IN THE CONSUMER DISPUTES REDRESSAL FORUM
KANNUR

Complaint Case No. OP/02/2005
(Date of Filing : 05 Jan 2005)

1. K.Sreedharan,S/O.Bappu ,Kollarath
House,Macheri,P.O.Mouvenchery,Via.Chakkarekal
Kollarath
House,Macheri,P.O.Mouvenchery,Via.Chakkarekal
2. Sreeja,D/O.Late Sreedharan
Kollarath
House,Macheri,P.O.Mouvenchery,Via.Chakkarekal
Kannur
Kerala
3. Sreejesh.C,S/O.Late Sreedharan
Kollarath
House,Macheri,P.O.Mouvenchery,Via.Chakkarekal
Kannur
Kerala
4. Sreejith.C,S/O.Late Sreedharan
Kollarath
House,Macheri,P.O.Mouvenchery,Via.Chakkarekal
Kannur
Kerala
5. T.P.Nandini,W/O.Late Sreedharan
Kollarath
House,Macheri,P.O.Mouvenchery,Via.Chakkarekal
Kannur
Kerala .....Complainant(s)

Versus

1. M/S Dhanalakshmi Hospital , Thana,Kannur
2
Thana,Kannur 2
2. Dr.Narayana Prasad,Ortho Pediatric Surgeon
Dhanalakshmi 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 : 15 Dec 2020

Final Order / Judgement

SMT. RAVI SUSHA : PRESIDENT

Complainant filed this complaint under Sec.12 of the Consumer Protection Act 1986 for getting an order directing the OPs to pay Rs.5,00,000/- due to the deficiency in treatment of 2nd OP.

Brief facts of complaint's case are that the complainant had met with an accident on 14/1/2002 and immediately taken to OP.1 's hospital and admitted there as IP No.21132.2 nd OP, doctor treated the complainant from 14/1/2002 and on 19/1/2002 surgery ORIFT Bone grafting with bepedical flap coverage was done after general anesthesia. Complainant was discharged on 30/1/2002 with an advice to review after 6 days. Thus on 11/2/2002, the complainant went to 2 nd OP, he reviewed and advised to review again after 6 weeks. During this period the complainant had acute pain over operated part of leg and the same had submitted to 2 nd OP, but he did not care the same and was told that he will be alright within short time. Whenever the complainant is going to 2 nd OP he was prescribing to take X ray and perusing the same and was telling that there is very good improvement need not worry. As per the advice of 2 nd Op, complainant went 2 nd OP on 26/3/2002, on that day 2 nd OP had seen that the screws fixed to the steel rod were shaking and it had came out from the position fixed and complainant was admitted in 1 st Op hospital as IP NO.22808 and removed two screws and PTB from the steel rod and applied ptb cast over the fractured part in addition to the steel rod already fixed. The complainant was having acute pain over the fractured part of leg and told to 2 nd OP, but he did not care the same and discharged on 27/3/2002 with an advice to review after one week. The pain was persistent over fractured part and then he reviewed as per advice on 5/4/2002, 20/5/2002, 20/6/2002 and 29/7/2002. 2 nd OP advised to take X ray and found non union of bone but he advised to have some pain killers like voveran for one month and advised to review after one month. On 3/9/2002 taken X-ray and advised to take bed rest with weight bearing on his leg. Since pain existing he met 2 nd OP on 29/11/2002 but 2 nd OP did not care the difficulties of the complainant and advised to undergo bed rest with life hazardous medicine. During these period the complainant was totally bed ridden and was unable to walk. He was unable to do his primary needs without the help of others. After 29/11/2002 complainant visited 2 nd OP on 7/1/2003,4/3/2002,7/5/2002 ,29/7/2002,3/9/2002,7/1/2003,4/3/2003 and on 14/1/2004. On 14/1/2004 there was puss over the operated part and the skin over the operated part had lost and the steel rod fixed was shaking. Hence 2 nd OP admitted him as IP NO.34478 and removed the implanted steel rod from the leg. Then the leg was hanging. The 2 nd OP did fibular osteotomy and patellar tendon bearing cast was applied for 8 weeks. He was discharged on 18/1/2004. As the pain over the operated part was persistent this complainant again met the 2 nd Op on 23/1/2004 and again on 30/1/2004. But there was no use instead of prescribed some life

hazardous medicine. On 19/2/2004 he again met 2 nd OP then 2 nd OP removed plaster cast. Then it was noticed by 2 nd OP mobility over operated part of leg and non union of the borne. Hence advised to undergo illizaro fixation. It is alleged by the complainant that during the treatment of 2 years under 2 nd OP he suffered much pain and was bed ridden and the fractured part did not united due to the negligent operation of the 2 nd OP. The complainant suffered acute pain through out under the treatment of 2 nd OP. There was no improvement in condition of the complainant. 2 nd OP given letter on 23/3/2004 referring the complainant to Dr. Sudhakar Shetty at Mangala Nursing at Mangalore , on examination the physician of that hospital was surprised to see that the treatment till then made by 2 nd OP was manifestly wrong and the reason for non-union of the fracture was due to surgical operation and post operative treatment given by 2 nd OP was in a negligent manner. 2 nd OP did not care the recurring unbearable pain instead of prescribed health hazardous sedative drugs and toxic content medicines. The wrong and negligent treatment resulted in partial deforminity and disability on the affected part. Due to the negligent operation and treatment of the 2 nd OP this complainant was completely on bed for the last 2 ½ years, he was unable to walk or to sit. Hence filed this complaint for getting compensation of Rs.5,00,000/- with interest from the opposite parties.

After receiving notice opposite parties filed separate versions and their defence versions are of total denial. 1 st OP is the hospital and 2 nd OP is the treating doctor. Contents of both the written versions more or less the same.

In the versions ,admission of the complainant immediately after road accident ie on 14/1/2002 consultations, operations conducted, impatient treatment reference given are not denied by both the opposite parties. It was contented by the Ops that after admission , the complainant was diagnosed to have a comminuted fracture of lower 3 rd tibia and fibula right side. The patient had other injuries like a lacerated wound over the chin and abrasions over the face and anterior aspect of left leg. After necessary pre-operative investigations and check-ups on 19/1/2002, 2 nd OP did an open Reduction and ternal fixation (ORIF) with bone grafting with utmost care and attention under spinal Anesthesia. Patient was given appropriate medicines in the post operative period and there was no wound infection in the post operative period. On 30/1/2002 on removal of suture minimal wound gaping was noticed which was treated with secondary suturing and the patient was discharged on 30/1/2002. On 11/2/2002 wound healed well and sutures were removed. The patient was advised strict non-weight bearing and to review after 6 weeks for removal of plaster cast and x-ray examination . On 26/3/2002 when came for review plaster cast was removed and admitted for removal of 2 projecting crews, which was causing skin irritation and pain and was discharged on 27/3/2002 and then periodic follow up as Op on 5/4/2002, 20/5/2002, 20/6/2002, 29/7/2002, 3/9/2002, 7/1/2003 and 4/3/2003 . Then the fracture was showing evidence of union in the form of callus and the patient was ambulant with the help of a walking stick. On 14/1/2004 when he was reviewed, complaining of pain he was admitted and on the same day evening under spinal anesthesia , implants were removed. Then intra operatively majority of the fragments were found united except one main fragment. The condition of the patient was explained to the relatives and fibular osteotomy was done and discharged on 18/1/2004 with below knee slab. He was reviewed on 23/1/2004 when sutures were removed and PTB cast (patellar Tendon Bearing) was applied and was allowed full weight bearing ambulation, which could help in axial loading of the bone and promote union. He was again reviewed on 30/1/2004,3/3/2004, on 19/3/2004. 19/3/2004 removal of plaster cast was done, clinically fracture site was mobile and x-ray showed non union. Then the patient was advised to undergo illizarou

fixation . On 23//3/2004 the patients relative came and expressed their desire to take a second opinion, hence he was referred to Dr.Sudhakar Shetty at Mangalore at their request. It was further contended by Ops that the allegations of complainant that (1) he had acute pain over the fracture leg and 2 nd OP did not care the same and instead applied plaster cast (2) on 26/3/2002 he was complaining of irritation and pain from screws that were producing and hence the screw were removed after admitting the patient(3) pus on the operated part (4) administration of health hazardous medicines, life hazardous medications, pain killers , (5) bedridden from 14/1/2002 onwards, are all incorrect and denied. According to Ops, 2 nd OP was always caring and empathetic to the complaint of the patient and also prescribed necessary analgesic and anti-inflammatory medicines to the patient and application of plaster cast was to secure the immobility of the affected part so as to help fracture union. Ops pleaded that the complainant was confined to bed from 14/1/2002 only for a short period when he was admitted for surgery. After surgery usually he was advised non weight bearing ambulation with the aid of crutches and then partial weight bearing and later full weight bearing as is gradually done in a case of similar nature. It is further pleaded that the large metal plate binders complete as it is on and the serioa x-rays taken during follow up showed evidence of new bone formation as visible through the sides of the implant ie, the fracture was uniting and therefore maintained the implant for the requisite normal period of 2 years as is required in a case of lower limb fracture and when the implant was finally removed after 2 years on 14/1/2004 majority of the fragments had united but only a main fragment was not united. So standard treatment of fibular osteotomy was done. After that PTB cast was applied and was allowed full weight bearing ambulation. Since on 19/3/2004, the fracture showed non-union, he was advised illizarous fixation treatment. According to Ops as the complainant and his relatives wanted a second opinion , and referral to Dr.Sudhakar Shetty, 2 nd OP gave a detailed referral letter. Ops contended that there is no negligence or deficiency of service on the part of 2 nd OP. 2 nd OP pleaded that non-union was because of the poor inherent fracture healing properties of the complainant. So ops cannot be blamed. It is also pleaded that the initial treatment of ORIF with bone grafting for bone loss and later fibular osteotomy when non union was noted and finally suggested illizarou fixation when persistent non union was noted were the appropriate treatment measurers for the complicated fracture of the complainant. It is further pleaded that there is no negligence or deficiency in service on the part of Ops as alleged by the complainant and prays for the dismissal of the complaint.

While pending of this complaint original complainant expired and his legal heirs , wife and three children were impleaded as additional complainants 2 to 5. On behalf of complainants, additional 5 th complainant Sri.Sreejesh has filed his evidence on chief affidavit and he was subjected to cross examine by the Ops. 2 nd OP filed his evidence on chief affidavit and he was subjected to cross examined by the complainant. From the side of complainant Exts.A1 to A14 and case sheets Exts X1 to X4 were marked. Medical superintendent of Mangala Hospital was examined as PW2 and through PW2, case sheet of that hospital was marked as Ext.X5.

Both parties have not filed their written arguments notes. Both learned counsels have made oral arguments and OP's learned counsel submitted citation of case laws.

Main argument of the learned counsel for the complainant is that the complainant suffered much pain and suffering apart from incurring huge money for the treatment of OP2 from

14/1/2002 to 19/2/2004(2 years) and OP2 did not care the recurring unbearable pain and fractured part not united, instead he prescribed health hazardous sedative drugs without caring to see and verify what exactly to do for curing the fractured part to unit.

On the other hand the senior counsel for the Ops submitted that the initial treatment of ORIF with bone grafting for bone loss and later fibular ostotomy when non- union was noted and finally the suggested illizarou fixation when persistent non union was noted were the appropriate treatment measures for the complicated fracture of the complainant and also submitted that the plate and screw implant given after ORIF and bone grafting treatment for the complicated fracture of the complainant was maintained for a period of 2 years as the appropriate treatment and due to inherent poor healing properties in the complainant. Ops' learned counsel further submitted that OP2 had given only approved standard analgesic medications .

We have to see whether there is any evidence with regard to these contradictory statement and whether there is any deficiency in service or negligence on the part of 2 nd OP?

Let us consider the testimony of witness PW1 who is none other than the son of original complainant. He admitted that ORIF with bone grafting surgery was done by 2 nd OP under spinal anesthesia and after that on 26/3/2002 two screws were removed and PTB cast applied. PW1 deposed that during all those periods acute pain was subsisting and hence the patient could not walk and on 14/1/2004 implant was removed due to pain. PW1 denied the statement of the OP's counsel ie on 14/1/2004 it was noted that majority of the fragments had united but a main fragment (fibula) was not united . PW1 deposed that on 14/1/2004 non union of bones was noted. PW1 admitted that on 14/1/04 fibular osteyotomy procedure was done. Further PW1 denied the question of OP's counsel that the patient was discharged on 23/1/04 with a condition to bear full weight and denied about formative of callous. It is also deposed that on 19/3/04 plaster cast removed and fracture sight showed non- union. Then 2 nd OP suggested illizarou fixation treatment. PW1 further deposed that there was puss over the operated part. PW1 categorically stated that on June 2002 itself non union of the bone was noted and on March 2002 steal rode were shaked and came out. And further deposed about prescribing of health hazardous pain killers. His evidence showed that in all period of treatment by 2 nd OP, the patient suffered acute pain , non union of bone and this was due to negligent operation treatment of 2 nd OP and the complainant was on bed for 2 1/2 years and he was unable to walk.

The learned counsel for the Ops pointed out that this was a case of medical negligence and here the complainant had not led any evidence of any expert from the field in support of allegations of medical negligence leveled by the complainant against 2 nd OP doctor. What is pertinent to note at this juncture is a fact that Dr.sudhakara Shetty , who treated him after OP hospital has not been examined. But it is admitted that he is expired. The learned counsel of OP submitted that complainant has not taken any effort to examine even his assistances. The learned counsel of complainant replied that the assistant doctor who treated the complainant is in abroad. So that could not be possible. Any way during examination of PW2 Medical Superintendent of Mangala Hospital Mangalore, no question was put forward to him about the Assistant of Dr.Sudhakara Shetty.

Here the solitary evidence before us is case sheets of complainant of 1 st OP hospital (Ext.X1 to X4) and of Mangala hospital(Ext.X5). On careful perusal of Exts.X1 to X4, we can see that the fracture happened to the complainant was communiated fracture of distal end of tibia and

fibula to right leg on 14/1/2002 due to road transport accident. The patient was conscious and oriented at the admission time. He was treated with open reduction and internal fixation with bone grafting with implant inside done only on 19/1/2002 and discharged on 30/1/2002. The voveran tab 1-0-1 started daily from 14/1/2002 onwards along with other medicines. On 26/3/02 removed two jelling out screws and PTR cast applied and discharged on 27/3/02. After that on 14/1/04 implant removed site was mobile and fibular osteotomy done and cast applied for 8 weeks. On 16/1/04 physiotherapist suggested Nwb cruch walking. On 26/3/04 implant removed. In Ext.X 5 it is written in findings portion that " the patient was diagnosed to have open fracture of tibia and fibula. He was treated in the form of open reduction and internal fixation(ORIF) along with skin grafting. He was on cast for 2 months following operation. After removing the plaster patient was not able to bear weight and experienced pain over lower leg. 2 months back implant removed was done at the same hospital and PTB cast was given. Patient has now come for further management". Further local examination of right leg:-

1. Patient on PTB cast, cast removed
2. Wasting of thigh and calf muscles present
3. Discoloration around lower half of leg present
4. Posteriorly 15x4 cm scar of skin grafting present.
5. Abnormal mobility present
6. Crepitus(+) shortening of 5cm present
7. Movements of knee and ankle painfeels
8. Impt Ununited fracture lower third right -tibia and fibula. It is seen in Ext.X5 that at Mangala Nursing Home prescribed T.Dolo 1-0-1, T.Rantac 1-0-1,T.becosule 1-0-1 ie not prescribed T VoveranD.

Ext.X5 shows that after Illizarou fixator application done on 3/4/04 and discharged the patient on 28/4/04 with no fresh complaints.

From Ext.X1 to X4 it is evident that the patient was given voveran tab 1-0-1 from the admission date till the date of discharge. Voveran tablet is a pain relieving medicine. Side effect of voveran tablet are

1. Head ache, dizziness Or spinning head
2. Nausea, vomiting , indigestion or stomach pain
3. Bloating weight loss and skin rashes

Such a life hazardous medicine was given by 2 nd OP to the patient for two years. Which substantiate the allegations of complainant ie acute pain subsisting throughout and also about giving of pain killers and life hazardous medicine. Another aspect evidenced from the case sheets that after treatment of 2 years and 2 months by 2 nd OP there was non union of lower third tibia and fibula and the patient could not walk and was bed ridden. Which reveals that this long term treatment of 2 nd OP has not given any relief to the complainant eventhough the complainant obeyed all the instructions of 2 nd OP. From any of the medical records we could not find out that on 14/1/2004, when the implant was finally removed. The majority of the fragments had united but only a main fragment was not united." From the nature of treatment given by 2 nd OP shows that 2 nd OP as an Orthopedic surgeon was doing experimental treatment on the complainant and he has not given any important about the pain and suffering of the patient.

The learned counsel of Ops submitted that 2 nd OP also suggested Illizaro fixation but complainant's relatives wanted a second opinion and wanted referred to Dr.Sudhakara Shetty. For taking such a decision by the complainant's relatives, we cannot blame them, because with respect to complainant all the treatment methods adopted by 2 nd OP were utterly failed. Further opposite parties submitted that the continuing non union inspite of appropriate treatment was due to the complicated nature of the fracture(communicated fracture of lower one third of tibia and fibula with bone volume loss needing internal fixation and bone grafting) and due to inherent poor healing properties in the complainant. Here from the medical records there is no evidence that due to accident " bone volume loss" was happened. The fracture diagnosed as " communiated fracture of lower 3 rd tibia and fibula right side." It is also a fact that the patient had no history of any other injury other than RTA injury, diabetics, hypertension, tuberculosis on general examination . Moreover Ext.X5 shows that he became alright within one month from their treatment. So we cannot consider the above said submission of opposite parties.

The learned counsel of opposite parties submitted certain citations (1) 2010 CPJ 29(SC) Kusum Sharma and Ors vs. Btra Hospital and Medical Research Centre in which Hon'ble Supreme Court held that Doctor not guilty of medical negligence as long as they perform their duties and exercise ordinary degree of professional skill and competence

(2) 2010 CPJ 62 (NC) Prabha Shankar vs. Neelmai Rai (Dr.) in which Hon'ble National Commission held that onus of proof is on the party alleging negligence-No expert evidence produced in support that defective line of treatment adopted by OP doctor.

(3) IV (2017) CPJ 585 HC St.Stephen Hospital vs. Dhani Ram in which it was held by Hon'ble NC that Medical negligence-Road accident-severe injuries to left leg- Hospitalization for about two months- left leg amputed at AIIMS later- deficiency in service alleged-negligence not proved.

In this case facts of the case is different. Here the complainant availed 2 nd Ops treatment for his communiated fracture on his right leg due to road transport accident, the doctor (Orthopedic surgeon) treated the patient for a prolonged period of 2 years and 2 months. Final diagnosis after this period is non union of fracture tibia and fibula. 2 nd OP doctor made experimental one and another method of treatment on the patient during these prolonged period prescribed life hazardous medicine like voverin and claimed that he had given the appropriate treatment. It is pertinent to be noted that within one month the patient was discharged from 2 nd treatment hospital (Mangala Hospital Mangalore) after illizaro fixation treatment with no fresh complaint. It can be further noticed that on 9/4/2004 ie just after 5 days from illizarou fixator application) patient was comfortable and was on partial weight bearing ambulation ie the ability to walk from place to place independently with or without assistive devices. It is also seen as per Ext.A6 discharge summary from Mangala Medicard that at the admission time " non union (Rt) tibia and fibia minimal "callus seen " , these two above noted facts speak that contention of the Ops that the continuing non union in spite of appropriate nature of the fracture and due to inherent poor healing properties in the complainant and on 3/3/2004 check X –ray with the cast was done which was showing good callus, are baseless. In such cases it is for the hospital or the doctor concerned to discharge the burden of proving that no negligence was committed and all appropriate treatment was made at the appropriate time and also about the

dose and the medicine given to the patient and also improvement of treatment shown in X-rays taken in OP hospital as claimed by OP because , we are unaware about the change of result shown in X-rays.

In this case on perusal of Ext.X1 to X5 principal of Rep Ipsa Loquitur ie "the facts itself speak and tell their own story" is squarely applicable considering the sequence of events, selection of treatment adopted and medicine given by the 2 nd OP doctor.

Here the Ops have no case that the complainant was negligent his directions and was absent at review dates. We can see that the complainant visited 26 times within 2 years and 2 months to 2 nd OP for review. But the after effect is of the treatment is (Ext.X5) non union (RT) tibia and fibula.

On consideration of the case and the medical records before us, we are of the opinion that the 2 nd OP is guilty of medical negligence amounting to deficiency in service. Since 2 nd OP doctor was working in 1 st OP hospital there is vicarious liability on the part of 1 st opposite party hospital also. So both opposite parties are liable .

In the result complaint is allowed in part. Opposite parties 1&2 are directed to pay Rs.1,50,000/- as compensation to the additional complainants for the deficiency in service and professional negligence on the part of 2 nd opposite party. Opposite parties are further directed to pay Rs.25,000/- as cost of the proceedings. Both opposite parties are jointly and severally liable to pay award amount. 1/4 th of the award amount is entitled to each complainant. The order is to be complied with within one month from the date of receipt of the order. Failing which the amount of Rs.1,50,000/- will carry interest @8% per annum. The complainants are at liberty to recover the amount as per the provisions of Consumer Protection Act 2019.

Exts.

A1-Discharge card(photocopy)

A2-Discharge card

A3-Discharge card(treatment dates of 14/1/04 to 18/1/04 ,23/1/04,to 30/1/04, 5/3/04)

A4-29/7/02 to 23/3/04 Op prescription list

A5-referring letter

A6- Discharge card(31/3/04 to 28/4/04)

A7-22/3/04- treatment certificate given by OP

A8-lawyer notice

A9& A10-Reply notice

A11-photos and negatives

A12 series (15Nos.) - X rays

A13- series (5Nos.) –X-rays

A14 series(3Nos)- X-rays

X1- Out patient records(46 pages)

X2-Admission records(22 pages)

X3-History and physical examination records

X4- Out patient record

X5- case sheet

PW1-Sreejesh.C- 4 th complainant

PW2-Dr.Dharmaraja .K -witness of complainant

DW1-Dr.Narayana Prasad -OP.2

Sd/ Sd/ Sd/

PRESIDENT MEMBER MEMBER

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/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