**NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION**
**NEW DELHI**

**CONSUMER CASE NO. 87 OF 2013**

1. Smt. MANJULATA GARG,
W/o SHri Ram Murti Garg, 36, Sharda Vihar, Phase-I, Amar Vihar, Dayal Bagh,
AGRA. .....Complainant(s)

Versus

1. DR. R. C. MISHRA & 2 ORS.,
2/4, AB, Swadeshi Bima Nagar, Civil Lines,
AGRA.
2. Dr. Muneshwar Gupta,
Kamayani Hospital, 672, Geeta Mandir, NH-2, Sikandara
AGRA.
3. Kamayani Hospital,
672, Geeta Mandir, NH-2, Sikandara
AGRA .....Opp.Party(s)

**BEFORE:**
**HON'BLE DR. S.M. KANTIKAR,PRESIDING MEMBER**
**HON'BLE MR. BINOY KUMAR,MEMBER**

**For the Complainant :** Appeared at the time of arguments
For Complainant : Mr. Manoj Sharma, Advocate

**For the Opp.Party :** Appeared at the time of arguments
For OP-1 : Mr. S. S. Kulshrestha, Senior Advocate
For OP – 2 & 3 : Mr. Parth Kaushik, Advocate

**Dated : 21 Jun 2022**

**ORDER**

**Pronounced on: 21st June 2022**

**ORDER**

**DR. S.M. KANTIKAR, PRESIDING MEMBER**

***The Underlying Facts As Alleged By the Complainant:***

1. On 11.05.2011, Smt Manjulata Garg (since deceased herein referred to as " Patient") was taken to OP-1 i.e. Dr. R.C. Mishra for complaints of severe backache. Her husband informed the OP-1 about the Osteoporesis of the patient. After examination, the OP-1 advised to admit her immediately to the Kamayani Hospital (OP-3 - Hospital). It was alleged that the physician's opinion and neurological evaluation was not

done and no proper pre-anaesthetic check-up was done by the Anaesthetist. The MRI dated 11.05.2011, done at Eisha Diagnostic showed collapse of D-10 vertebra and the X-Ray showed traumatic compression of D-11 vertebra and severe Osteoporosis. However, the OP-1 did not bother to recheck/confirm the report by repeat X-ray or MRI. The patient was operated on 12.05.2011 at 5 PM. The operation took 3 ½ hours to complete. The OP-1 after operation informed the patient's husband that due to very weak/fragile bones, he did not fasten the screws to its full extent. Thereafter, patient's condition deteriorated and she remained at the hospital till 21.05.2011. It was alleged that during the said period about Rs.5,00,000/- was spent on treatment. The Patient further alleged that on 21.05.2011, the Opposite Parties forcefully discharged the patient, though her condition was critical and serious. Due to such abrupt act of the Opposite Parties, on the same day, the patient was taken to Rashmi Medicare Centre in Agra. She was admitted in ICU under care of Dr. Tarun Singhal. On the next day, it was informed that the patient was febrile and had respiratory distress. She developed hospital acquired respiratory infections with pleural effusion. The patient remained under treatment in Rashmi Medicare Centre till 04.06.2011. The patient was later on diagnosed as tubercular infection (TB) at Indian Spinal Injuries Centre (ISIC) in New Delhi.

2. There was no cure from the backache; it remained persistent at the site of surgery. Therefore, on 04.06.2011, she was admitted to ISIC, where Dr. Deepak Raina examined the patient and told that a wrong surgery has been performed at Agra and since the patient was suffering from Osteoporosis, such kind of surgery was not recommended. He further informed that 8 screws were necessary for fastening, but the OPs-1 & 2 fastened just 4 screws. It was with the intention to gain more money. At ISIC, X-Ray and CT Scan report revealed Osteoporosis and bilateral pleural collections, which was suggestive of consolidation/collapse of the lungs. It was alleged that on 21.05.2011 the patient was thrown out of the hospital in a critical condition and only the discharge summary was handed to the patient's relative. The Bad Head Ticket (BHT) and detailed bills were issued only after legal notice.

3. At ISIC on 21.07.2011, the patient was re-operated on the same vertebra with bone cement augmentation under the supervision of Dr. Deepak Raina and Dr. K. Das. On 31.10.2011, post-operative check X-Rays and CT scan confirmed successful operation with intact screws.

4. Thus, it was not a reasonable degree of care/skill, but it was negligence of the Opposite Parties, who have ignored Osteoporosis and performed the operation unscientifically, which led to permanent disability of the patient. Being aggrieved, the patient filed a complaint before this Commission and prayed for Rs. 1,02,01,000/- from the Opposite Parties under different heads.

**Defense:**

**5.** The Opposite Parties filed their respective written versions. The preliminary objection that for want of the pecuniary jurisdiction of this Commission, the complaint has been filed based completely on illusionary highly inflated figures just to extract money illegally from the opposite parties. The OPs denied the allegations of negligence during treatment of the patient. It was also denied the forceful discharge of the patient from the Kamayani Hospital in critical condition. It was also denied that the operation was performed despite the patient's weak and fragile bones with severe osteoporosis.

6. The OP-1 in his reply submitted that, he was a visiting consultant Neurosurgeon at Kamayani Hospital, Agra. The patient was a mother of an Anaesthesiologist admitted under his neurosurgery unit on 11.05.2011. The patient had a fall in the bathroom on 02.05.2011, about 10 days prior and took treatment somewhere. At the time of admission In the Kamayani Hospital, the patient's vitals were normal i.e. pulse 94/min & BP 120/70 mm of Hg. Despite having backache, she was moving her limbs spontaneously. The x-ray showed wedge-fracture D-11 with mild kyphotic deformity and MRI indicated the canal compression at D-11, without intrinsic cord changes. The motor movement in lower limb was adequate, but she did not co-operate for assessing exact power due to severe pain. She was a known case of hypothyroidism and osteoporosis as allegedly told by her son under treatment of a physician, as informed by her doctor-son. A decision for trans-pedicular screw fixation between vertebrae was taken and it was intimated to the patient's attendants. After the physician's assessment and anaesthetic clearance, she was operated under general anaesthesia (GA) on

12th May 2011 in evening. The operation lasted for three hours and a half due to obesity of the patient requiring repeated per-operative imaging on image-intensifier. The screw-fixation was followed by de-compressive laminectomy of D-11 lamina. No Dural injury was found and no CSF leak was noticed. Suboptimal purchage of one screw at D10 was suspected and it was intimated to the attendants after surgery. Locally available bone was used as graft and put along screw-head. Patient had difficulty in breathing on 14th May 2011, when she was examined by the In-house physician. The one regular physician was called on 15th May 2011 and treatment was modified from time to time. Bedside x-ray chest showed problem with one screw, soon after it was intimated to the patient's relatives. On 21.05.2011, due to the patient's fever it was decided to change the antibiotics, but her son sought discharge from the KamayanI Hospital, assuring that he would manage the antibiotics at home in consultation with a physician of his own choice. After the discharge, the patient was taken home and, then, after 9 hours to Rashmi Medicare Centre for treatment of her fever. There Dr. Sanjay Gupta(neuro-surgeon) an associate of OP-1 continued to see the patient regularly and made complimentary visits. As one screw was loose, the OP-1 promised to re-operate and reset the loose screw, but the patient never brought back. The patient got discharge from Rashmi Medicare Centre on 27.05.2011. Therefore there was no negligence, but filed a frivolous complaint.

7. The OP-2, Dr. Muneshwar Gupta, the Managing Director of OP-3 Kamyani Hospital filed the written version. He made similar submission as of the OP-1 on treatment aspect. He further submitted that maximum amount of ₹50,000 may be required for surgery, however as the complainant was mother of the doctor, the hospital charged nominal amount of ₹32,000 and same was reflected in the bill/ discharge report. He further submitted that as he is a Radiologist, he had no role in surgery. He further confirmed that the OP-1 informed the husband of complainant that due to weak bones he did not pass on the screws in the full extent. During hospitalization postoperatively, the patient developed fever. Her doctor son expressed his desire, to take care of his mother at his house with the guidance of physician. Therefore patient was discharged on making payment as billed ₹44,000, a full and final settlement. However, after 9 hours on the same day from the house, she was taken to the Rashmi hospital and was admitted till 27.05.2011. During the first week of June 2011 the complaint’s husband and her son approached the OP-1 with the information that one screw was loose and for not giving a desired result after treatment, demanded ₹4,00,000 as a compensation. They also threatened about dire consequences if not paid. Since the patient was mother of a doctor, in good faith OP-1 offered to re-operate the patient. The OP-2 further submitted that the Complainant filed the complaint to claim Rs.10,21,000/- without any basis to bring pecuniary jurisdiction of this commission. The complainant took different stands i.e. in the legal notice he claimed ₹44,000/- however in the complaint filed before the Commissioner of Police stated that Rs.1,46,000/- as charged by the hospital and he quoted different figure of Rs.7,00,000 in the newspaper article. However interestingly the complaint mentioned an amount of Rs. 23,00,000/- as expenses but actually ₹44,000/- was spent at OP-3 hospital. He further submitted that the Disability Certificate was issued on 06.02.2013; i.e. 2 years after the surgery performed on 12.05.2011by the OP-1. It cannot be relied as to attribute negligence of OPs.

8. The respective parties filed their evidence by the way of affidavits with medical literature on the subject.

**Arguments:**

9. The Counsel on both the sides filed brief synopsis with time line of treatment and events in the instant case.

**Arguments from Complainant:**

10. The learned counsel for the Complainant reiterated the facts and chronology. He submitted that the OP-1 ignored patient’s hypothyroidism and osteoporosis. Only physician evaluation was done but pre-anaesthetic check-up was not done. Same was held by the MCI ethics committee in its letter dated 19.01.2013. It was an

elective operation, but the OP-1 never bothered to see the x-ray and MRI reports which showed disparity. [D-10 and D-11]. The compression was at D-10 and not D-11. The OP-1 never pointed out said difference and he himself also did not sure about which segment to operate, thus it was blatant negligence. He further argued that the patient's bones were weak and fragile due to severe osteoporosis as clearly depicted in X-ray, but OP-1 never bothered to put bone cement. The OP-1, himself had accepted after the operation that screws are loose and it needs to be re-positioned by bone cement technique. The Cement augmentation is being used extensively and successful in spine surgery to date.

11. No X -Ray of the spine was performed for five days after the surgery, which clearly shows malicious intent of the O.P. No.1 who was trying to hide a botched up the surgery by placing screws outside the pedicle into the lungs. The misplacement of the screw was only revealed after patient developed pneumonia because of the screw perforating the pleura/lung. During the intervening period Dr Mishra has been trying to mislead and cover up his mistake by blaming screw placement into the lung due to the patient's osteoporosis and obesity. Therefore, as a result of his botched up surgery, he discharged patient in a critical state. The Complainant relied upon the following articles:

(i) Thoracolumbar Burst Fractures, Short X Long Fixation: A Meta – Analysis[1];

(ii) The Biomechanics of Long Versus Short Fixation for Thoracolumbar Spine Fracture[2]

(iii) Complications associated with thoracic pedicle screws in spinal deformity[3]

(iv) Polymethylmethacrylate Augmentation of Pedicle Screws Increases the Initial Fixation in Osteoporotic Spine Patients [4]

(v) Surgical Strategies to Improve Fixation in the Osteoporotic Spine: The Effects of Tapping, Cement Augmentions, and Screw Trajectory[5]

(vi) Hydroxyapatite coating improves fixation of pedicle screws[6]

12. The OP-1 expressed his innate difficulty while placing pedicle screws in thoracic spine, shows his lack of skill. He further argued that the fracture, which was to be fixed by eight screws, was fixed by just four screws. The OP-1 has quoted osteoporosis of the bone in his defence of the screws cutting out. If he had suspected osteoporosis of the bone, why did he not insert more screws or used hydroxyapatites coated screws, or bone cement.

13. The Opposite Parties filed their respective written arguments. The learned Counsel for the OP-1 vehemently argued that Dr. R. C. Mishra is highly skilled surgeon and treated the patient as per standard of practice. The patient's son was apprised before the operation about the procedure and about the bone graft was to put at the screws set for stabilisation and healing. He used bone graft to prevent possible cement embolism. In the instant case, the mal positioned screw of D10 may be due to obesity and excessive fat of the patient and therefore, the operation was lasted for 3 ½ hours. The OP-1 took the decision based on the scientific situation of the spine. The screw fixation was followed by D-Compressive laminectomy of D11 lamina. There was no dural injury. The OPs-2 & 3 argued that the Complainant deliberately made baseless claim of Rs. 1,02,01,000/- from the OPs-2 & 3. There was no expert opinion and the ethics Committee of MCI did not find any negligence on their part. The learned Counsel for the OPs relied upon the following articles:

(i) Cement Embolism into the Venous System after Pedicle Screw Fixation: Case Report, Literature Review, and Prevention Tips[7]

(ii) Screening for Osteoporosis: U.S. Preventive Services Task Force Recommendation Statement[8];

(iii) Successful Short-Segment Instrumentation and Fusion for Thoracolumbar Spine Fractures[9]

(iv) Outcome-Based Classification for Assessment of Thoracic Pedicular Screw Placement[10]

(v) Outcome-Based Classification for Assessment of Thoracic Pedicular Screw Placement[11]

**Observations & Reasons:**

14. We have perused the material on record, *inter alia*, the Medical Record, literature and standard text books on neurosurgery and gave our thoughtful consideration.

15. It is evident from the record that Dr. R.C. Mishra (OP-1) is highly skilled and qualified specialist - having vast experience of 29 years in Neurosurgery. He remained as Professor Head in various Medical Colleges. From the record the patient's attendant and her doctor son were apprised of the surgery and the pre & postoperative problem, the bone-graft to put at the screw for stabilization and healing. Therefore, OP-1 used bone-graft with his discretion to avoid cement embolism.

16. The contention of Complainant that such fractures have to be fixed at least two level above and two levels below to stable, or augment the fractured vertebrae with screw/ cage or cement. In the instant case admittedly the OP-1 fixed four pedicle screws, two above (short segment fixation) and two below for a fracture of vertebra the spine. The O.P No.1 in his defense relied upon article from the year 2000 and he claimed that he has been carrying out the good old treatment method. As per the article short segment fixation could be employed in a very small subset of patients with simple fractures, and those who were willing to wear a brace for four months. In our view the method of treatment adopted by OP-1 was as an accepted medical practice. Pedicle screw fixation is widely used in spine surgery for numbers of indications, such as degenerative disease, trauma, tumor, infection, and deformity. It reduces the range of motion of the stabilized spine, increases the fusion rate, and is generally considered to be safe with relatively low complication rate associated with the device. Therefore, the decision to perform short or long fusion remains individualized to each patient, and depends on a multitude of factors as discussed. The current study results suggest that either approach can achieve sufficient correction if performed appropriately. Thus, the surgeon must balance the advantages and disadvantages of each fusion procedure when deciding which surgical procedure is most suitable for a patient.

From the article, **'Outcomes of Short Fusion versus Long Fusion for Adult Degenerative Scoliosis: A Systematic Review and Meta-analysis'[12]** The long segmented fusion is used to fix the mobility of vertebra. In the instant case D11 is a stable vertebra, it was damaged; therefore short segmented fusion was not a wrong method. Only 4 screws were used 2 at D10 and 2 at D12. Thus, cost of extra 4 screws was saved.

17. We further note that, the Patient's husband made separate complaints before the Director General of Police, Agra; Medical Council of India and Chief Medical Officer, Agra. The Ethical Committee of U.P Medical Council vide order dated 09.02.2012 observed that the doctors were not guilty of medical unprofessionalism and misconduct and thus exonerated the opposite parties of all the charges. The appeal filed by the Complainant before the MCI which vide order dated 19.01.2013, upheld the decision of the U.P Medical Council and exonerated the OPs with a warning to the OP-1 to maintain proper records and follow proper procedure. The warning of MCI shall not construed as medical negligence during surgery performed by the OP-1.

18. The disability certificate of the Patient cannot be relied because it was issued on 06.02.2013 almost after 2 years of the operation performed by OP-1 on 12.05.2011.

**DISCUSSION:-**

19. The main crux of the matter is whether the treatment adopted by OP-1 has deficiency and was it contrary to the reasonable practice in Neurosurgery?

20. We have gone through the medical literature on spinal surgeries. Whether Osteoporosis is contraindicated for spinal screw fixation surgery. It is an admitted fact that the DEXA Scan facility to ascertain the bone density was not available with Kamyani Hospital. From the medical literature DEXA scan is not mandatory in

each case. Pedicle screw loosening is a common complication after spine surgeries. Traditionally, it was assessed by radiological approaches, both X-ray and CT scan, while reports using mechanical method to study screw loosening after spine surgery are rare. As stated, the patient's son (anaesthetist) informed OP-1 about Osteoporosis; we do not see OP-1 ignored the Osteoporosis. For proper fixation he chose not to use cement augmented screws. The OP-1 for reinforcing the stabilization and healing used locally available bone-graft at the aforesaid screw-site. It was an age-old procedure of bone-strengthening better than use of bone cement. The old method was still in use and there is nothing on record to prove such method was legally abandoned/ stopped. Therefore, in our view the OP-1 used the accepted method of treatment and thus it was a reasonable standard of practice, no a deviation of practice. We put reliance upon the case **Achutrao Haribhau Khodwa and Ors. v. State of Maharashtra & Ors.**[13], in which Hon'ble Supreme Court noticed that '**in the very nature of medical profession, skills differs from doctor to doctor and more than one alternative course of treatment are available, all admissible**'.

21. According to the literature and standard text books in Neurosurgery and Orthopaedics the cement augmentation has its own potential side-effects and irreversible neurological deficits or sometimes entails death. Moreover, sometimes re-absorption of screw chemicals of the augmented pedicle screw lead to loosening. Sometimes the broken screw can't be taken out. In the instant case, four screws were used as two in D-10 & two in D-12. One screw-problem may be classified as 'mal-positioned' due to obesity and excessive fat, which led to inadequate x-ray evaluation. It is pertinent to note that three screws were retained during 2nd surgery at ISIC, thus meaning thereby Osteoporosis effect was not for the three screws..! In our view, the mistake of the patient's son that he took premature discharge from Kamayani Hospital, he took her home first and then, after about 9 hours, at 8 pm got her admitted in Rashmi Medicare Centre. The duty of care for the patient reflects as out of courtesy, the patient was regularly seen by colleague of OP-1 Dr. Sanjai Gupta at Rashmi Medicare Centre. This fact is evident from the letter dated 26.10.2012, issued by Dr. Tarun Singhal of Rashmi Medicare Centre, which is reproduced as below:

***TO WHOM IT MAY CONCERN***

> *This is to inform that Patient Mrs. Manjulata Garg W/o Mr. Ram Murti Garg was admitted in our Rashmi Medicare Centre from 21.05.2011 to 27.05.2011 under my care. Dr. Sanjay Gupta (MS. M.Ch. Neurosurgeon) was also looking after her, (who was in the operative team of patient Mrs. Manjulata Garg in Kamayani Hospital) till her discharge. He had visited her complimentary without any charge.*

22. The patient thereafter had developed hospital acquired respiratory infection with pleural effusion which has turned out to be TB at ISIC which cannot be attributed to the treatment given by OPs. We agree with the observations and the Order of MCI dated 19.0.2013 which exonerated the OP-1 with warning to maintain proper record and follow proper procedures before and after surgery in future. Such warning itself does not constitute medical negligence of the OPs.

23. The Hon'ble Supreme Court in ***Kusum Sharma Vs Batra Hospital & Ors.[14]*** discussed that:

> the breach of expected duty of care from the doctor, if not rendered appropriately, it would amount to negligence. It was held that, if a doctor does not adopt proper procedure in treating his patient and does not exhibit the reasonable skill, he can be held liable for medical negligence.

In the instant case we do not find any breach of duty of care from the OP-1 who treated the patient, who was in-turn a mother of one anaesthetist. To succeed in any medical negligence claim the Complainant must demonstrate that four essential ingredients of medical negligence are "**4 D**" namely 1) Duty of Care, 2) Dereliction (breach) of duty, 3) Direct Causation and 4) Damage proximate to the breach. In the instant case the Complainant conclusively failed to prove all those ingredients of medical negligence.

24. Let us carefully go through the three Discharge Summaries of ISIC:

In the **first discharge summary** dated 07.06.2011, her general condition was satisfactory. She was evaluated for spinal injury. The X-ray chest revealed collection in right lung, which the chest physician examined and

right ICD insertion was done and 200 ml of the pus drained. The patient was treated with IV antibiotics. Thereafter, the lung collection reduced significantly and she was discharged. There was no mention about neurological symptoms.

In the **second discharge summary** dated 23.07.2011, the patient was admitted on 17.07.2011. It has recorded in the past history about pneumonitis / pleural effusion for which USG guided drainage was done. The right lung empyema noted for which ICD was inserted. The surgical treatment was advised for spine. After PAC and informed consent, the patient was operated on 21.07.2011, wherein implant removal with posterior stabilisation with cement, enhanced pedicel screw insertion D8-D12 was done under general anaesthesia. Post-operative treatment was uneventful and she was mobilised with brace. She was discharged with domiciliary care. The patient was advised to continue for AKT4 treatment. Thus, there was no neurological science in the instant patient.

The **third discharge summary** dated 23.07.2011 revealed that the patient was admitted in ISIC on 14.06.2012 for difficulty in walking and loss of control over urination. The muscle power grade 3 was noted in right leg. The sensory were intact. She was diagnosed as Para paresis. She was advised for physiotherapy and managed with Neuro-physicians advice.

Therefore, collective reading of three discharge summaries, it is clear that the patient suffered neurological symptoms almost after one year of the surgery performed at ISIC. The MRI report dated 16.06.2012 showed mild atrophy of the cord at D8 to D11 suggesting myelomalacia. It is further to note that in the first two discharge summaries, there was no mention of TB or Anti Tubercular treatment (ATT) treatment. The third discharge summary was almost after one year and it revealed continuation of ATT treatment. Nothing is forthcoming about the AFB positive status or the diagnosis of TB. Moreover, nothing is on record to show when and where ATT with AKT4 started. All the discharge summaries of ISIC are silent on this issue. As per the medical literature, TB usually gets manifested 6 weeks after exposure of infection. Therefore, the Complainants arguments on this issue are unsustainable as we do not find any nexus between operation performed by OP-1 and further development of paraparesis and/or tuberculosis.

25. From the medical literature[15] it is known that , the application of Augmented(cemented) pedicle screws fixation for osteoporotic multilevel lumbar degenerative disease (LDD) can achieve better stability and less screw loosening, but it also accompanied by longer operating time, higher incidence of Cement leakage (CL), Pulmonary Cement Embolism (PCE) and wound infections. Due to increase of level and bone cement dose are accompanied by the rising incidence of CL remains a common complication of cement-augmented pedicle screw instrumentation (CAPSI). CL may cause severe complications such as nerve injury, vascular damage, pulmonary cement embolism (PCE), cardiac embolism, and anaphylactic shock. It should be kept in mind that the vertebral venous plexus (VVP) does not have valves, through which more chances of micro thrombi / emboli carried to brain to cause severe damage.

26. We would like to rely upon the recent judgment (30-11-2021) of Hon'ble Supreme **Bombay Hospital & Medical Research Centre vs. Asha Jaiswal & Ors.**[16], held no negligence of the treating doctor. In paragraph 32 and 34 of judgment observed as:-

32. In **C.P. Sreekumar (Dr.), MS (Ortho) v. S. Ramanujam [17]**, this Court held that the Commission ought not to presume that the allegations in the complaint are inviolable truth even though they remained unsupported by any evidence. This Court held as under:

> "37. We find from a reading of the order of the Commission that it proceeded on the basis that whatever had been alleged in the complaint by the respondent was in fact the inviolable truth even though it remained unsupported by any evidence. As already observed in Jacob Mathew case [(2005) 6 SCC 1 : 2005 SCC (Cri) 1369] the onus to prove medical negligence lies largely on the claimant and that this onus can be discharged by leading cogent evidence. A mere averment in a complaint which is denied by the other side can, by no stretch of imagination, be said to be evidence by which the case of the complainant can be said to be proved. It is the obligation of the complainant to provide the facta probanda as well as the facta probantia."

34. Recently, this Court in a judgment reported as **Dr. Harish Kumar Khurana v. Joginder Singh & Others**[18] held that hospital and the doctors are required to exercise sufficient care in treating the patient in all circumstances. However, in an unfortunate case, death may occur. It is necessary that sufficient material or medical evidence should be available before the adjudicating authority to arrive at the conclusion that death is due to medical negligence.

26. It is apparent from the record that the complainant vaguely demanded his claim *supra* (para 7). The OP-1 adopted the standard reasonable practice and also followed ethical principles to his professional colleague the anaesthetist, whose mother was operated by OP-1. We haven't expected, but surprised that the patient's son being an anaesthetist, how can raise frivolous allegation that pre anaesthetic check-up was not done. We find the doctors treated the patient reasonably and there was no deficiency or negligence during the treatment. In our view, the complaint was filed, simply to blame for untoward incident to get some compensation. The Complainant aims to turn the wheels of fortune in his favour by demanding such immense damages.

27. In the obtaining facts and the available evidence on record, it is not feasible to conclusively attribute non-adherence to duty of care and standard of practice, it is difficult to conclusively establish medical negligence / deficiency on the treating doctor and the hospital.

28. The Complaint is dismissed. The parties to bear their own costs.

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[1] Coluna/Columna, 2016:15(1): 78-84

[2] SPINE Volume 31, Number 11 Suppl, 2006 pp S70-S79

[3] Eur Spine J (2010) 19: 1576-1584

[4] J Spinal Disord Tech, Volume 25, Number 2, April 2012

[5] Global Spine Journal Vol. 4 No. 1/2014

[6] Vol. – 84-B, No. 3, April 2002

[7] Orthop Rev (Pavia). 2013 Sep 12;5(3):e24.

[8] 1 March 2011 Annals of Internal Medicine Volume 154, Number 5

[9] Spine Volume 25 Number 9 2000

[10] Spine Volume 33 Number 4, pp 384-390

[11] Volume 33(4), 15 February 2008, pp 384-390

[12] Orthopaedic Surgery2017;9:342–349•DOI: 10.1111/os.12357]

[13] (1996) 2 SCC 634

[14] (2010) 3 SCC 480

[15] Tang et al. BMC Musculoskeletal Disorders (2020) 21:274

[16] 2021 SCC OnLine SC 1149

[17] 2009) 7 SCC 130

[18] (2021) SCC Online SC 673

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**DR. S.M. KANTIKAR**
**PRESIDING MEMBER**

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**BINOY KUMAR**
**MEMBER**