in the report of the medical board. It is submitted that the State Commission has categorically indicated that a very vital part of the notings of Dr. Jayesh Parmar have been overlooked and there was ample evidence to demonstrate that all pre-operative steps were taken which the medical board record could not contradict.

**17.** On the other hand, learned counsel for the complainant in rejoinder reiterated the stand that the report of the medical board could not have been discarded by the State Commission and the supplementing evidence on record also indicates that appropriate steps were not taken before entering upon surgery of the patient.

**18.** Having considered the submissions raised, it would be apt to mention that the initial surgery, which was conducted on 04.11.2014 was reported to be successful and on discharge the patient was advised for check up after 07 days. The initial surgery conducted on 04.11.2006 was successfully conducted by Dr. Nitin Goel at Suyash Hospital from where the patient was discharged on 08.11.2006 in reportedly satisfactory condition. On discharge, the patient was specifically advised follow up for review after 07 days that is endorsed on the hospital record. It is undisputed that the patient failed to turn up as advised after seven days. This is also recorded in the expert opinion dated 23.08.2010 as follows:

> As per the records made available to us, the patient late D. K. Agrawal, 57 yrs old male, was a case of Benign Prostatic Hyperplasia (BPH) with bladder outlet obstruction (BOD). He was operated upon by Dr. Nitin Goel on 04/11/2006 at Suyash hospital, Raipur. The procedure done was TURP. He was subsequently discharged on 08/11/2006 in a stable condition with clear instructions to report after seven days for follow up. The patient didn't turn up after seven days.

An allegation was made in the complaint that the patient was feeling uneasy at the time of discharge on 08.11.2006 which was conveyed to Dr. Goel. This allegation in para 7 of the complaint has been clearly denied in Para 4 of the written statement and also in the cross-examination of Dr. Goel while answering question no. 3. No evidence is available to construe that the patient was in unsatisfactory condition while being discharged on 08.11.2006.

**19.** On the other hand there is a categorical assertion in Para 5 of the written statement and para 1 of the additional pleas in the written statement where Dr. Goel clearly asserts that the patient failed to turn up for follow up advise after 07 days and had reportedly against advice, instead of taking rest, had undertaken scooter rides. The bumpy ride and kick starting of the scooter was also noted which fact does not appear to have been denied in any rejoinder. This statement in the written statement of Dr. Goel about the scooter rides does not seem to have been put to him during cross-examination. Thus the fact that the patient was negligent in not visiting the doctor for follow up after 07 days and his having undertaken a scooter ride does not appear to have been contradicted. This may have led to haemmorage and blood clotting resulting in obstruction in the passage of urine and bleeding.

**20.** This condition prevailing, the patient instead of visiting Dr. Goel straightaway, he was taken to another doctor namely, Dr. Paliwal at Korba Hospital and Stone Clinic on 24.11.2006. He was then referred to Dr. Goel reporting bleeding. From Korba, the patient was taken to Bhargava's Nursing Home at Bilaspur. Thus the patient visited for treatment to two other hospitals before he finally reached the opposite party no. 1.

**21.** On admission, according to the documents and the expert opinion report, the patient was treated in a clinically appropriate way. The physician and anesthetist were consulted. These were Dr. Bisen and Dr. Jayesh Parmar respectively. Medication and Oxygen was administered as per protocol. The order sheet dated 25.11.2006 at 2.00 p.m. (noon) records as follows:

> **Pre anaesthetic check up**
>
> 52 y/M Pt. D. K. Agarwal Pt. of clot retention for evacuation

O/E Thin built, conscious, oriented

Pallor : - ++ No ICT/Cynosis

Pulse 91/min. B. P. 110/70 mm/hg

CVS $S_1$+ $S_2$+ Ⓝ No murmur

RS – Hε Bε No adventitious sound

MO – 3 finger Adequate

- MPC Gr II

The above notings are accompanied by observations on pathological investigations with a direction to arrange for blood and shifting the patient to the OT. What the expert body opined was about lack of preoperative steps that were imperative. The said notings have not been mentioned or noticed specifically in the medical expert opinion while commenting that preoperative tests have not been observed. The State Commission found that the expert body overlooked the notings on record, particularly that of Dr. Jayesh Parmar who is stated to be also a critical care expert, that is contained and endorsed on the order sheet at 4.40 p.m. on the same day. This noting, even though post operative, records and confirms the preoperative care taken as noted above and also notes the monitoring of continuous ECG recording, the B.P. and pulse that is evident on a perusal of the same. No reference to the same appears to have been made in the expert opinion report.

**22.** The finding of the State Commission therefore cannot be faulted with as it does appear that the expert body did not refer to it or had not noticed the same.

**23.** The patient appears to have not adhered to the advice rendered earlier for check up after 07 days and appears to have aggravated the situation by riding a two wheeler resulting in the condition in which he was admitted again for surgery. The precautions appear to have been taken and the post operative condition indicated his general condition as stable. The respiratory problems developed late at night and according to the expert opinion, all protocols were observed as per standard practice.

**24.** Accordingly no ground is made out to establish any infirmity in the line of treatment or any negligence on the part of the opposite parties. The findings of the State Commission indicate no scope for interference in this appeal which is hereby dismissed.

.....J

**A. P. SAHI**

**PRESIDENT**