# NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION
# NEW DELHI

## CONSUMER CASE NO. 326 OF 2012

1. DR. MANJU DADU
W/o Dr Narendra Dadu First Floor, J-12/25, Rajouri Garden
NEW DLEHI 110027 .....Complainant(s)

Versus

1. FORTIS ESCORT HEART INSTITUTE & RESEARCH CENTRE & 2 ORS.
Okhla Road
NEW DLEHI 110025
2. DR ASHOK SETH, CHAIRMAN, CARDIAC SCIENCES
Fortis Escorts Heart Institute & Research Centre
NEW DELHI 110025
3. DR A K SINGH, HEAD OF DEPARTMENT OF NEUROSURGERY,
Fortis Escorts Heart Institute & Reserch Centre
NEW DELHI 110025 .....Opp.Party(s)

**BEFORE:**

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

FOR THE COMPLAINANT : MR. PRAVIN BAHADUR, ADVOCATE
MR. MOHIT K. MUDGAL, ADVOCATE
MR. SACHIN DUBEY, ADVOCATE
MR. SAURABH KUMAR, ADVOCATE

FOR THE OPP. PARTY : MR. JOY BASU, SR. ADVOCATE
MR. ARJUN DEWAN, ADVOCATE
MR. AKASH ARORA, ADVOCATE
MR. ANOOP GEORGE, ADVOCATE

**Dated : 07 August 2024**

**ORDER**

**1.** Heard Mr. Pravin Bahadur, Advocate, for the complainant and Mr. Joy Basu, Sr. Advocate assisted by Mr. Arjun Dewan, Advocate, for the OPs.

**2.** Dr. (Mrs.) Manju Dadu has filed above complaint, for directing the opposite parties to (i) refund Rs. two crores, paid by her as the medical expenses to the opposite parties; (ii) pay Rs. five crores, as compensation for medical negligence and consequent injury caused to the complainant; (iii) pay Rs. Ten lakhs, as litigation costs; and (iv) any other relief which is deemed fit and proper in the facts and circumstances of the case.

**3.** The complainant stated that Fortis Escorts Heart Institute & Research Centre (OP-1) is a renowned private heart institute of India, Dr. Ashok Seth (OP-2) was Head of Cardiology Department and Dr. A.K. Singh (OP-3) was Head of Department of Neurosurgery of OP-1. Dr. Narendra Dadu, aged about 62 years (the patient), the husband of the complainant was medical practitioner and run his clinic at Rajouri Garden, New Delhi. The patient was diabetic for past 20 years. In November, 2010, the patient visited Fortis Escorts Heart Institute & Research Centre for his routine check-up, in which, his angiography was done, which revealed that his 2 arteries were blocked and 3rd artery was ballooning. Then his angioplasty was done in OP-1 and two blocked arteries were stented. The patient suffered from pain in cheek in March, 2011. He called Dr. Ashok Seth but he was not available. Then he took appointment with Dr. Ashok Seth, which was fixed for 06.05.2011. During talk on 06.05.2011, Dr. Ashok Seth opined that for an angiography to check the patency of the earlier two stented arteries and the third un-stented artery. The patient was on Anti-Platelet medicines since, November, 2010, he asked Dr. Ashok Seth as to whether he had to stop any medicine but Dr. Ashok Seth told not to stop any medicine. Angiography was done on 10.05.2011 at 12:00 noon, which revealed 60% to 70% blockage of 3rd artery (i.e. right coronary artery) and two stented arteries were fine. Dr. Ashok Seth advised for angioplasty of third artery at 17:00 hours. Considering the reputation and experience of Dr. Ashok Seth and after consultation with the family members, the patient agreed for angioplasty, which was started on 10.05.2011 at about 18:30 hours and completed at 19:00 hours. The doctors informed the elder daughter of the complainant that the patient had been put on ventilator, as he had some breathing problem and foaming at the mouth due to reaction with the dye used during angiography although the patient had no such reaction, when his angioplasty was done in November, 2010. The OPs did not inform about any serious condition of the patient. The patient was shifted to 'Intensive Care Unit' at 20:00 hours, where he was kept for 36 hours. The complainant was informed that the patient was given Heparin during 10.05.2011 to 11.05.2011 till night for maintaining the patient's blood pressure for doing IA Ballooning. It appears that the patient suffered from brain hemorrhage due to Heparin but the OPs failed to diagnose it on time and went on giving Haprin. Dr. Nivedita Dadu, elder daughter of the complainant suspected that brain hemorrhage to the patient and informed and informed the floor doctors and even Dr. Ashok Seth but they ignored it. When the condition of the patient became very critical then CT scan was done on 12.05.2011 at 10:00 hours and the complainant and family members were informed that the patient had suffered from seizure/brain hemorrhage at the time of angioplasty. The OPs then called a Neurosurgeon from the Fortis Hospital, Basant Kunj (15 KM away) to carry out a ventriculostomy as Fortis Escorts Heart Institute & Research Centre (OP-1) did not have the required facility of neurosurgery although on its display boards, they have listed a "team of neurosurgeon". Ventriculostomy of the patient was performed on 12.05.2011 at 14:00 hours. On 13.05.2011 at 10:00 hours, another CT scan was done, which showed a Hematoma, which required surgery, for which, the patient had to be shifted to the Fortis Hospital, Basant Kunj. However, Fortis Escorts Heart Institute & Research Centre (OP-1) could not arrange an equipped ambulance timely and the ambulance was called from the Fortis Hospital, Basant Kunj, which took unusual time and the patient could be shifted to the Fortis Hospital, Basant Kunj on 13.05.2011 at 16:00 hours, where his surgery was performed at 18:00 hours. Even after surgery, on 13.05.2011, the patient remained in coma for almost one month. When he came out of coma, he suffered from complete paralysis of left side and lost his ability to speak, hear or understand other people. Fortis Hospital, Basant Kunj was providing only normal

nursing care to the patient after surgery, for which, they were charging exorbitantly, therefore the complainant get the patient discharged on 16.06.2011 and shifted to Dr. RML Hospital, New Delhi, where the patient remained there till 11.08.2011. After discharge on 11.08.2011, the patient could barely walk with the help of an attendant and walking stick. The patient was admitted in Fortis Escorts Heart Institute & Research Centre (OP-1) on 10.05.2011 in a healthy condition and he was regularly attending his clinic. Angiography conducted on 10.05.2011 at 12:00 noon, revealed 60% to 70% blockage of 3rd artery (i.e. right coronary artery) and two stented arteries were fine and there was no need for angioplasty. Dr. Ashok Seth (OP-2) and his team unnecessarily conducted angioplasty. The patient was a known diabetic for last 20 years but the OPs committed gross negligence in giving Heparin to the patient, which caused brain hemorrhage. The OPs took 72 hours in diagnosing brain hemorrhage of the patient, which was most crucial time to save the patient from grievous injury. Inordinate delay in providing treatment of brain hemorrhage to the patient caused grievous injury to the patient. The patient was earning Rs.30000/- per month from his medical profession and now he is totally unable to do anything and requires help for doing his routine work. The patient has two unmarried daughters, depending upon him. The complainant spent about Rs.50/- lacs in treatment of the patient, during this period. Fortis Escorts Heart Institute & Research Centre (OP-1) is an institute of stature and its charges are very high. But instead of providing standard services to the patient, the doctors, nurses, employees of OP-1 mishandled and neglected the patient at every stage, which amounts to serious deficiency in service. Due to gross negligence committed by the OPs and injury caused to the patient, whole family suffered from tremendous mental agony. The complainant gave a legal notice to the OPs on 21.04.2012 to make good the loss suffered by the patient. In spite of service of the notice, the OPs failed to respond it. On these allegations, the complaint was filed on 06.12.2012.

**4.** Fortis Escorts Heart Institute & Research Centre and Dr. Ashok Seth (OPs-1 and 2) filed their joint written reply and stated that OP-1 is a renowned and best for medical services, which provides world class cardiac facilities to the patient and neurological treatment is provided by its associate hospital based at Vasant Kunj. OP-1 depends on Fortis Hospital, Vasant Kunj for non-cardiac specialties, especially neurosurgical back up. Dr. Ashok Seth and Dr. A.K. Singh (OP-2 & 3) were Head of their Departments but at present Dr. A.K. Singh has left OP-1 hospital. It has been denied that OP-2 gave appointment to the patient for 10.05.2011. OP-2 never keeps any patient on wait list. Dr. Narendra Dadu, aged about 62 years (the patient) was a known case of type –II diabetes mellitus for past 20 years, hypertension, coronary artery disease, multiple tuberculoma with tubercular meningitis for last one and half year and was on ATT since December, 2009. OP-2 did angioplasty and stented two blocked arteries of the patient successfully in November, 2010. The patient was admitted to Fortis Escorts Heart Institute & Research Centre on 10.05.2011 for evaluation by coronary angiography and needful treatment as history suggestive of heart disease in the form of post meal angina, stress echo and stress thallium done were positive for reversible ischemia. Angiography revealed 70% stenosis in right coronary artery and Dr. Ashok Seth advised for elective angioplasty of 3rd artery in view of positive stress and recent symptoms of angina and discussed with the family. The patient and his elder daughter are doctors as such they were aware of risks, benefits and repercussion and they consented for angioplasty and insisted for it on the same day as they did not want another admission for a PCI and process of puncturing to be done again. The patient was taken for angioplasty after

explaining the risk and taking informed consent on 10.05.2011 at 18:30 hours. He was given heparin in the right dose as a part of starting the angiography procedure. About 19:00 hours, after first shoot of angioplasty, i.e. Step-I, the patient became seriously breathless and kept on worsening. He suddenly developed severe breathlessness and his BP shot up to 200/110mmHg. He was de-saturated. The patient was immediately supplemented with oxygen by mask and shifted off the cath table and the procedure was discontinued. This was possibly a severe pulmonary edema. He did not respond to diuretics and had to be put on ventilator support. At about 20:00 hours, he had low BP and became further unstable. To support the blood pressure, intra-aortic balloon pump (IABP) was inserted and small dose of anticoagulation for IABP was unavoidable and mandatory to be given otherwise the limb arteries would form clots. His blood prothrombin time and PTTK values were constantly monitored. Unfortunately, the patient suffered from spontaneous major brain hemorrhage. This cerebral hemorrhage was detected in time by clinical suspicion during his ventilated state and was then timely seen and operated by neurosurgical team. He survived with major residual neurological deficit. Thereafter, he had no clinical sign of bleeding in brain like fits, convulsion or papillary changes till 12.05.2011. The patient had never seizures before 12.05.2011. Sedation has to be given to a patient, who is on the ventilator and this can prevent the immediate detection of brain bleed. It was a large brain bleed which has a poor prognosis. As soon as, the patient started abnormal jerky movement on 12.05.2011, CT scan was done on urgent basis. Neurosurgical consultation was done immediately without delay and ventriculostomy was performed on 12.05.2011 at 14:00 hours without wasting any time. Repeat CT scan revealed hematoma (big size). After due deliberation with OP-3, it was deemed proper in best interest of the patient to shift him in Fortis Hospital Vasant Kunj and the patient was then transferred there. It has been denied that no ambulance service was available at OP-1 at the time of transfer of the patient. There was no delay in detection of brain hemorrhage and treating it at the earliest. No powerful anti-coagulant was ever given to the patient in the hospital. The patient was already on anti-platelets as such spontaneous bleeding could occur to such patient. In ICU setting, the patient is monitored even more vigorously than normal ward setting, considering severely ill and critical patient. The OPs accorded world class medical care and was treated with standard protocol. There was no negligence at any stage. The patient was discharged from Fortis Hospital, Basant Kunj on won request. It has been denied that the hospital was providing only normal nursing care to the patient after surgery or charging exorbitantly. The complainant spent Rs.213228/- at OP-1 hospital and Rs.1410311/- at Fortis Hospital, Vasant Kunj. Exorbitant claim has been made without any basis. The complaint is liable to be dismissed.

**5.** The complainant filed Rejoinder reply, Affidavits of Evidence of Dr. Manju Dadu, Dr. Nivediata Dadu and Dr. Nandini Dadu. The opposite parties filed Affidavit of Evidence of Dr. Ashok Seth. The OPs filed medial record of the patient along with IA/8771/2022, which was allowed on 28.09.2022. Both the parties have filed their written arguments.

**6.** We have considered the arguments of the parties and examined the record. The medical record as produced by the opposite parties shows that medical check-up of the patient was done on Fortis Escorts Heart Institute (OP-1) on 07.05.2011. Radiology Report of chest (pg.147 of medical record) dated 07.05.2011 showed “bronchovascular marking are prominent in both lung field”. Radiology Report of chest (pg.149) dated 10.05.2011 showed “congested lung fields”. Even then Dr. Ashok Seth advised for angioplasty, although the

patient, aged about 62 years was a known case of type –II diabetes mellitus for past 20 years, hypertension, coronary artery disease, multiple tuberculoma with tubercular meningitis for last one and half year and was on ATT since December, 2009. The OPs in their written reply stated that the patient was taken for angioplasty at 18:30 hours on 10.05.2011, he was given heparin in right dose as a part of starting the angiography procedure. About 19:00 hours, after first shoot of angioplasty, i.e. Step-I, the patient became seriously breathless and kept on worsening. He suddenly developed severe breathlessness and his BP shot up to 200/110mmHg. He was de-saturated. The patient was immediately supplemented with oxygen by mask and shifted off the cath table and the procedure was discontinued. This was possibly a severe pulmonary edema. From above facts, it is proved that OP-2 had ignored the lungs condition of the patient and proceeded for angioplasty although the patient was co-morbid and angioplasty was elective and not compulsory at that time. They cannot shirk their responsibility by saying that the patient and his daughter were doctors and they had given their informed consent, knowing well the risks and benefits.

**7.** The OPs further stated that the patient did not respond to diuretics and had to be put on ventilator support. At about 20:00 hours, he had low BP and became further unstable. To support the blood pressure, intra-aortic balloon pump (IABP) was inserted and small dose of anticoagulation for IABP was unavoidable and mandatory to be given otherwise the limb arteries would form clots. His blood prothrombin time and PTTK values were constantly monitored. Unfortunately, the patient suffered from spontaneous major brain hemorrhage. This cerebral hemorrhage was detected in time by clinical suspicion during his ventilated state and was then timely seen and operated by neurosurgical team. He survived with major residual neurological deficit. Same facts have been stated in paragraph-8 and 12 of Affidavit of Evidence of Dr. Ashok Seth (OP-2). No powerful anti-coagulant was ever given to the patient in the hospital. The patient was already on anti-platelets as such spontaneous bleeding could occur to such patient.

A perusal of Heparin Protocol (pg. 196 of medical record) shows that two doses heparin were given on 10.05.2011, four doses heparin were given on 11.05.2011 and two doses heparin were given on 12.05.2011. Progress Notes (Pg.186 of medical record) shows that Dr. Rajneesh advised not to decrease or stop injection heparin infusion on 11.05.2011 at 4:00 hours. On pg. 94 of medical record, Dr. Vishal Rastogi advised for Injection heparin 200 on 11.05.2011 at 20:00 hours. Nurse Notes (Pg.42 of medical record) shows that on 11.05.2011 at 24:00 hours, noted as “Patient is on heparin infusion”.

Blood test report dated 10.05.2011 noted “Platelets 350”, Blood test report dated 11.05.2011 noted “Platelets 274”, Blood test report dated 12.05.2011 at 1:59 hours noted “Platelets 75”, Blood test report dated 12.05.2011 at 12:33 hours noted “Platelets 60”, Blood test report dated 12.05.2011 at 17:20 hours noted “Platelets 50” Blood test report dated 13.05.2011 noted “ Platelets 63”.

**8.** The OPs further stated that the patient survived with major residual neurological deficit. Thereafter, he had no clinical sign of bleeding in brain like fits, convulsion or papillary changes till 12.05.2011.

Urine sample of the patient was taken on 11.05.2011 at 4:09 hours and its report (Pg. 154 of medical record) showed ‘red blood cells’ in it. Progress Notes (Pg.186) noted on 11.05.2011

as “Blood stained frothing secretion came out through the Endo-tracheal tube”. In Discharge Summary (Pg.10 of medical record), noted that the patient was found to be neurologically non-responsive on next morning and sedations were discontinued. Consultation Form dated 11.05.2011 (Pg.110) suspected “Hypnosis Brain Injury”. From these symptoms bleeding in brain from 11.05.2011 is not ruled out.

From the medical record, it is proved that the statement of the OPs that only two small doses of heparin were given on 10.05.2011 i.e. one before start of procedure of angioplasty and other to support low blood pressure, is incorrect. Heparin was given to the patient till 12.05.2011, in spite of the fact the patient was already on Anti-Platelet medicines, he was neurologically non-responsive, bleedings were notices from various vital organs and platelets level was regularly falling considerably.

**9.** Progress/Investigation/Procedure notes dated 12.05.2011 at 3:45 hours noted as “Patient had generalised convulsion” and again at 12.05.2011 at 9:00 hours (Pg.95 of medical record) noted as “Myoslam jerks. Had generalized convulsion at night & early morning”. Then CT scan of brain was conducted. The OPs did not produce CT scan report. Its gist has been noted on Consultation Form dated 12.05.2011 at 12:30 hours (Pg.108 of medical record) as CT Brain of patient shows “Intraventricular Bleed”. Then ventriculostomy was performed on 12.05.2011 at 14:00 hours. From above recordings, it is proved that convulsion had started from night of 11.05.2011 while ventriculostomy was performed on 12.05.2011 at 14:00 hours i.e. more than 14 hours was taken.

**10.** Repeat CT scan of the brain was conducted on 13.05.2011 at 10:00 hours. The patient could be shifted to the Fortis Hospital, Basant Kunj on 13.05.2011 at 16:00 hours, where his surgery was performed at 18:00 hours. In spite of the fact that the patient was in critical condition, the OPs took six hours in shifting the patient for neurosurgery.

Dr. Narendra Dadu, aged about 62 years (the patient) was a known case of type –II diabetes mellitus for past 20 years, hypertension, coronary artery disease, multiple tuberculoma with tubercular meningitis for last one and half year and was on ATT since December, 2009. The OPs claim to provide world class medical service and their charges are also high. But OP-2 ignored lungs condition of the patient and started angioplasty, which resulted in severe pulmonary edema within half an hours of starting procedure. Platelets were falling day to day. Bleeding in urine and through indo-tracheal tube was started on 11.05.2011 and the patient was neurologically no-responsive but heparin was continued till 12.05.2011. Although convulsion was noticed in the night of 11.05.2011 but CT scan of brain was conducted on 12.05.2011 at 12:30 hours and ventriculostomy was performed on 12.05.2011 at 14:00 hours. Repeat CT scan brain was done after 20 hours and six hours were taken in shifting the patient for operation. Due to gross negligence committed by OP-2 permanent brain injury has been caused to the patient. Even after surgery, on 13.05.2011, the patient remained in coma for almost one month. When he came out of coma, he suffered from complete paralysis of left side and lost his ability to speak, hear or understand other people and is in vegetative state and he is totally unable to do anything and requires help for doing his routine work. The complainant, Rejoinder reply has stated that she had taken service of full time qualified male nurse to take care of daily routine activities of the patient and incurring about Rs.37000/- per months.

**11.** Supreme Court in **Arun Kumar Manglik v. Chirayu Health & Medicare (P) Ltd., (2019) 7 SCC 401,** held that in the practice of medicine, there could be varying approaches to treatment. There can be a genuine difference of opinion. However, while adopting a course of treatment, the medical professional must ensure that it is not unreasonable. The threshold to prove unreasonableness is set with due regard to the risks associated with medical treatment and the conditions under which medical professionals function. This is to avoid a situation where doctors resort to "defensive medicine" to avoid claims of negligence, often to the detriment of the patient. Hence, in a specific case where unreasonableness in professional conduct has been proven with regard to the circumstances of that case, a professional cannot escape liability for medical evidence merely by relying on a body of professional opinion. In the present case, the record which stares in the face of the adjudicating authority establishes that between 7.30 a.m. and 7 p.m., the critical parameters of the patient were not evaluated. The simple expedient of monitoring blood parameters was not undergone. This was in contravention of WHO Guidelines as well as the guidelines prescribed by the Directorate of National Vector Borne Diseases Control Programme. It was the finding of the Medical Council of India that while treatment was administered to the patient according to these guidelines, the patient did not receive timely treatment. It had accordingly administered a warning to the respondents to be more careful in the future. In failing to provide medical treatment in accordance with medical guidelines, the respondents failed to satisfy the standard of reasonable care as laid down in *Bolam case* [*Bolam* v. *Friern Hospital Management Committee*, (1957) 1 WLR 582] and adopted by Indian courts. To say that the patient or her family would have resisted a blood test, as is urged by the respondents, is merely a conjecture. Since no test was done, such an explanation cannot be accepted.

**12.** So far as the compensation is concerned, Supreme Court in **Nizam Institute of Medical Sciences Vs Prasanth S. Dhananka, (2009) 6 SCC 1,** held that we must emphasise that the court has to strike a balance between the inflated and unreasonable demands of a victim and the equally untenable claim of the opposite party saying that nothing is payable. Sympathy for the victim does not, and should not, come in the way of making a correct assessment, but if a case is made out, the court must not be chary of awarding adequate compensation. The "adequate compensation" that we speak of, must to some extent, be a rule of thumb measure, and as a balance has to be struck, it would be difficult to satisfy all the parties concerned. It must also be borne in mind that life has its pitfalls and is not smooth sailing all along the way (as a claimant would have us believe) as the hiccups that invariably come about cannot be visualised. Life it is said is akin to a ride on a roller-coaster where a meteoric rise is often followed by an equally spectacular fall, and the distance between the two (as in this very case) is a minute or a yard. At the same time we often find that a person injured in an accident leaves his family in greater distress vis-à-vis a family in a case of death. In the latter case, the initial shock gives way to a feeling of resignation and acceptance, and in time, compels the family to move on. The case of an injured and disabled person is, however, more pitiable and the feeling of hurt, helplessness, despair and often destitution enures every day. The support that is needed by a severely handicapped person comes at an enormous price, physical, financial and emotional, not only on the victim but even more so on his family and attendants and the stress saps their energy and destroys their equanimity. In **Balram Prasad v. Kunal Saha, (2014) 1 SCC 384,** Supreme Court has awarded compensation in heads of loss of income, medical treatment expenses, travel and hotel expenses, loss of consortium, pain and suffering and litigation costs.

**12.** In the present case, the complainant has stated that the patient was earning Rs.30000/- per month from his profession medical profession. Loss of income if Rs.360000/- per annum. In order to capitalize loss of income we multiply annul income by 7 and loss of income is Rs.2520000/-. The opposite parties admitted payment of Rs.213228/- at OP-1 hospital and Rs.1410311/- at Fortis Hospital, Vasant Kunj. If we include travelling expenses, it would be about Rs.17 lacs. On day to day medical and nursing care of the patient, we assess expenses of Rs.10000/- per month, annual expenses is Rs.112000/-. If we capitalize it by multiplying by 7, it will be Rs.784000/-. For loss of consortium, we award Rs.2 lac and for pain and suffering Rs.10/- lacs. Litigation costs, we award Rs.2/- lacs. Total amount comes Rs.6404000/-. We round off the amount to Rs.65/- lacs.

## ORDER

In view of the aforesaid discussions, the complaint is allowed. Opposite Parties-1 and 2 are jointly and severally directed to pay Rs.65/- lacs with interest @6% per annum from the date of filing this complaint till the date of payment, within a period of two months from the date of the judgment.

.....J
**RAM SURAT RAM MAURYA**
**PRESIDING MEMBER**

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**BHARATKUMAR PANDYA**
**MEMBER**