IN THE CONSUMER DISPUTES REDRESSAL FORUM
KANNUR

Complaint Case No. CC/09/291
(Date of Filing : 27 Oct 2009)

1. PV Valsarajan, Puthenveettil House, PO Pappinissery, Kannur Dt,
PV Valsarajan, Puthenveettil House, PO Pappinissery, Kannur Dt,
Kannur
Kerala .....Complainant(s)

Versus

1. The Chief Administrator,/Manager, Speciality Hospital, Thana, Kannur,
The Chief Administrator,/Manager, Speciality Hospital, Thana, Kannur,
Kannur
Kerala
2. 2. Dr KC Hansraj, Speciality Hospital, Thana ,Kannur
2. Dr KC Hansraj, Speciality Hospital, Thana ,Kannur
Kannur
Kerala .....Opp.Party(s)

BEFORE:
HON'BLE MRS. RAVI SUSHA PRESIDENT
HON'BLE MRS. Moly Kutty Mathew MEMBER
HON'BLE MR. Sajeesh. K.P MEMBER

PRESENT:

Dated : 22 Jan 2021

Final Order / Judgement

SMT. RAVI SUSHA : PRESIDENT

Complainant filed this complaint under Sec.12 of the Consumer Protection Act 1986 seeking compensation of Rs.3,00,000/- from the Ops for the deficiency in service and unfair trade practice adopted by the 2 nd OP.

The case of the complainant is that on 4/9/2007, the mother of complainant Eliyamma fell down on the floor of her house hitting her head on the marble floor. After the fall she vomited and became speechless. She was taken to 1 st OP hospital. After reaching the hospital she did

not respond to any calls. She was under treatment of 2 nd Op Dr.Hansaraj of 1 st Op hospital without any problem from 2005 till 4/9/2007 as she was having hypertension. 2 nd OP doctor K.C.Hansraj attended at the first time of admission of this patient told that it is a case of stroke and prescribed some medicines and left the patient in a causal manner without giving any further direction or instruction to the complainant or his nursing staff and after giving those medicines the condition of the patient became worse. Further on the next day when the condition of the patient became critical, 2 nd OP advised to take scanning of the head of the patient, but even after receiving the scan report at 12.30 noon of the same day, 2 nd OP doctor examined the report only in the evening and referred to Neurologist for further treatment. In the night neurologist Dr.Nirmal came and after examining and report he told that there is haemorrhage and bleeding and also told that the present damage to the head is different from the earlier damage, he also prescribed some medicines. When the complainant asked to Dr.Nirmal why no scanning was done immediately from the hospital as it was a suspected case of haemorrhage, then the doctor told that only just when he was told about the case and he had changed some unwanted medicine. Medicines, liquid food and water were given to the patient through nose by inserting tube. The 2 nd Op doctor told to the complainant that whatever possible have been done and not much could be expected, therefore it is better to take her home and continue treatment at home as directed. On 17/9/07 the patient was discharged. At the time of discharge the patient could only open her eyes and there was no other movement and she was made to lie on a water bed. Thereafter when the condition of patient deteriorated she was taken to the Specialty hospital on 9/12/07 and 29/12/07 and discharged after giving I.V fluid. For taking her to some other better hospital, complainant approached 2 nd OP to give a letter about the treatment and condition of the patient. 2 nd Op gave him a letter .The complainant submitted an application to get a copy of the case sheet of the treatment but the 1 st Op refused and states that those documents are to be preserved there in the hospital and it will not be given to any one except on the order of a court. The act of 1 st Op amounts to unfair trade practice and insufficient service. The patient was treated at Unity hospital Mangalore for 9 days without any improvement in her condition finally she was discharged. In the mean time she developed bedsore, so the complainant got her admitted in the Mission Hospital Cherukunnu on 13/2/2008, though she was treated there for 50 days, she expired there on 4/4/2008. The complainant submits that if the diagnosis was done properly in the initial stage and treatment given accordingly the patient could have survived and her life could have been prolonged. The complainant further submits that 1 st Op treated his mother in a most negligent manner and administered wrong medicine in the initial stage , this gave anti effect to the internal part of the brain and ultimately caused her death. The complainant states that the patient was brought before the 2 nd Op with a symptoms of haemorrhage(brain stroke). It is the normal practice that when a patient is brought before the hospital suspecting brain stroke, to refer to CT scan . It is needed to complete the diagnosis and help doctors to decide on the proper treatment. Because , not all strokes are caused by blood clots. Most strokes are caused by bleeding ruptured blood vessels. But unfortunately on that critical stage, 2 nd Op treated the patient, prescribed and administered aspisol tablets, a medicine containing aspirin contents, before referring for the CT scanning of the patient brain. It is well known to the medical practitioner taking aspirin is not advised during a stroke, because not all strokes are caused by blood clots. CT scanning of the brain of the patient reveals that the stroke was caused by bleeding , 2 nd Op giving aspirin, at this juncture to the patient could potentially make these bleeding strokes more severe. It is

submitted that Ops who initially attended to and treated the mother of the complainant had shown utter negligence, rendered insufficient service and adopted unfair trade practice. Hence filed this complaint for getting compensation of Rs.3,00,000/- from the Ops.

Both Ops filed separate versions. The contentions adopted by both Ops are more or less same.

The Ops contested the complaint saying that there had been no negligence or deficiency on their part and whatever procedure was done upon her, was in accordance with established medical practice and in most caring . The 2 nd Op stated that from the year 2005 he treated the complainant's mother Smt.Eliyamma on several occasions. She was brought to the 2 nd OP on 22/11/2005 with left sided hemiplegia and right basal ganglia infaret. 2 nd Op advised CT scan which showed right basal ganglia infaret, normal pressure hydrocephalus and aca-aneurism. She recovered from the illness very well and she was discharged on 25/11/2005 with left hemiparesis, at the time of discharge the patient was asked to continue aspirin 75 mg+clopidogrel 75mg and Tab citicholine 599mg daily. The patient was again seen by 2 nd Op on 9/12/05,25/12/05,16/2/2006 etc. for various complaints and was treated accordingly, the patients relatives were satisfied with the treatment of op.2. On 4/9/07 at 7.40 pm, the patient was brought to the 1 st Op hospital with complaints of giddiness followed by fall and altered sensorium. The patient was immediately examined by causality medical, officer, at the time of examination the patient was conscious, there was abnormal gaze towards the right side, and aphasia. Her vital signs were normal and other systems were normal. The 2 nd OP was not available in the hospital at the time came specifically to see the patient.2 nd Op examined the patient and found the same clinical symptoms and signs, with the previous history of infarct with left hemiplegia in mind, a provisional diagnosis of Right MCA Territory recurrent stroke was made. As the patient was taking aspirin she was asked to continue the same while the 2 nd OP prescribed Inj.Citicholline, Rabiprazole and intravenous fluids in addition. As the patient has taken aspirin in the morning, it was not administered on that day. The patient was monitored in the medical intensive care unit and her vital parameters were stable. On 5/9/07 the 2 nd OP reviewed the patient and found to have some worsening of neurological parameters. She was drowsy with left sided paucity of movements. With the previous history of Right MCA stroke, the possibility of ischaemic Restroke was clinically considered. The condition of patient was explained to relatives. Just before going for CT scan, patient was administered aspirin and clopidogrel which she has been taking from 2005 onwards. The CT report showed subarachnoid haemmorhage. So the antiplatelets were withheld, anti edema measures were started. Patient was shown to the consultant neurologist and his opinion taken. The patient had partial recovery, all supportive care was given, and considering her advanced age and extensive subarachnoid haemmorhage she survived and was discharged on 17/9/07. At the time of discharge she was conscious, able to sit up, and was taking oral feeds and communicating. Only the best efforts of the Ops saved the patient. This was well appreciated by the complainant at the time of discharge. The patient was again shown to the 2 nd OP on 9/10/07 and 29/12/07 for minor ailments associated with her preexisting diseases. There was no delay in attending the patient. The averment that the normal practice is to refer the patients with stroke CT scan is scientifically improper and it immediately depends on various factors. Stroke can be ischemic or haemorhanic. 85% of the stroke are ischemic and only 15% is haemmorhagic, the chance of recurrent strokes are there even if the patient is on antiplatelet medications. In ischaemic strokes an early CT scan will not reveal any adnormality, only delayed Ct scan or diffuse weighted MRI will reveal the radiological findings of stroke. As the patient is already on

antiplatelet medications which will take minimum of seven days to wear off its effect after stopping the medications, the continuation of medicine for another day is not going to make any immediate difference. The present line of treatment was adopted by the 2 nd OP in good faith and in the patient's interest. Gradual worsening of the patient was due to the natural course of the illness and not due to the administered single dose of aspirin and clopidogrel medication. 2 nd Op further contended that he was informed of the scan report by 11 am in the morning and he had made the necessary changes in the management according to the CT scan report, there was no delay in evaluating the CT report . Despite her advanced age and very serious bleeding into the brain, the patient survived due to expert care given by Ops. The patient died almost 1 year after the prescribed incident which was a natural happening due to her advanced age and disease process. The complainant had connected his mother's death to hospital treatment for undue financial gain. There is no negligence on the part of the Ops. So the ops are not liable to pay any compensation to the complainant.

The parties adduced evidence in support of the rival contentions. On the side of complainant, complainant filed chief affidavit and was examined as PW1, marked Ext.A1 to A16 and Ext.X1 series. Dr.Viswanathan .P was examined PW2. Both witness were made cross examined for the Ops. On the side of Ops, 2 nd OP filed chief affidavit and examined as DW1 marked Exts.B1 & B2. DW1 was made cross examined for the complainant.

The learned counsel for the complainant filed argument note. The learned counsel for the Ops made oral argument. We have also perused the relevant records brought before us.

The material questions involved in this case are

1. Whether in the facts and circumstances of the present case, it is duly proved that Mrs.Eliyamma(mother of complainant) died as a result of medical negligence committed by Dr.K.C.Hansraj by providing treatment in a most negligent manner and administered wrong medicine in the initial stage of admission of the patient?
2. If so what relief entitled to complainant?

One of the allegations made by the complainant was that 2 nd OP doctor K.C.Hansraj attended at the first time of admission of this patient told that it is a case of stroke and prescribed some medicines and left the patient in a causal manner without giving any further direction or instruction to the complainant or his nursing staff and after giving those medicines the condition of the patient became worse. Further on the next day when the condition of the patient became critical. 2 nd OP advised to take scanning of the head of the patient, but even after receiving the scan report at 12.30 noon of the same day, 2 nd OP doctor examined the report only in the evening and referred to Neurologist for further treatment. On analysis of this allegation, the relevant material on record Ext.A1 shows that the patient Eliyamma(75 years) was admitted on 1 st OP hospital on 22/11/2005 at department of cardiology and discharged on 25/11/2005 , treated by Dr.M.K.AnilkumarMD,DM, the final diagnosis was CVA(R) Basal ganglia Infact(a type of stroke), medicine advice on discharge was Tab cloflow plus(75 mg) 1-0-1 Tab strocit 1-1 ,Tab crinalax (1), Tab Rebeloc 20 1 daily for two weeks. Ext.A4 shows that the patient was admitted again at 1 st OP hospital on 25/12/2005 and discharged on 26/12/2005 at department medical, treated by 2 nd OP doctor Hansraj.M.D. Final Diagnosis-Normal pressure hydro Cephalus(NPH) and medicines given at discharge time. were Tab clocoflow 75(mg) 1 daily, Tab Rostar (5 mg) 1 daily etc for 1 month. Ext.A6 shows that

she was admitted at Pariyaram Medical College hospital on 24/4/2006 to 2/5/2006 and the final diagnosis was IACA, systemic HTN, old CVA. So it has come on records from Exts.A1 to A6 that she was under treatment of cerebrovascular accident from 22/11/2005 having age of 75 years. It is an admitted fact that whenever the patient Eliyamma was admitted in the 1 st OP hospital for any ailment, the 2 nd OP who is a qualified MD in General medicine and practicing in GM in OP1 hospital used to attend and give her necessary treatment and medicine. It is also admitted that on 4/9/2007 she fell down on the marble floor hitting her head on the floor and after the fall she vomited and became speechless. Only allegation is that just after the admission 2 nd Op doctor did not suggest to take CT scan of the patient's brain. Complainant's version is that if diagnosis was done properly in the initial stage and treatment given accordingly the patient could have survived or her life could have been prolonged.

On the other hand 2 nd OP doctor submitted that he came immediately after the admission of the patient and examined and found with the previous history of infarct with left hemiplegic in mind, a provisional diagnosis of Right MCA territory recurrent stroke was made and as the patient was taking aspirin, she was asked to continue the same and prescribed some more medicine. It is submitted that as the patient has taken aspirin in the morning, it was not administered on that day. The patient was also monitored in the medical intensive case unit. On the next day morning when the condition of patient became worsen, she was advised to take CT scan and just before going for CT scan, the patient was administered aspirin and clopidogrel which she has been taking from 2005 onwards. The CT report showed subarachnoid hemorrhage . so the antiplatelets were with hold, anti edema measures were started. OP.2 also denied the allegation and stated that there was no delay in attending the patient and also stated that to refer the patient with ischemic strokes, an early CT scan will not reveal any abnormality. 85% of the stroke are ischemic strokes, and only 15% is hemorrhage. Here the patient had a previous history of ischemic stroke so according to 2 nd OP one of the reason for delay is that the chances of recurrent ischemic stroke is high and as the patient is already on anti platelet medications like aspirin and clopidogrel which will take minimum of seven days to wear off its effect after stopping the medication, the continuation of a single dose of aspirin and clopidogrel is not going to make any immediate difference. 2 nd Ops version is that the line of treatment adopted by him in good faith and in the patient's interest.

The available medical record with regard to the treatment of 2 nd OP before us is Ext.B1. Ext.B1 shows that the treatment given by 2ns OP is the same as he stated in the version and deposition time.

In this case the question is one of negligence of Dr.K.C.Hansraj and in particular whether the diagnosis was done properly in the initial stage by taking CT scan of brain of the patient and treatment given accordingly could have survived the patient. Each case however depends upon its indications. It is therefore necessary to have expert opinion on this point. Here Dr.Viswanathan.P, Civil Surgeon, MD (Physician) District Hospital Kannur has given a medical report as per the direction of this Forum, which is marked as Ext.X1(d). In ext.X1(d) expert doctor reported that after examined the provided documents connected to this case that stroke happened to the patient was due to subaractioned bleed detected by CT scan done on the next day. The patient was a case of Hyper tension old stroke in 2005. It is further reported that subarachrind haemorrhage is a serious medical condition. The doctor had prescribed Aspisol 150 mg on the day of admission and aspisol 150 mg and clavix 75mg , the next day(both ante platelet agents which prevents clotting of blood inside blood vessel) along with

other medicines. He had also given strocit IV infusion . These were given before getting scan report. This is unscientific. Strocit infusion was not needed in this case. Above mentioned anti platelet drugs and strocit infusion was stopped after getting CT scan report.

The expert doctor ,Viswanathan.P was summoned before the Forum on the application of complainant and was examined as PW2 and marked Ext.X1(d). In Ext.X1(d) the PW2 doctor reported that 2 nd OP doctor given aspirol 150mg clavix 75 mg and also strocit IV infusion before getting scan report. This is unscientific. Strocit infusion was not needed in this case. On the testimony of PW2 during chief examination in page 2 deposed that Antiplatelet drugs like aspirol 150 and clavix 75mg is used for Istemia stroke. This is a case of bleeding hemorrhage, strocit IV is also not required for hemorrhage. Further deposed that these antiplatels will worsen the condition of bleeding.

The learned counsel for the Ops vehemently cross examined PW2. PW2 deposed that in page 6 Hospital records shows this is a known case of CVA. This shows that she suffers from chronic diseases. On 4//9/07 clevix 75mg is minimum dose. PW2 further deposed in the same page that I have not stated that there was negligence on the part of 2 nd OP in treating the patient. The advice of medicines before CT scan is unscientific. I cannot say that those two administered drugs caused the death of Eliyamma. After getting Ext.A8 CT scan report, 2 nd OP stopped antiplatelet. This is a correct method by Dr.Hansraj 2 nd Op. Sub Arachnoids hemorrhage is a serious condition. Mortality rate of this disease is very high. This is the oral evidence adduced by PW2 before us.

On a careful examination of the oral and documentary evidence tendered by the parties, go to show that 2 nd OP doctor immediately attended the patient who was having due experience to deal with the case of complainant's mother. It also appears that after getting CT scan report, 2 nd Op stopped antiplatelet drugs.

On the analysis of PW2 expert doctor's evidence, it is amply clear that the treatment given by 2 nd OP doctor by stopping antiplatelet drug after getting Ext.A8 CT scan report was proper. In fact evidence shows that after the discharge from 1 st OP hospital, the patient was again taken to 1 st Op hospital on 9/12/2007 and 29/12/2007 and she died after 7 months from the disputed treatment of 2 nd OP.

For the sake of argument , even if it is assumed that there was delay committed by 2 nd OP doctor for taking CT scan and administered single dose of aspirin and clopidogrel, cannot be considered as gross negligence" on his part. At the most, it could be treated an error in the judgment by the medical professional. It is an undisputed fact he is a well experienced medical practitioner having qualification MBBS,MD General Medicine and having 20 years experience to treat patients. It is also admitted by complainant that from 2005 onwards his mother was under the treatment of 2 nd OP. Thus on the basis of his experience, and as his patient, 2 nd OP provided the necessary treatment. It is well settled that mere error in judgment will not amount to medical negligence.

In view of the discussion held above, we do not find any professional negligence or unfair trade practice on the part of 2 nd opposite party. Since 2 nd OP is working in 1 st OP hospital, 1 st OP is arrayed as 1 st opposite party. So no negligence or unfair trade practice can be attributed against opposite parties 1&2. Hence the complaint is liable to be dismissed.

In the result complaint fails and hence it is dismissed. No cost.

Exts:

A1-Discharge card-dt 25/11/05

A2-CTscan report 24/11/05

A3-Prescription dt.9/12/05 by OP

A4-Discharge card-26/12/06

A5-Prescription dt16/2/06

A6-Discharge card 2/5/06 from Periyaram

A7- do- 17/9/07

A8-CT scan report-5/9/07

A9-Certificate given by OP 17/9/07

A10-prescription dt.9/10/07 by OP

A11-Discharge card dt.11/12/07 "

A12-request letter by complainant to OP 29/12/07

A13-prescription dt.29/12/07

A14-Discharge summary 17/1/08

A15-Nurses report 4/9/07

A16-Certficate from Cherukunnu hospital

X1 series medical report

X1(a) letter dt.3/12/09,X1(b)letter dt.27/12/09,X1(c) letter dt.29/1/10 X1(d)- medical report

B1& B2-case sheet from OP.1 hospital

PW1-P.V.Valsalan- complainant

PW2- Dr.Viswanathan .P-witness of complainant

DW1-Dr.K.C Hansaraj- OP.2

Sd/ Sd/ Sd/

PRESIDENT MEMBER MEMBER

Ravi Susha Molykutty Mathew. Sajeesh K.P

eva

/forwarded by Order/

SENIOR SUPERINTENDENT

[HON'BLE MRS. RAVI SUSHA]
PRESIDENT

[HON'BLE MRS. Moly Kutty Mathew]
MEMBER

[HON'BLE MR. Sajeesh. K.P]
MEMBER