

**IN THE NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION
AT NEW DELHI**

NC/CC/285/2014

Smt. Parul

... Complainant

Versus

Metro Heart Institute
with Multi Speciality & Ors.

... Opp. Parties

BEFORE:

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

Appeared at the time of arguments:

For Complainant : Ms. Ila Sheel, Advocate
Mr. Utsav Suri, Advocate
with Ms. Parul and Dr. R.M. Batwara,
(Complainants in person)

For the OPs : Mr. Sandeep Kapoor, Advocate
Mr. Satender Adhana, Advocate for OPs-1, 3 & 5

Mr. K.G. Sharma, Advocate for OP-2

OP-4 deleted vide order dtd. 12.07.2018

Pronounced on: 05th October 2026

ORDER

JUSTICE A.P. SAHI, PRESIDENT

1. This complaint has been filed alleging medical negligence in the treatment of the complainant's husband late Daksh Kumar, who underwent a surgery at the OP-1 hospital that was conducted by the OP-2 in the said hospital. According to the complainant, the patient had entered the hospital hail and hearty for a Laparoscopic Mesh Hernioplasty. He had been

diagnosed and was advised surgery for an Umbilical Hernia which according to the Hospital and the Doctor was an Obstructed Umbilical hernia. The complainant has however alleged that the surgery was made to look emergent whereas it was a simple operation of umbilical hernia. The patient however unfortunately died post-surgery due to complications that arose and the complainant alleges gross medical negligence against the OP for the same. The surgery took place on 25.03.2014 and the patient died on the very next day i.e. 26.03.2014. His death was on account of Pulmonary Embolism as well as other reasons that has been debated at the Bar by the learned counsel for the parties.

2. The case had been argued on 06.07.2024, when the learned counsel for the complainant, Advocate Ms. Ila Sheel advanced her submissions. Her arguments were recorded in detail which is extracted hereinunder:

1. *This is a medical negligence complaint regarding the husband of the complainant who was **39 years of age** who passed away as finally diagnosed on suffering an attack of Pulmonary Embolism after having undergone a Hernia surgery conducted by the opposite parties.*

2. *The allegations are that **lack of due care and complete absence of patient management** as per protocol resulted in the passing away of complainant's husband and as such the opposite parties are liable to compensate for this loss on account of their negligence. At the time of death the **deceased had three minor children**, two daughters and a son, which responsibility has now fallen on the shoulders of the complainant*

entirely hence she deserves to be compensated in the terms as prayed for.

3. Notices were issued on this complaint after its filing on 06.08.2014 whereafter pleadings were exchanged and evidence was filed. Vide an Order dated 16.09.2016 IA No. 4034 of 2016 moved by the complainant seeking to bring on record the **medical opinion given by one Dr. R.M. Batwara** was **allowed** subject to further proof of the said medical opinion. The affidavit of Dr. Batwara was accordingly filed. It is necessary to mention this fact as learned counsel for the opposite parties Mr. Sharma and Mr. Kapoor have alleged that with the nature of the allegations made no negligence is made out and even if any such deficiency in the management of the patient is being pointed out, the same may require an expert opinion as the medical opinion relied on by the complainant is of no avail. They submit that the said **medical opinion is by somebody who is not competent in the subject concerned** and they have relied on a judgement of the Apex Court to substantiate this objection.

4. The contention on behalf of the complainant is that the doctor who was attending to the patient on the fateful night was one Dr. Bhanwar who is neither a cardiologist nor a specialist and, therefore, even this is negligence as the patient was left into the hands of a novice who was not competent to diagnose the complications that had arisen post surgery.

5. The arguments had commenced on two earlier occasions but could not be concluded. Even though the submissions were noted on 22.01.2024, the arguments on behalf of the complainant were advanced by the learned counsel on **10.04.2024** which is extracted hereinunder:-

"This is a medical negligence case where the patient was admitted to the Opposite Party Hospital for the performance of, according to the Complainant, a surgery to treat Umbilical Hernia, whereas according to the Opposite Party it was a case of Obstructive Hernia. Nonetheless the surgery proceeded after admission and according to the learned Counsel for the Complainant all the vitals of the patient appeared to be normal with no complications having been reported at that stage. The contention is that the health status of the patient was fit with no medical abnormality or complications. He was admitted for surgery for which consent was taken and the surgery was performed.

The surgery according to the submissions, that have been advanced, did not indicate any complications but after the patient was brought into the ward he complained of chest pain. According to the learned Counsel for the Complainant the then attending doctor for post-operative care was not fully qualified and was not a cardiologist and consequently he proceeded to examine the chest pain only from the point of view of a cardiac problem whereas according to the learned Counsel for the Complainant the case was one of Pulmonary Embolism for which no test or care was taken. The submission therefore is that the status of the patient started deteriorating and the Consultant Surgeon and the Cardiologist who ought to have attended on the patient were absent. In effect the argument is that the patient was left under the care of an un-qualified person, and in order to assess the status of

the complaint of the patient, **no tests or any steps were taken** for which the records which have been brought on record. According to the learned Counsel for the Complainant the hospital records indicate **conflicts in recording of the progress of the patient**, and which also indicates, that in all probability the **documents which have been relied on by the Opposite Parties seem to have been later on tailored to suit the averments made in the Written Version.**

The contention in essence is that the line of treatment as per protocol was absent and there was **no diagnosis of Pulmonary Embolism** as a result whereof the patient suddenly collapsed due to this alleged negligence on the part of the Opposite Party. The narration of facts and documents which have been indicated to support the same are according to the Complainant reflective of a complete negligence on the part of the Opposite Parties to take post operative care as expected under medical protocols. Not only this the tests for Pulmonary Embolism were not carried out and were **attempted at the last moment when the patient had already collapsed.** The contradictions which have been pointed out by the learned Counsel for the Complainant, according to her indicate that when the patient had not responded to the treatment, then in that event it was incumbent upon the Opposite Parties to have immediately pressed into service the **concerned Cardiologists which was done at a very late stage when the patient had already registered '0' heartbeat.** The entire progress sheet in relation to the

patient as between 10.00 p.m. and 12.40 a.m. and then to 06.00 a.m. has been read out to contend that the **progressive deterioration of the patient went un-attended** and consequently had resulted in the death of the patient due to the negligence of the Opposite Party. It was pointed out that the **imaging as well as the echocardiology which was performed at 05.56 a.m. was at the stage when the patient had collapsed.**

Learned Counsel also pointed out to the alleged discrepancies in the notings of the Nurse's register, and also the names of the nurses who attended on the patient to urge that these documents seem to have been prepared in order to support the stand taken by the Opposite Parties.

Learned Counsel has then invited the attention of the Bench to the Death Summary to urge that according to the **Doctor's sheet the CPR was performed at 05.55 a.m. whereas the death summary records that urgent CPR was done for 1 hour and then the patient was declared dead at 06.00 a.m.** It is urged that the timings of the Doctor's sheet **do not** match with the death summary and therefore they create **a serious doubt about the status of the documents on record.** The vitals chart has also been read out and then submissions have been advanced by pointing out the documents filed by the Opposite Parties including the **note sheets of the nurses prepared between 12.50 a.m. onwards till 04.15 a.m.** contained at Page No.180 – 181 of the Written Version of the Opposite Party.

Learned Counsel then concluded her arguments by pointing out to the literature that was also on the record filed by the Opposite Party to contend that in effect the entire procedure appears to be negligent. The literature indicates the necessary diagnostic tests which are required to be undertaken and consequently none of the said necessary medical protocols not having been followed, the patient was left in the hands of an un-qualified doctor who collapsed due to this negligence.

Since the arguments are likely to continue for long, and no further time is left today to proceed with the matter, therefore as agreed between the Parties, list on 06.07.2024 (Saturday)."

6. *Recapitulating the arguments, learned counsel for the complainant advanced her submissions further contending that firstly **the patient had to undergo a simple surgery for Hernia**. There is a contest by the opposite parties on this issue namely that it was not a simple case of Hernia and was rather a complicated case of Obstructive Umbilical Hernia. For this the complainant was advised to go for Laparoscopic Mesh Hernioplasty. The complainant has explained this method of surgery in the following terms in paragraph 9 of the complaint:-*

That an umbilical hernia is a sac (pouch) formed from the inner lining of the abdominal cavity that pushes through a hole in the abdominal wall at the belly button which is repaired by an outpatient surgery. Laparoscopic Mesh Hernioplasty being a minimally invasive surgery is considered comparatively safe as compared to open surgeries.

In Laparoscopic Mesh Hernioplasty mesh patches of synthetic material are used to repair hernias, which are sewn over the weakened area in the abdominal (belly) wall after the hernia is pushed back into place. The patch decreases the tension on the weakened belly wall, reducing the risk of recurrence of hernia.

7. However, the fact remains that the outdoor patient card filed by the complainant along with the complaint as annexure P-1 dated 25.03.2014 at the time of the admission of the patient under the opposite parties no. 2 and no. 3 records the diagnosis as Obstructive Umbilical Hernia and was accordingly planned for surgery. Ultra sonography, CAG package, vital markers, ECG, ECO, x-ray chest and other routine blood tests as well as urine test were advised coupled with certain drugs to be injected and the physician's clearance as well as the anesthetist's clearance was also undertaken.

8. The physical examination record indicates that there was swelling in the umbilical region for the past one day with pain. The patient was normal in all other respects and was not on any medication. All his vitals were indicated as normal. His chest was clear but there was redness and pain indicated in the umbilical region. Thus the patient was admitted for surgery that was performed in the operation theatre at about 7.30 p.m. in the evening.

9. At about 10.30 p.m. the patient complained of a slight chest pain and uneasiness. It is at this very stage that the progress note sheets of the doctors, the nurses' sheet and the investigation reports have been pointed out by the learned

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counsel for the complainant to substantiate the arguments in support of the allegations made and the evidence led.

10. *It is urged that the progress notes at 10 p.m. record that the patient was conscious and oriented with a blood pressure of 130/70 and pulse rate of 20 per minute and heart rate of 70 per minute. The oxygen saturation was 96%. The patient was advised to be shifted as per the consultant to a room and at 11 p.m. his general condition was reported to be fair. Consequently, from the surgical ICU he was sent to a private room where again his blood pressure was recorded as 110/70 and was reported to be conscious and oriented. This progress note has been signed by one Dr. Shally.*

11. *In the nurses' note sheets at **9 p.m. the patient had complained of pain for which an analgesic** were administered. This was when the patient was in the surgical ICU. Thus, the complaint of pain had been made by the patient and at 11 p.m. the patient was shifted to the room. This recording of pain at 9 p.m. and then shifting to the room is by **a nurse named Aneesh**. This fact is also recorded in the **summary prepared by the nurses (page 177 of the reply of the OP)**.*

12. *It appears that at **12.40 a.m. (26.03.2014) in the same intervening night the patient again complained of chest pain which seems to have been persisting.** The attending Doctor Shally seems to have **advised ECG** and the case was discussed with Dr. Bhanwar. The ECG report has been filed along with the complaint (at page 57), the timing whereof appears to be at **about 12.40 a.m.**, just immediately after midnight. **The said ECG records "normal sinus rhythm, T-***

waive abnormality, consider inferior ischemia, abnormal ECG".

13. Learned counsel submits that it appears that having observed the abnormality in the ECG report **an urgent Trop-I test along with CPK-MB markers was advised.** It appears that **Dynapar injection for pain** was administered. Learned counsel submits that again at 12.45 a.m. the general condition of the patient was recorded as fair with the blood pressure 110/70 and a pulse rate of 80 per minute with no fresh complaints. It is urged that the **symptoms of uneasiness, chest pain** and other co-related indications **had already commenced which according the learned counsel required more aggressive examination.**

14. It is further pointed out that at 12.50 a.m. Dr. Bhanwar had also recorded his findings that indicated that there was a complaint of chest pain. He accordingly advised repeat ECG after six hours. Learned counsel for the complainant has at this stage emphasized that the next attendance of Dr. Bhanwar has been shown at 4 a.m. and **there are no intervening entries** on the progress note sheet (page 65 of the complaint). It is urged that the **subsequent notings at 2 a.m. and then 4.50 a.m. seems to have been introduced later on which is at page 66.** This doubt with regard to the findings at 2 a.m. and 4.50 a.m. has been argued on the strength of the **simultaneous recordings by the nurse in the nurses' sheet contending that the nurse also has noted the complaint of chest pain at 12 midnight** and the investigations carried out thereafter at 12.40 a.m. The nurse namely **Gopika recorded** that the patient was normal and she also recorded the normal state of the patient

at 2 a.m. It has been urged that this endorsement by the nurse at 2 am contradicts the recording of chest pain in the summary (at page 177 of the reply) with a further endorsement of pain reduced. The submission is that that this discrepancy between notings at page 177 and page 180 of the reply clearly demonstrates and establishes the manipulation in the record as in spite of the fact that the patient was suffering from pain and his condition was deteriorating, no care was taken and an incorrect noting of the patient being normal was being recorded. It is argued that accordingly the progress note of the doctor at 2 a.m. recorded by Dr. Shally that the patient was sleeping with no fresh complaints and his general condition was fair raises a serious doubt about the said medical record.

15. Learned counsel for the complainant urges that with these conflicting notes and the fact that at 4.50 a.m. the patient has been suddenly reported to be unconscious and unresponsive establishes that the patient had already suffered a pulmonary embolism attack which was neither diagnosed nor any tests were carried out in spite of the fact that the patient kept on complaining of pain. The record that the patient was having a fair general condition or was sleeping comfortably are all incorrect notings that create serious doubts. This amounts to gross negligence on the part of the opposite parties.

16. It is submitted that at about 4.50 / 5.00 a.m., on the one hand the patient was stated to be unresponsive and unconscious and was immediately shifted to the medial ICU, but at the same time again the vitals were recorded with blood pressure of 70/50 and pulse rate of 136.

17. It is then urged that the nurses' note sheets records **at 4.15 a.m. that the patient informed that his chest pain had reduced.** This noting is by the nurse **Gopika**. The contention is that if the chest pain had reduced, what caused the sudden deterioration of the patient at 4.50 a.m. is not explained.

18. Learned counsel submitted that the diagnostic **tests which are required to be carried out as per the literature relied on by the opposite parties themselves was not carried out** and reference has been made to the literature **at page 245 of the reply** of the opposite party.

19. It is submitted that the ultimate death, with the deterioration of the patient suddenly at 5 a.m., was then sought to be rectified by the opposite parties by which time it was too late in as much as the first test in this situation was conducted almost after the patient had collapsed. It is urged that the **vitals of the patient according to the Glasscom scale had fallen down to E-1(eyes), M-1(motor response) and V-1 (verbal)** which according to the literature that has been again relied on by the opposite parties clearly indicates that the patient was dead.

20. It is urged that this is corroborated by the fact that **at 5 a.m. the oxygen saturation was not recordable and it is for the first time that Pulmonary Embolism was suspected.** It is urged that admittedly in this condition the patient was immediately put on the ventilator and it is at this belated stage that **an urgent x-ray of the chest, ABG test and other diagnosis tests were advised.** The contention is that these tests were almost a hopeless exercise. The Eco cardiography that was conducted records that it was done at 5.56 a.m. after the patient had virtually passed away. It is also submitted that this

report also suggested of Pulmonary Embolism but the other findings are contrary to the status of the patient who had almost collapsed and was sought to be revived through the ventilator support.

21. The submission, therefore, is that the patient was completely mishandled negligently with no attendance worth the name as the tests were carried out belatedly.

22. She has then urged that the afore-said submissions are supported by the **affidavit of Dr. R.M. Batwara** which is an expert opinion by a qualified person that substantiates the contentions raised on behalf of the complainant. The said affidavit is extracted hereinunder:-

"1. I say that I have I have been approached by Mrs. Parul Khandelwal W/O late Shri Daksh Khandelwal, resident of Palwal, Haryana, to give my medical opinion based on photo-copies of treatment papers of late Mr. Daksh Khandelwal at Metro Hospital, 16A, Faridabad from 25.03.14 to 26.03.14. I have **post-graduate degree in hospital management from University of New England - Australia & post graduate in Radio-diagnosis**. I have served Indian Railways for about 35 years as Gazetted Group A officer. I held various **administrative posts** of Medical Superintendent & above up to Chief Medical Director (Higher Administrative Grade) level for about 21 years. I have sufficient experience to provide comments on the case.

2. I say that after carefully going through the available case sheet & other relevant papers made available to me, I have come to **conclusion that there has been**

medical negligence & carelessness in treatment of Mr. Daksh Khandelwal, at Metro Hospital, Faridabad during the period mentioned above, leading to untimely death.

3. I say that following points suggest that the **patient safety was compromised and adequate evidence based diagnostic & treatment protocols /schedule was not to save life** of Mr. Daksh Khandelwal in time.

i Mr. Daksh Khandelwal was quite healthy and had no risk factors and was not suffering from any critical illness which could have lead to sudden death when he reported in Metro Hospital OPD, on 25.03.14. His physical examination and all investigations done pre-operatively shows that he was quite healthy & fit.

ii. Adequate, diligent post-operative care was not undertaken. There was complacency and **negligence in post-operative monitoring** of the patient. In this case the patient was shifted from surgical ICU to private deluxe room in **just two hours**; in spite of post-operative instructions/ **advice of anaesthetist for close monitoring** till next morning, it appears that there was **deficient follow** up and monitoring of the patient in post-operative period by the surgeon, the anaesthetist/Intensivist, and the staff which lead to failure in diagnosing deteriorating health and provide adequate treatment accordingly.

iii. The patient was **not provided most important life support monitoring** and evidence based treatment to the patient. **Multi-parameter monitoring, central venous line to infuse fluids, blood/ blood products**

and medicines and CVP/invasive BP monitoring, repeated ABG monitoring, X-Ray chest and CBC was urgently required to diagnose and save life of the deceased, timely putting patient on life support system, but hospital failed in provide it. NS & emergency medications were given through peripheral collapsed venous line In a hemo-dynamically critical situation.

iv. X-Ray chest, was not performed in time & omitted as initial primary investigation which could have given prompt indication to chest complications. Chest x-ray is routine in ICU even after ET tube placement. Central Venous Line was not started.

v. No record of follow up ECG after initial ECG is available. It should have been repeated at regular interval even if initial ECG was normal. CCU (cardiac care doctor) was called just 8 minutes before certifying death. Primary complaints at about mid night at 12 am was chest pain followed by worsening of hemodynamic status, he should have been shifted to ICU/CCU immediately. The most common cause of chest pain i.e. Ac. M.I or pulmonary embolism etc. was not confirmed in initial hours and proper treatment was not started, which could have saved life. Relevant specialist doctors to treat complications did not attend patient.

vi. Qualified required specialists were not available in the hospital at night time to take care of the deceased when he became critical in short span of time. The doctor's and nurse's notes are showing discrepancies and

appear to be written post facto. Nurse has shown that patient received dead, but this was cut in the records. As per Nurses note CPR was immediately started on transfer to MICU but doctors note records first CPR much later after shifting to MICU. The varying heart rate from 36 to 162/mt within in a short span of time with same BP recording, **is un-explainable as there are no monitor records or ECG tracings. No straight-line ECG recording /tracing to record exact time of death is available.**

4. I say that there are **sufficient reasons to suspect negligence** & carelessness in healthcare services provided to the deceased Mr. Daksh Khandelwal at Metro Hospital, 16A, Faridabad during the from 25.03.14 to 26.03.14 while he was admitted there.

5 I say that the contents of the instant affidavit is true and correct to the best of my knowledge and belief and nothing material has been concealed thereof."

23. It has been urged with the aid of the afore-said submissions that in spite of the fact that all symptoms were indicating the complications of pulmonary embolism, yet the confirmatory test of Eco was conducted in a highly belated manner at 5.56 a.m. by which time the patient had already collapsed. The patient was ultimately declared dead at 6 a.m.

24. The contention, therefore, is that the continued pain complaint and the initial symptoms were attended to after almost four hours after the embolism had set in and the patient went almost unattended in as much as Dr. Bhanwar was neither a

cardiologist nor he was an expert in the field and, therefore, the patient was left at the mercy of incompetent people without the opposite party no. 2 and 3 attending to the deceased timely. This gross negligence coupled with the lapses in diagnosis and treatment establishes the negligence on the part of the opposite parties.

25. The complainant has summarized these allegations in paragraph 45 of the complaint coupled with the allegations about the manipulation in the documents in paragraph 46 thereof.

26. Rounding up her submissions, learned counsel for the complainant urged that in the above background where the medical negligence is clearly established the complainant is entitled for compensation on account of this deficiency which the learned counsel points out has been categorically supported by the facts that have been stated in paragraph 51 to 57 of the complaint.

27. It is in this background that Mr. Sharma and Mr. Kapoor, learned counsel for the opposite parties have refuted the afore-said submissions contending that there is no manipulation in the records and the presentation by the learned counsel for the complainant on that count is misleading. They also submit that there was no reason to suspect pulmonary embolism when the vitals were normal and the pain complained of by the patient was attended to. The appropriate treatment for chest pain after an ECG was carried out at 12.40 a.m. which in no way reflected any symptoms of pulmonary embolism. Since the vitals of the patient were normal and he was comfortably sleeping, there seems to have been a sudden deterioration only at about 4.50 a.m. that was promptly attended to by carrying out all possible tests. Prior

*to this there were no symptoms to suspect pulmonary embolism. The contentions on behalf of the complainant are unfounded. They also submit that the Glasscom scale indications are **neurological readings but physically the patient was very much alive and, therefore, the contention** that he had already collapsed is incorrect.*

28. To substantiate their submissions they pray that the matter may be adjourned for today to enable them to further contest the position with medical authorities as well as judgements in this regard.

29. Learned counsel for the complainant has also agreed that the matter be taken up once again to conclude the arguments on 09.07.2024.

List accordingly.

3. This was followed by another round of submissions that has been recorded in the order dated 04.11.2025 which is extracted hereinunder:

1. The Complaint had been heard earlier but was directed to come up before the Division Bench and hearing commenced today with the submissions of the Learned Counsel for the Complainant who invited the attention of the bench to the arguments recorded on 22.01.2024, 10.04.2024, and 06.07.2024. Arguments had also been advanced on behalf of the Opposite Parties on 09.07.2024 but were not recorded in the Order Sheet and, therefore, Learned Counsel for the Complainant Advocate Ila Sheel once again narrated the facts pertaining to the Complaint as indicated in the earlier orders and supplemented her submissions on the basis of the material on record urging that this is a case of medical negligence that commences with a hasty approach to perform a simple surgery

of Hernia, the post-operative care based on misdiagnosis, the patient not being attended to by the Doctor and the experts, the patient being left under the care of an unqualified doctor and in order to cover up the serious and negligent deficits, the Opposite Parties also indulged in manipulating the hospital records.

*2. Learned Counsel for the Complainant urged that the patient **had no intestinal obstructions at all and, therefore, there was no emergent need of a surgery.** Yet the Opposite Parties to make the diagnosis look emergent introduced the word "Obstructive" Umbilical Hernia only with a view to carry out the surgery on the same day at night. The surgery could have been conducted on the next day during day time but for obvious reasons the surgery was conducted at 07:00 PM on 25.03.2014 making it appear to be an emergent situation. For this Learned Counsel invited the attention of the bench to the OPD Card appended as Annexure P-1 to urge that the words "Obstructive" Umbilical Hernia appear to have been endorsed later on and to fortify this argument, it is also urged that the Consultation Form was filled up by the Consultant Dr. Sandeep that also contains a wrong endorsement to that effect. She has doubted these endorsements alleging that they seem to have been introduced later on and to further confirm the same, she has pointed out to the **Insurance Claim Form (Page 232, R-15) where the word "Obstructive" seems to have been interpolated in a different** handwriting altogether. Thus, a simple case of Hernia with neither any strangulation of intestines or obstruction therein was depicted*

as a case of Obstructive Hernia only to give it a shape of an emergency operation.

*3. Further advancing her submissions, she has urged that the **Pre-Anesthetic Check-Up Form (Page 46)** categorically encircles the word "**Elective Hernioplasty**" excluding any endorsement of the word emergency. She submits that even this document, which is of the hospital, confirms that the proposed surgery was not an emergency and was an elective surgery.*

*4. It is further submitted that the nature of the Complaint by the patient can be gathered from the Nursing Admission Assessment (page 38) where even though pain has been reported as "yes", yet the score of the pain has been recorded as "zero". She, therefore, submits that there was no **severity of any such symptom** to gather that the surgery was required to be performed in an emergency.*

5. It is further her submission that the patient was absolutely fit and there were no high risks involved so as to carry out the surgery immediately on the same day.

*6. She further pointed out that the Cardiology/Cardiogram Report also indicated that the patient was healthy and the **Left Ventricle Ejection frequency was 65%** which was normal. The report available at page 48 has been read by the Learned Counsel to support her submission. It is, therefore, contended that the patient was absolutely normal and healthy and had no*

complications nor was there any emergent situation warranting a surgery immediately.

*7. Learned Counsel has then pointed out to the Ultrasonography Report (page 51) to urge that the report of an Obstructive Hernia was not related to any strangulation or obstruction in the intestines. On the other hand, the report indicates the presence of "Edematous Omentum" which is indicative of the presence of the **fatty layer in the Hernial Sac with mild fluid**. It is submitted that **this is not an intestinal obstruction** so as to give cause for an emergent operation. The Ultrasonography, therefore, did not depict any such emergency.*

*8. Learned Counsel then proceeded to point out the recitals in the operation notes filed at page 197 of the reply of the Opposite Parties. She has read out that the procedure executed and recorded explains the obstructions to be present as Omentum adhered in the sac. It is, therefore, submitted that even the **operation notes do not indicate any strangulation or obstructions in the intestines at all**.*

9. The contention is that the patient had in normal condition with all vitals normal entered the hospital and there was no emergency for any surgery on the very same day.

*10. It is, therefore, submitted that this haste in performing the surgery for no valid emergent reason clearly indicates a totally **incorrect step taken for obvious reasons to conduct the***

surgery during night hours which is usually avoided due to non-availability of medical facilities and doctors at night and to ensure that the patient is under the direct watch of the performing surgeons during day time. It is also submitted that the patient was left in the care of an unqualified doctor, namely, Dr. Bhanwar and with no nursing attendance nor any monitoring of the vitals which led to the catastrophe and the death of the patient virtually on the same night.

11. To further augment her arguments, Learned Counsel urged that the patient was against norms shifted from the surgical ICU to the room at about 11:00 PM in spite of the fact that the patient had been complaining of pain that a stand recorded in the Nursing Admission Sheet (at page 177 of the WS) where against the timing of 9:00 PM Nurse Anesh had recorded that the patient has complained of pain and was administered Analgesics with a change in a comfortable position to reduce the pain. She submits that this pain continued throughout that had been narrated hereinafter, but her contention is that this shifting of the patient from Surgical ICU to the room was also against norms. A copy of the **Surgical ICU Manual** that has been filed alongwith the written version of the OPs has been read out by the Learned Counsel particularly **the criteria and the decision** that is advised to be taken during surgeries. She points out that the shifting **decision is the responsibility of the consultant. She urges that the consultant was not present when this decision was taken but even** assuming for the sake of argument that the shifting was done at the instructions of the consultant, **the same was incorrect** in as

much as the patient had been complaining of pain and, therefore, he ought not to have been sent to the room, that too even without monitoring the vitals. The patient could have been shifted only in the morning next day, if necessary, as was done in the case of others surgeries that cannot be performed on the same day. For this, Learned Counsel has invited the attention of the bench to the Shifting Chart at page 238 (R-19) of the written version to point out that one Mrs. Rita another surgical patient was shifted on the next day. It is, therefore, submitted that the decision to shift the patient was also against the norms and was a clear negligence on the part of the hospital staff and the consultant. The violation of protocol is, therefore, established and as a matter of fact the shifting was carried out by some junior doctor and was not by the consultant.

12. She has then urged that the complications began when no care was taken of the pain complained of by the patient and the patient was left in the care of Dr. Bhanwar, who was neither a Cardiologist nor was he a specialist and, therefore, the complaint of the patient of a chest pain was neither diagnosed as it ought to have been in a post-surgery condition for Pulmonary Embolism. The chest pain as noted above was recorded at 9:00 PM by the nursing staff and then again stands once again noted in the Nurse's notes at 12:00 midnight (page 179 of WS). The progress notes at page 64 of the Complaint have then been read out to indicate that at 12:40 AM, the case was discussed with Dr. Bhanwar by one Dr. Shally, who recorded the vitals and once again recorded the complaint of

chest pain. An urgent advice was given for carrying out tests and Dynapar Injection was administered. An ECG was carried out that is indicated to have been shown to Dr. Bhanwar. At this stage, it was once again emphasized by the Learned Counsel that **Dr. Bhanwar and Dr. Shally were not Cardiologists or specialists. The ECG was carried out reportedly at about 12:40 midnight** on 26.03.2014 that has been placed at page 57 of the Complaint. Learned Counsel urged that that **same records abnormality indicating "Inferior Ischemia"**. According to the Learned Counsel, the approach **was to rule out the possibility only of a Heart Attack** as no fresh complaints were observed at about 12:46 AM.

13. Even at this moment, the Opposite Parties failed to diagnose Pulmonary Embolism in spite of the symptoms of an Abnormal ECG which ought to have been done as per the medical literature placed at page 243 of the written version. Learned Counsel also submits that **no follow up diagnostic tests** as per the protocol in the said **literature at page 245** was followed. The only steps taken was to repeat the same injection of pain relievers in spite of the fact that at **12:50 AM** (page 65 of the Complaint), the progress note records breathlessness with **an endorsement of calling the Consultant Dr. B D Pathak**. It is urged that Dr. B D Pathak did not attend to the patient nor any Cardiologist was called and it was Dr. Bhanwar, who continued to attend to the patient who was neither qualified nor was he competent to deal with this complication of Pulmonary Embolism that had set in. It is

urged by the Learned Counsel that had this diagnosis been made with the attendance of a cardiologist, the same could have been treated and which is normal post-operative complication well-known after surgeries. It is urged that Dr. Bhanwar simply ruled out the possibility of a Heart Attack and in spite of the symptoms, the patient was not attended by any Cardiologist in spite of the fact that the hospital claims itself to be one of the best Heart Ailment Super Specialties.

*14. It is then pointed out from the Nurse's note that the investigations had been sent and the reports were normal. The nurse's note at page 180 records that the patient was normal at about 2:00 AM whereas the endorsement at page 177 of the written version records complaint of chest pain at 2:00 AM endorsed by **Nurse Gopika**. It is urged that the same Gopika had signed the nurse's not at page 180 and, therefore, these two endorsements contradict each other. Learned Counsel urged that these notes seem to have been prepared at convenience and the endorsements do not match each other and, therefore, are uncreditworthy.*

15 The contention raised by the Learned Counsel is that, in fact, the patient seems to have been left totally unattended without any monitoring instruments in the room to record vitals continuously. It is during this period that the patient seems to have deteriorated and his condition worsened which the progress note of the doctor erroneously records the patient to be sleeping as there were no fresh complaints as recited at page 66 of the Complaint. Learned Counsel submits that this

endorsement of the doctor (Doctor Shally) at 2:00 AM on 26.03.2014 at page 66 of the Complaint is in clear contrast to the endorsement by Nurse Gopika at 2:00 AM recording that the patient had complained of chest pain, who was administered Injection Dynapar and ECG was taken. Thus, the entries referred to at page 177 of the written version, page 180 of the written statement and page 66 of the Complaint about the condition of the patient at 2:00 AM are all inconsistent and, therefore, are all manipulated entries which seem to have been done later on.

16. Learned Counsel submits that with this huge gap of negligence by not attending to the patient in spite of clear symptoms of deterioration, establishes that no care was taken to call for a Cardiologist and take care of the patient who had gradually entered into severe stages of Pulmonary Embolism.

17. Learned Counsel then pointed out that **the investigation notes at page 180 of the WS indicates that at 3:30 AM, Nurse Gopika had visited the patient who asked her to give sips of water that was administered.** Learned Counsel submits that even this **entry is highly doubtful** as it indicates that as if the chest pain had reduced. There is an endorsement at 4:15 AM by the same nurse indicating that the patient had stated that the chest pain had reduced. Learned Counsel submits that this indication about the patient does not match with the developments that immediately stand reported thereafter at about 4:50 AM. The endorsement in the progress note at page 66 records that the patient was complained of

being unconscious and unresponsive that were informed to Dr. Bhanwar and the patient was shifted to the MICU that is signed by Dr. Shally. Learned Counsel submits that this indicator leaves no room for doubt that the patient was practically dead for all purposes and was at least brain dead at 4:50 AM. It is urged that everything else was done thereafter recording vitals as per the Glasgow Coma Scale that indicated the parameters as E-1, V-1 and M-1. Learned Counsel submits that this recording leaves no room for doubt that the patient was in a life threatening stage and for that the **parameters have been explained with the medical literature filed as Annexure R-28 in the WS at page 290.** It is urged that the said parameters clearly indicate that the digit 1 reflects a nil response and, therefore, the patient was practically dead at 5:00 AM itself and it is at that stage that the diagnosis of Pulmonary Embolism has been endorsed that occurs at page 67 of the Complaint. It is then pointed out that even at that stage no Cardiologist had arrived or took care of the situation but it is after the patient had already lost his breathe and was progressing towards his last moments that the diagnostic tests were advised for Pulmonary Embolism.

18. Learned Counsel submits that these steps ought to have been taken when the patient had first complained of chest pain between 9:00 PM and 12:00 midnight followed by the Abnormal ECG Test. Consequently, the attempts made at 5:00 AM were all fruitless and according to the Complainant, these are mere endorsements on papers without any actual performance to cover up the deficits including the complete absence of any

medical attendance and the patient having been left into the hands of Dr. Bhanwar, who was not even qualified to take care of the patient.

19. Learned Counsel then submits that to further give a semblance of the treatment, the patient was put on ventilator (page 68 of the Complaint). By this time, the vitals of blood pressure recorded as 50/30 mm Hg. The advice given at that time was almost worthless as the patient had deteriorated to the point of a final journey and all these attempts were an eyewash which stands recorded at 5:40 AM (page 69) indicating that SPO-2 was not recordable and there was laboured breathing. Learned Counsel submits that the Opposite Parties could have gathered symptoms of deterioration had there been a continuous monitoring of the vitals which was not done at all and then the patient suddenly collapsed whereafter certain steps seem to have been taken that were of no use.

20. Learned Counsel submits that what is alarming is that **at 5:52 AM the call was sent to the Surgeon Dr. B D Pathak and for the Cardiologist for the first time when it was advised that the patient was not fit for Thrombolytic Therapy.** Telephonic calls were exchanged and the patient was seen by the CCU doctor and strangely enough an **Echocardiography** was carried out that has been filed at **page 131 of the written statement.** Learned Counsel points out that this was yet again a **futile exercise as the timing of the said Echocardiography is 5:56 AM** that was done long after the patient was dead. She has pointed out to the **timings**

of the said imaging from the recordings of the image report at page 133.

21. Learned Counsel submits that this stands confirmed with the **nurse's report recorded at page 181 of the** WS at 5:20 AM where it is stated that the **patient had become Asystolic.**

22. The CPR was carried out which was obviously futile and consequently the patient died due to this gross negligence on the part of the Opposite Parties.

23. Learned Counsel then urged that finally the death summary prepared incorrectly records the timings and the symptoms. There was no question of any urgent CPR being conducted for one hour and declaring the patient dead at 6:00 AM as no such attempt was made and the indication that the ECG Cardiac Markers were normal at 5:00 AM is absolutely incorrect. The patient was already dead. Thus, the death summary reflects a totally wrong picture of the status of the patient and has been prepared with the help of manipulated documents to reflect as if the patient had been attended to. The contention, therefore, raised is that this is a clear case of gross negligence on the part of the Opposite Parties in having been failed to diagnose the patient and this **error of diagnosis** and not taking care through specialists clearly amounts to negligence for which reliance has been placed on the authority cited by the Learned Counsel of medical negligence **by Michael Jones**. With the submissions so raised, it is urged that the error of diagnosis is

severe and there is a complete failure on the part of the Opposite Parties without attending to the possible alternatives as per protocols that occurred on account of handling of the patient by incompetent and unqualified people as such the negligence is clearly made out and the Complaint deserves to be allowed.

24. Learned Counsel Ila Sheel concluded her arguments subject to any clarifications and since no further time was left today, let the Complaint appear once again for Mr. Kapoor and Mr. Sharma, Learned Counsel appearing for the Opposite Parties to commence their arguments at 2:00 PM on 02.03.2026.

4. After the conclusion of the arguments on behalf of the complainant, the arguments were advanced by Mr. K.G. Sharma, learned counsel for the OP-2, Surgeon and his submissions were recorded on 20.05.2026 which is extracted hereinunder:

*1. The hearing on the last occasion was proceeded on 04.11.2025 when the learned counsel for the complainant concluded her arguments and the matter was posted thereafter for the respondents to proceed. Couple of adjournments led to the listing of the case today when Mr. K. G. Sharma, learned counsel has advanced his submissions on behalf of the OP-2 – Dr. B.D. Pathak. Mr. Sharma commenced his arguments with the opening submission that the complainant's counsel has advanced submissions relying on the medical opinion of Dr. R.M. Batwara dated 18.04.2016. He points out that **this opinion was introduced after an order was passed on 22.09.2015** by this Commission to the following effect:*

"Counsel for the parties present. After seven months of adjournment, Counsel for the Complainant wants to move an application. Rejoinder and affidavit filed. Said application be moved.

Adjourned to 11.05.2016."

2. *The application was moved on 29.04.2016 annexing therewith the medical opinion of Dr. Batwara dated 18.04.2016. To support the said opinion, the affidavit of Dr. R.M. Batwara was filed on 28.12.2016 where he has supported the opinion given by him.*

3. *Mr. Sharma contends that the opinion as well as the supporting affidavit of Dr. Batwara cannot be admitted in evidence, in as much as, **Dr. Batwara is neither qualified for the said purpose nor is he a Surgeon.** He submits that the evidence is not credit worthy even otherwise, but the fact remains that Dr. Batwara is a **simple MBBS doctor with no expertise or any degree in surgery** whereas the surgery in the present case has been performed by Dr. B.D. Pathak, whose qualifications as a Surgeon and his vast experience clearly establish his expertise in the field. Thus, the stand of the OP-2 cannot be countered with an opinion of a doctor who is neither qualified nor a Specialist of the field nor is possessed of any experience in surgery.*

4. *Mr. Sharma further emphasized that the qualifications of Dr. Batwara also recite some certificate of a qualification described as "G.D.H.M. (University of New England – Australia). Mr. Sharma submits that **no such degree or qualification of the said University from Australia is recognized in India***

and for that he has produced the chart notified by the Medical Commission of India (erstwhile Medical Council of India) to demonstrate that there are only three Universities of Australia, the degrees whereof are recognized in India. The **same does not include the University of New England and consequently the claim of the** complainant about Dr. Batwara is untenable and his opinion therefore cannot be given any credit and deserves rejection.

5. To support his contention, Mr. Sharma has cited the Apex Court's decision in the case of **Ramesh Chandra Agrawal vs. Regency Hospital Ltd. & Ors. reported in (2009) 9 SCC 709** to urge that the role of an expert is to aid the Court's knowledge provided the expert is from within a recognized field of expertise and is qualified in that particular discipline. He therefore submits that the ratio of the said decision is squarely attracted on the facts of the present case to establish that **Dr. Batwara does not hold any essential qualifications of the field of surgery** and professes to hold qualifications which are not recognized in India. Even otherwise he is not a Surgeon and therefore his opinion is uncreditworthy and the affidavit filed in support thereof also deserves to be rejected.

6. Mr. Sharma further buttressed his submissions by contending that as against Dr. Batwara, the **OP-2 had performed about 24000 laparoscopic** surgeries way back when he had treated the patient and as on date he has to his credit an approximate **50,000 surgeries to his credit** that finds mention in the **Limca Book of Records**. Not only this, Mr. Sharma invited the attention of the Bench to paragraphs 2, 3

and 4 of the affidavit of evidence of Dr. Pathak filed on 24.11.2017.

7. Mr. Sharma then urged that the background in which the OP-2 undertook the task of treating the deceased patient also needs to be taken note of, in as much as, the brother of the deceased patient was also a doctor and a Medical Officer with the Department of Health, Govt. of Haryana at B.K. District Hospital, Faridabad where the OP-2 had also worked from the 2003 to 2009. With this connect the brother of the patient alongwith him visited the OP-2 complaining of the problem of hernia and pain in the umbilical region. The OP-2 advised an Ultrasonography of the abdominal area to be conducted immediately as the OP-2 had suspected an "obstructed umbilical hernia". The OPD card of the OP-1 hospital filed at page no. 27 of the complaint has been read out to indicate that the diagnosis of an obstructed umbilical hernia was recorded with an advise of ultrasonography and surgery was also planned with an advise of carrying out all pathological, radiological and other relevant tests together with the requirements of the injections and medicines for the surgery and for a pre-anaesthetic check-up as well as a physician's clearance. The diagnosis stood confirmed with the report of the Ultrasonography that has been filed along with the complaint at page no. 51. The diagnosis was clearly recorded with the noting that the abdomen reflected "redness and pain" in the umbilical region that stands recited in the consultation form at page 33 of the complaint and is also recorded more elaborately in the in-patient history and physical examination record that is at page 29 to 31 of the complaint. The patient was sent for medical clearance for surgery to the physician who upon

consultation gave medical clearance for surgery that stands endorsed on the consultation form at page 33 of the complaint. Mr. Sharma points out to this document to urge that the swelling and pain in the umbilical region was clearly noticed that was described by the patient since "one" day. However, the same noting also recorded that the swelling had been reported for the past one month that was reducible.

8. Mr. Sharma submits that the swelling was there, but it was reduced with the aid of medicines. The same history sheet records that now the pain and the swelling has reached non-reducibility since the past one day and therefore he contends that it was an urgent surgery that had to be conducted or else in such cases of obstructed umbilical hernia there is likelihood of gangrene developing in the event the surgery is not performed.

9. He again reiterates that all this was discussed in the presence of the patient and his brother who is also a doctor and they nowhere objected to the said procedure being planned for carrying out the surgery.

10. He then points out that an **informed consent was duly signed by the brother of the patient Dr. Lokesh Khandelwal.** He has read out the consent document contained at page 43 of the complaint that has been duly signed by the patient, the family member of the patient as well as the patient's brother. He submits that since no High Risk Consent was required, the said form was also filled-up which is at page no. 44 and was duly signed by the brother of the patient. The consent of anaesthesia was also signed by the patient, the relatives and also endorsed on behalf of the brother. The pre-anaesthetic check-up has also been filed on record.

11. The cardiogram report indicating that everything was normal and the echocardiogram also indicating the parameters to be normal have been filed on record and therefore Mr. Sharma contends that the surgery was carried out with all due precautions and in accordance with the protocol.

12. According to him, the surgery went uneventful and was successful and consequently, since all the parameters were normal, the patient was taken to the ICU where he remained for about two hours. Since all parameters were normal and the vitals were stable, he was shifted to a room which according to Mr. Sharma was **adjacent to the surgical ICU at 11pm at night.**

13. The patient made a complaint of chest pain at about 12.40am in the night on 23.06.2014 and it was discussed with Dr. Bhanwar, Incharge of the ICU whereupon ECG was done and a Trop-I, CPK and MB was advised and Dynapar injection was advised for pain. He has pointed out to the recordings at 12.46am to indicate that the patient was normal and the aforesaid treatment was administered. Mr. Sharma then submits that Dr. Bhanwar attended on the patient, but an allegation has been made that he was not duly qualified to attend on the patient in the ICU. He also submits that the shifting of the patient to the room was also alleged to be an incorrect decision and he has therefore proceeded to answer these contentions by urging that according to the **guidelines for an Intensive Care Unit, Admission and Discharge Criteria published by the Ministry of Health & Family Welfare, Govt. of India** provides for the qualification of the Critical Care Specialist or **Intensivist.**

14. He has read out the same to urge that an Intensivist has to be qualified as prescribed therein and in case the doctor not having either of the mentioned qualifications or training, they should have extensive experience in Intensive Care in India after their MBBS for at least 3 years in an ICU with at least 50% time spent in the ICU. Mr. Sharma alleges that this **qualification is clearly possessed by Dr. Bhanwar, in as much as, he had by that time an experience of 6 years of working as an Intensivist in the ICU.** For this, Mr. Sharma has invited the attention of the Bench to the certificates of Dr. Bhanwar indicating his **experience certified by the Fortis Escorts Hospital as well as by SD Memorial Hospital cum Medical Research Institute.** The said certificates of experience are on record from page 103 to 105 of the reply / W.S. filed on behalf of the respondents on 24.10.2014. He points out that the first certificate of experience is from 10.12.2007 to 31.08.2008 which is about a little more than 8 months from the SD Memorial Hospital at page no. 105, the experience at Escorts Hospital and Research Centre Ltd. from 24.09.2008 to 09.10.2010 is at page no. 104 and the third certificate from Fortis Escorts for the period 18.01.2011 to 03.03.2013 is at page no. 103. He submits that this experience was almost of 6 years whereas the requirement under the guidelines is only of at least 3 years. Mr. Sharma has read out paragraph 2 of the evidence affidavit of Dr. Bhanwar to elaborate on the same. Thus, **Dr. Bhanwar was possessed of the said threshold of experience as prescribed by the guidelines referred to above.** He therefore submits that the argument that Dr. Bhanwar was not possessed of the qualifications to attend on the patient in the

ICU cannot be countenanced in the light of the evidence indicated above.

15. *Coming to the issue of the shifting of the patient he has once again invited the attention of the Bench to the guidelines where under the heading **"expert consensus statement", the discharge criteria has been referred to in clause-4 thereof.** He submits that there was no such symptom so as to withhold the shifting of the patient and he submits that the patient was shifted to the room which was adjacent to the Surgical Care Unit itself with the attendance of the doctors. He therefore submits that the said argument has been raised only for the purpose of adding a flavour to the unsubstantiated allegations of negligence. He submits that **when the parameters were all normal, there is no reason to doubt the shifting of the patient.***

16. *He then submits that he has advanced all his submissions on merits in the written arguments that are on record and he has also read out the portions of the reply on behalf of the respondent, more particularly the evidence affidavit of Dr. Pathak to buttress his submissions.*

17. *He has then read out the progress notes that have been recorded by the doctors attending on the complainant and for this he has commenced reading out the progress notes from page 62 to page 71 that records the progress notes from 10pm on 25.03.2014 to 6am on 26.03.2014 when the patient ultimately passed away.*

18. *With the said notes, he has also explained the recording of the progress along with the recording of the nurses notes to contend that there is no inconsistency in the recording of the*

progress and the follow-up action by the nurses including their timings which in no way contradict the entries recorded by the nurses. We were taken through the progress notes to urge that the patient was received from the surgical ICU to the room at 11pm when he was conscious and oriented and was attended by Dr. Shally. At 12.40am on the same night on 26.03.2014, a chest pain was complained of for which ECG was done and shown to Dr. Bhanwar by Dr. Shally and the vitals were also recorded. Dr. Bhanwar seems to have recorded an urgent report of CPK & MB as well as a Trop-I test. Since the patient had chest pain, an injection Dynapar was immediately advised and according to the OPs, the same was also administered. At 12.46am, the general conditions were recorded as fair and there were no fresh complaints.

19. Mr. Sharma points out that the nurses notes also corroborates the same and the saturation level of oxygen was recorded at 98% which is at 12.50am. Dr. Bhanwar attended on the patient at 12.50am and recorded his observations indicating a complaint of chest pain and breathlessness. He also endorsed the administering of Dynapar injection and directed repetition of ECG at interval of 6 hours. The other parameters were normal and therefore it is submitted by Mr. Sharma that the patient was being looked after as the call was being attended by the team of the ICU as it was very near from the deluxe room of the patient as recorded in the said notesheet.

20. He then points out that according to the nurses notes at 3.30am, the patient was given sips of water. He then points out that at 4.00am, the call was again attended by Dr.

Bhanwar, who has recorded the Trop-I and CKMB test and has also indicated that the patient was sleeping well. He has pointed out that Dr. Shally has also attended the patient at 2.00am when she recorded that the patient was sleeping and there were no fresh complaints. The nurses notes records that at 4.15am, the chest pain of the patient was reduced.

21. He then points out that a sudden turn seems to have taken place in the condition of the patient at 4.50am when Dr. Shally noted that the patient was unconscious and unresponsive with the vitals reduced and she immediately informed Dr. Bhanwar. The patient was immediately shifted to the Medical ICU.

22. The progress notes then recorded on 26.03.2014 at 5am indicates that the patient was unconscious and unresponsive and therefore he was lodged in the Intensive Care Unit where his vitals were noted and with the said deteriorating vitals, **the patient was urgently intubated and connected with ET Tube. Bleeding from ET was also noted and** Dr. Bhanwar also **recorded a suspected "Pulmonary Embolism" Attack.** He immediately advised diagnostics tests that are recorded therein including 2D Echo.

23. At this stage of the arguments, Mr. Sharma adverted to the affidavit of Dr. Pathak, the OP-2 pointing out towards paragraph 29 and then paragraph 35 thereof to indicate that a **bedside investigation of Echo was performed.** He has also invited the attention of the Bench to the treatment immediately extended after noticing all the said parameters including the bleeding in ET and he urged that since pulmonary embolism had been confirmed and **there was bleeding, no blood thinner**

or coagulant was advisable and on the other hand to stop the bleeding, the requisite injection was prescribed.

24. We wanted therefore to proceed with the arguments regarding the developments between 5am to 6am, i.e. the crucial period during which the patient is stated to have been taken care of by proper medication and attendance of doctors. Mr. Sharma contended that the medical literature that has been filed along with the written arguments and the record, it is evident that a stroke of pulmonary embolism occurs very swiftly and at times records dangerous results for which he has attempted to explain such happenings post-surgery in cases of umbilical hernia with the aid of the literature cited by him.

25. However, no further time was left and therefore the matter require further submissions, for which learned counsel for the parties agree to once again assemble for the arguments on 07.09.2026 at 2.00pm.

5. Mr. K.G. Sharma concluded his arguments on 07.09.2026 pointing out to the details explaining the last moments of the episode and was followed by the concluding arguments of Mr. Kapoor, learned counsel for the Hospital. Learned counsel for the complainant also concluded the rejoinder and accordingly orders were reserved for delivery.

6. Mr. Sharma, learned counsel appearing for OP no.2 – Dr. Pathak, has urged that there is no allegation regarding any deficiency in the qualification or the experience of the answering respondent Surgeon. Learned counsel has urged that OP no.2 in his affidavit has disclosed his qualifications having

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done his MBBS in 1991 and followed by Masters in Surgery. The experience of 23 years of having worked at Deen Dayal Upadhyay Hospital, New Delhi, Safdarjung Hospital, New Delhi, Ram Manohar Lohia Hospital, New Delhi, ESI Hospital New Delhi and in the Department of Health, Government of Haryana for almost 16 years that have been narrated in paragraph 2 of the evidence affidavit filed on 28.11.2017. The same affidavit has also been read out where the qualifications of OP No.2 have been delineated in detail. He submits that none of these achievements of OP No.3 have been questioned nor any comment has been made on the competence of OP No.2 by the complainant.

7. He then points out that the patient had visited OP No.2 on 25.03.2014 along with his brother who is also a doctor. An ultrasound was suggested and conducted immediately as Obstructive Umbilical Hernia was suspected. There was swelling, an evidence of mild fluid with indications of acute inflammation which indicated an Obstructed Umbilical Hernia. Accordingly, the answering respondent recommended a mesh hernia repair where after Dr Pawan Kharbhanda and Dr Sandeep Ghosh, from the Department of Medicine gave their medical clearance for surgery which document has already been on record. Even they have noted the redness and pain in the Umbilical region, on a physical examination which indicated that the condition of the patient was deteriorating and there were no contra indications regarding surgery as otherwise the patient was normal.

8. Thus the surgery was conducted as per the clinical assessment and after following all protocols and after taking due informed consent. The surgery was essential and was successful.

9. Mr Sharma submits that this is confirmed by the fact that the vitals of the patient were found to be normal for which he has invited the attention of the Bench to the reply filed on behalf of the respondents which is extracted herein under:

<i>Date</i>	<i>Time</i>	<i>BP</i>	<i>Pulse</i>	<i>RR</i>	<i>Temp</i>	<i>Signature</i>
25.03.2014	12.30 pm	110/80	90/min	18/m	98.6 degree f	
	05.00p m	110/70	88/mm	20/mm	98.4 degree f	
	09.30 pm	130/80	74/mt	18/mt	98.5 degree f	
	11.00 pm	130/70	78/mt	22/mt	98.4 degree f	
26.03.2014	12.40 am	110/70	90/mt	20/mt	98.6 degree f	
	01.30 am	130/70	84/mt	22/mt	98.4 degree f	
	03.30 am	120/70	82/mt	24/mt	98.6 degree f	
	04.50 am	70/50	136/mt	36/mt	-	

10. He submits that the entire vitals of the patient were recorded normal on 25.03.2014 as well as even in the early morning hours of 26.03.2014. The temperature, the pulse, the respiration rate, the Blood Pressure all indicates the normal condition of the patient. Consequently, there could be no possible apprehension of pulmonary embolism as there was no breathing problem post-surgery or even thereafter on the next date as indicated above. Dr

Bhanwar, at about 04.00 am saw the patient, according to the medical records and was attended to and Trop one test was recorded and the general condition was also noted with the noting of sleeping well. He submits that prior to that the notings at 11.00 p m on 25.03.2014 indicates no complications but at 12.40 a m on 26.03.2014, the patient is shown to have complained of chest pain. Trop one test was immediately advised by Dr Shalley and injection Dynapar was also administered. At 12.46 a m, the patient was noted to have a fair general conditions with no fresh complaints. The same position continued at 02.00 a m as noted by Dr Shalley. Thus, it is upto this stage the patient had been attended and all precautions were taken with a repeat Dynapar injection as there was some breathlessness indicated and a repeat ECG was also recommended after 06.00 hours. Mr Sharma submits that timely and prompt attendance of the doctors with appropriate medical advice had been observed.

11. It is also pointed out that on the complaint of chest pain at about 12.40 am, the patient had been taken care of by administering appropriate injections and it is not the case of the complainant that the administration of such medicines were inappropriate. The oxygen level was also recorded at 96% (SPO2) at 12.50 a m. As noted above, the patient continued with the said normal position even thereafter, till about 04.50 am, Dr Shalley noted that the patient had suddenly become unconscious and was unresponsive with low vitals. Dr Shalley immediately issued instructions to shift the patient

to MICU with information to Dr Bhanwar. The patient was attended to by the doctor with the same symptoms and was urgently shifted to MICU with advice on medicines. The patient was intubated noting his vitals at about 05.00 am and at that stage the pulmonary embolism was suspected. Thus, within a short span all of a sudden the condition of the patient had deteriorated probably after 04.15 am, but he was promptly attended to and all emergency steps were taken. The patient was on ventilator and his vitals and symptoms were noted at about 05.20 a m indicating severe hypoxics and respiratory problem with hyper kalemia. The patient was attended by the CCU doctor and a 2D Echo test was carried out at the bed side that was suggestive of acute pulmonary embolism.

12. Mr Sharma has urged that this had to be done as the patient was not in a position to be moved out to the ground floor for CT Scan. Mr Sharma has then read out the successive recordings of the progress and consultation with the surgeon as well as all possible treatment that was necessary at that hour.

13. He submits that CPR was administered promptly and all efforts were made so as to revive the patient.

14. Mr Sharma, has then drawn the attention of the Bench to the literature filed with the complaint to explain the symptoms of pulmonary embolism, to explain the waves in the electro cardiogram and to urge that the said literature also indicates that a single test cannot confirm or be relied on to infer the pulmonary embolism because lack of adequate specificity. He

therefore, submits that a very high index of suspicion is necessary to infer a diagnosis of pulmonary embolism but in the instant case, the symptoms that were noted only occurred after 04.50 a m not prior to that. Consequently, ECG that was conducted earlier did not give any indication so as to infer the pulmonary embolism prior to 04.00 a m. He has then read out the literature to explain the T Waves included in Braunwald's Heart Disease. As pointed out, the waves that were available in the ECG report taken earlier did not indicate any symptoms of pulmonary embolism.

15. He further submits that the surgery was necessary inasmuch as, it was a case of obstructive Umbilical Hernia. Therefore in the event of any delay it could have caused gangrene. For this he has read out the literature appended along with the reply from Bailey and Love's Short Practice of Surgery. He contends that the said authority recommends that an engagement surgery should be carried out and to this effect the decision of the surgeon has to be respected. He has relied on the judgement in the case of ***Neeraj Sood vs Jaswinder Singh***, reported in 2024 INSC page 825, to urge that in the instant case inspite of best efforts the patient did not respond favourably and the patient was unable to survive but so far as the surgery is concerned the same was successful and in the absence of any failure in the surgery, no negligence can be attributed to OP no.2 the surgeon. He has referred to paragraphs 14 to 18 of the said decision.

16. He, therefore, submits that there is no proof of medical negligence against OP no.2 surgeon nor any negligence can be attributed to him relating to the surgery.

17. He further submits that there is no expert evidence to indicate any negligence that could be possibly attributed to OP no.2. He has then cited the decision in the case of ***Deep Nursing Home vs Manmeet Singh Bhateywal*** – 2025 INSC 1094, Paragraphs 15, and 23 to 25 to urge that there is no expert evidence and the Commission cannot itself convert itself into an expert body assigning to itself the role of expert medical professional. He also cited the decision in the case of ***Dr Harish Khurana vs Joginder Singh*** – AIR 2021 Supreme Court page 4, 690, paragraphs, 11, 14 and 22 to urge that the principles of *resp ipse loquitur* cannot be applied on the facts of the present case, inasmuch as, there is no evidence with regard to the failure of the surgery, as such, no inference can be drawn adverse to the OP no.2. He has also cited the decision in the case of ***Vinod Jain vs Santoria*** and then the judgment of the Apex Court in the case of ***Achutrao Haribhau Khodwa & Others vs. State of Maharashtra & others***, (1996) Volume 2, SCC Page 634 to urge that the skill of medical practitioners differs from doctor to doctor and there may be more than one course of treatment that may be advisable, as such the courts would be slow in attributing negligence on the part of a doctor, if the doctor has performed his duties to the best of his ability, due care and caution. The ratio of the said decision has been read out

to indicate that if the facts indicate that the doctor had acted in a manner which is acceptable to the medical profession then no medical negligence can be attributed.

18. The Arguments of Mr. Sharma was followed by the contentions raised by Mr. Kapur, for the Opposite Party No.1 hospital and the other doctors to point out that the hospital was available with all appropriate facilities and is a two hundred bedded hospital with NABH and NABL accreditations. He submits that there was no shortcoming in the facilities available in the hospital and there is a separate area which required for city scan facilities that is available in the hospital. He submits that it has to be segregated and cannot be possibly located in every area of the hospital. Nonetheless, all the facilities including the appropriate Doctors to attend were available. He submits that there was no deficiency in the qualifications of the Doctors either attending in the ward, the room or even in the MICU. The entire team was available and Dr. Bhanwar was qualified to take care.. He submits that there was perfect attendance and there was no negligence at all either on the part of the Surgeon or even on the attending Doctors. He therefore submitted that in the absence of any evidence of negligence either on the part of the Doctors or the Hospital, the contention raised is without any justification.

19. He submits that no expert evidence has been led by the Complainant that may indicate any expertise for which reliance has been placed on

Ramesh Chandra Agrawal –vs- Regency Hospital Ltd. & Ors. 2009

Vol.IX SCC page 709. He has then invited the attention of the Bench to the guidelines for Incentive Care Unit (ICU) Admission and discharge criteria as well as Incentive Care Unit (ICU) Admission and discharge criteria promulgated by the Ministry of Health and Family Welfare Govt. of India. He submits that this entire criteria was observed by the hospital which is fully equipped for dealing with such categories of patients. He therefore urges that in addition to what has been submitted by Mr. Sharma, Ld. Counsel for the Opposite Party No.2, it is also evident that Opposite Party No.1 hospital and Dr. Bhanwar Lal have taken due care of the patient which unfortunately expired in spite of best efforts.

20. Ld. Counsel for the Complainant tendered her Rejoinder by urging that in spite of the symptoms having occurred with a complaint of chest pain at 12.45 a.m. on 26.03.2014 no cardiologist was consulted. Ld. Counsel urged that Dr. Bhanwar was only a simple MBBS Doctor and was not holding any expertise in Cardiology. Consequently, there is absence of due care. It is then urged that the anaesthesiologist had clearly observed that the patient should be closely monitored for his vitals for which she has invited the attention of the Bench to the intra operative anaesthesia record filled up by Mr. Manish Indoria. This monitoring was not done and for that the Ld. Counsel has once again referred to the vitals chart already extracted hereinabove where she points out that it does not record the oxygen saturation level, nor does it indicate any ECG monitoring nor any tests having

been conducted for an IBP. She points out that the chest pain had already been complained of and later on at about 2.40 a.m. breathlessness was also noted but in spite of this, no Cardiologist or Pulmonologist was available or consulted nor any qualified Doctor was called upon to attend the patient. This was a crucial period for an early diagnosis in as much as pulmonary embolism had set in. She has cited the decision of this Commission in the case of ***Sheela Hirba Morto Naik Gaunekar –vs- Apollo Hospitals Ltd. 2005 SCC online NCDRC Page 10*** and another decision in the case of ***Indrani Bhattacharjee –vs- Chief Medical Officer, Farakka Super Thermal Power Project 2007 SCC Online NCDRC Page 58*** to point out that a failure to refer a patient to a specialist is also negligence. She has then invited the attention of the Bench to the Order of this Commission in the case of ***Inscol Hospital and Anr. –vs- Inderjit Arora and Ors. 2017 SCC Online NCDRC Page 133 Paragraph 15, 20, 33 & 34*** to urge that the attending Doctor, post-surgery did not carry out the appropriate tests including D-dimer and ABG for ascertaining the falling levels of the patient's condition which indicated that pulmonary embolism had been set in. She urges that the aforesaid decision in the case of Inscol Hospital was taken up in Appeal before the Apex Court and the Special Leave Petition has been dismissed. On medical negligence she has cited the decision in the case of ***V. Kishan Rao –vs- Nikhil Super Speciality Hospital & Anr. 2010 Vol. V SCC 513*** to urge that it is not necessary in every case to invite expert

evidence in as much as the Consumer Fora is presided over by experienced Judges and Members and therefore the arguments on behalf of the Opposite Party is without any basis.

21. She then invited the attention of the Bench to the fact that the patient was aged only 39 years when he died due to the negligence of Opposite Parties, therefore compensation deserves to be proportionately awarded (Paragraph 55 to 57 of the Complaint). In support of her submissions on the issue of compensation, she has cited the Supreme Court Judgments in the case of ***Nizam's Institute of Medical Sciences –vs- Prasanth S. Dhananka & Ors. 2009 (6) SCC Page 1, Maley Kumar Ganguly –vs- Dr. Sukumar Mukerjee 2009 Vol. IX SCC page 221*** and the latest decision of the Apex Court in the case of ***Jyoti Devi –vs- Suket Hospital and Ors. 2024 Vol.VIII SCC 855***. It is pointed out that keeping in view the age and status of the Complainant and his earning capacity to support the family, the Complainant is entitled to the compensation as prayed for.

22. A perusal of the above arguments and contentions noted would reflect that the complaint is about appropriate care not having been taken and the surgery having been conducted hurriedly on the allegations that it was not an emergent surgery at all. The facts alleged indicate that the patient was not attended to appropriately post-surgery and was left into the hands of an unqualified doctor. The appropriate tests to locate the complications that had arisen were not carried out in spite of the fact that the complications were

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known to occur for which appropriate steps ought to have been taken. The patient had suffered chest pain very early and had also complained of it, but the same was not appropriately dealt with. The ECG indicated the presence of tachycardia and other related symptoms which were indicative of the complications that had already commenced. Yet looking to the timings and the symptoms of the patient, it is clear that the patient was allowed to be slipped out of hands on account of sheer negligence. The tests which were carried out later on were too late in the day as the patient had almost collapsed and whatever was done by the OPs was a mere cover-up of the lapses of the hospital and the attending doctors that ultimately led to the patient's life having been lost on account of such negligence.

23. In order to appreciate the arguments, the complainant has brought on record the OPD Card of the patient who was 39 years of age, which records that the patient was diagnosed of Obstructed Umbilical hernia and was planned for the mesh surgery as referred to above. The OPD Card dated 25.03.2014 which was prepared in the morning hours is extracted hereinunder:

24. The patient was also advised physician clearance in the pre-anaesthetic check-up on the same day that was carried out at 12' Noon. The said investigation is extracted hereinunder:

Investigations	Drugs
PAC Physician clearance	
 Dr. Renu Kapoor 12 Noon 25/8/2014	

Already Done Successfully **20,000 Interventional Procedures (Angioplasty)**
More than 2500 Beating Heart Surgeries
More than 2500 Surgeries of International Patients
(Bypass, Knee Replacement, Laparoscopic Bariatric Surgery & Many Others)

25. On admission at about 12.20pm on 25.03.2014, the nature of the complaints were noted and the history of the patient's illness was recorded. The same records swelling and pain for the past one day in the umbilical region. It was also recorded that there was no swelling and it was reducible, but now the pain was being reported for the past ½ day. The abdominal area indicated redness and pain in the umbilical region. However, no complications were indicated and the provisional diagnosis was recorded as Obstructed Umbilical Hernia during the in-patient physical examination at the time of admission.

26. ECG, 2D Echo, X-ray Chest and X-ray Abdomen were all advised coupled with the pre-anaesthetic check and physician clearance.

27. The physician cleared the same once again recording about the complaint of Obstructed Umbilical Hernia. The physical consultations recordings are available and are extracted hereinafter:



Sector-16A, Fandabad -121 002 (Haryana)
Tel: 0129-4277777, Mobile 9811561000



CONSULTATION FORM

Referring Doctor: Dr. B.D. Kottarik Date & Time (Request Sought): 2/2/14

Consultation Sought Form Dr. *D. Lawan / B. Sandeep*
Date & Time (Request Forwarded) *25/8/14*

Patient Name Mr. Dakech, Juma Age & Sex 23/M Bed No./Ward CME

Patient Findings

CSB Dr. Pawan | Dr. Sander

For medical clearance for surgery. up

up obstructed amblyopia
Hemorrhage

~~SECRET~~
3007

No part No. 10/11/12/13/14/15/16/17/18/19/20/21/22/23/24/25/26/27/28/29/30/31/32/33/34/35/36/37/38/39/40/41/42/43/44/45/46/47/48/49/50/51/52/53/54/55/56/57/58/59/60/61/62/63/64/65/66/67/68/69/70/71/72/73/74/75/76/77/78/79/80/81/82/83/84/85/86/87/88/89/90/91/92/93/94/95/96/97/98/99/100/101/102/103/104/105/106/107/108/109/110/111/112/113/114/115/116/117/118/119/120/121/122/123/124/125/126/127/128/129/130/131/132/133/134/135/136/137/138/139/140/141/142/143/144/145/146/147/148/149/150/151/152/153/154/155/156/157/158/159/160/161/162/163/164/165/166/167/168/169/170/171/172/173/174/175/176/177/178/179/180/181/182/183/184/185/186/187/188/189/190/191/192/193/194/195/196/197/198/199/200/201/202/203/204/205/206/207/208/209/210/211/212/213/214/215/216/217/218/219/220/221/222/223/224/225/226/227/228/229/230/231/232/233/234/235/236/237/238/239/240/241/242/243/244/245/246/247/248/249/250/251/252/253/254/255/256/257/258/259/260/261/262/263/264/265/266/267/268/269/270/271/272/273/274/275/276/277/278/279/280/281/282/283/284/285/286/287/288/289/290/291/292/293/294/295/296/297/298/299/300/301/302/303/304/305/306/307/308/309/310/311/312/313/314/315/316/317/318/319/320/321/322/323/324/325/326/327/328/329/330/331/332/333/334/335/336/337/338/339/340/341/342/343/344/345/346/347/348/349/350/351/352/353/354/355/356/357/358/359/360/361/362/363/364/365/366/367/368/369/370/371/372/373/374/375/376/377/378/379/380/381/382/383/384/385/386/387/388/389/390/391/392/393/394/395/396/397/398/399/400/401/402/403/404/405/406/407/408/409/410/411/412/413/414/415/416/417/418/419/420/421/422/423/424/425/426/427/428/429/430/431/432/433/434/435/436/437/438/439/440/441/442/443/444/445/446/447/448/449/450/451/452/453/454/455/456/457/458/459/460/461/462/463/464/465/466/467/468/469/470/471/472/473/474/475/476/477/478/479/480/481/482/483/484/485/486/487/488/489/490/491/492/493/494/495/496/497/498/499/500/501/502/503/504/505/506/507/508/509/510/511/512/513/514/515/516/517/518/519/520/521/522/523/524/525/526/527/528/529/530/531/532/533/534/535/536/537/538/539/540/541/542/543/544/545/546/547/548/549/550/551/552/553/554/555/556/557/558/559/560/561/562/563/564/565/566/567/568/569/570/571/572/573/574/575/576/577/578/579/580/581/582/583/584/585/586/587/588/589/590/591/592/593/594/595/596/597/598/599/600/601/602/603/604/605/606/607/608/609/610/611/612/613/614/615/616/617/618/619/620/621/622/623/624/625/626/627/628/629/630/631/632/633/634/635/636/637/638/639/640/641/642/643/644/645/646/647/648/649/650/651/652/653/654/655/656/657/658/659/660/661/662/663/664/665/666/667/668/669/670/671/672/673/674/675/676/677/678/679/680/681/682/683/684/685/686/687/688/689/690/691/692/693/694/695/696/697/698/699/700/701/702/703/704/705/706/707/708/709/710/711/712/713/714/715/716/717/718/719/720/721/722/723/724/725/726/727/728/729/730/731/732/733/734/735/736/737/738/739/740/741/742/743/744/745/746/747/748/749/750/751/752/753/754/755/756/757/758/759/760/761/762/763/764/765/766/767/768/769/770/771/772/773/774/775/776/777/778/779/780/781/782/783/784/785/786/787/788/789/790/791/792/793/794/795/796/797/798/799/800/801/802/803/804/805/806/807/808/809/810/811/812/813/814/815/816/817/818/819/820/821/822/823/824/825/826/827/828/829/830/831/832/833/834/835/836/837/838/839/840/841/842/843/844/845/846/847/848/849/850/851/852/853/854/855/856/857/858/859/860/861/862/863/864/865/866/867/868/869/870/871/872/873/874/875/876/877/878/879/880/881/882/883/884/885/886/887/888/889/890/891/892/893/894/895/896/897/898/899/900/901/902/903/904/905/906/907/908/909/910/911/912/913/914/915/916/917/918/919/920/921/922/923/924/925/926/927/928/929/930/931/932/933/934/935/936/937/938/939/940/941/942/943/944/945/946/947/948/949/950/951/952/953/954/955/956/957/958/959/960/961/962/963/964/965/966/967/968/969/970/971/972/973/974/975/976/977/978/979/980/981/982/983/984/985/986/987/988/989/990/991/992/993/994/995/996/997/998/999/1000/1001/1002/1003/1004/1005/1006/1007/1008/1009/1010/1011/1012/1013/1014/1015/1016/1017/1018/1019/1020/1021/1022/1023/1024/1025/1026/1027/1028/1029/1030/1031/1032/1033/1034/1035/1036/1037/1038/1039/1040/1041/1042/1043/

Consultation Reply



30

1

8-80/mm

Date & Time.....

88-110/80

Chart = Air Clear

003 - MS22 (4)

P_A - redhen & pen² in unib²at
rejan (24)

inversion in lead

$\chi^2 = 6.6 = 60\%$
Regt normal

Re: Normal

Adm
medical contraindication for surgery

Signature of the Consultant

28. An informed consent is also available on record which also indicates the diagnosis of Obstructed Umbilical Hernia and the proposed Laproscopic Mesh Hernioplasty. The said consent form had been signed by the patient and also countersigned by the doctors and by Dr. Lokesh Khandelwal describing himself to be the brother of the patient. It may be pointed out that it was also the contention raised on behalf of the respondents that the brother of the deceased being himself a doctor had been apprised of the entire state of affairs and he had agreed to all the procedure that was carried out in his presence. The informed consent is extracted hereinunder:

INFORMED CONSENT

Name Daksh Kumar Age 39 yrs M/F M

Registration No. IPD No. 12/02/2017 Bed No.

I hereby authorize Dr. and those whom he may designate as associates or assistances to Perform upon me Unilateral Nephrectomy the following medical treatment, surgical operation & or diagnostic procedure

It has been explained to me that, during the course subsequent to Operation/Procedure unforeseen conditions may be revealed to be encountered which may necessitate surgical or other procedures in addition to or different from those contemplated. I therefore further request and authorize the above named physician / surgeon or his designates to perform such additional surgical or other procedures as he or they deem necessary or desirable.

I consent to the administration of anesthesia (general & / or regional) and to the use of such anesthetics as may be deemed necessary or desirable.

I further consent to the administration of such drugs, infusion, plasma or blood / blood products transfusions or any other treatment or procedure deemed necessary in the judgement of medical staff.

The nature & purpose of the operation & / or procedure, the necessary thereof, the possible alternative methods of treatment, the risk involved & the possibility of complication in the treatment of my condition have been fully explained to me I understand the same.

I certify that I have read & fully understood the above consent, that the explanations therein referred to were made & that all blanks or statements requiring insertion or completion were filled in & any inapplicable paragraphs stricken before I signed.

Signature of Doctor/Surgeon
V. S. Chawhan

Signature of Patient

Signature of Anesthesiologist
Manish

When patient is a minor or unable to affix signature of any disability

Signature of the Person

Authorized to consent for Patient

Signature of Anesthesiologist
Dr. Manish Soodharya

Name Daksh Khandelwal

Signature of Anesthesiologist
25/3/17

Relationship Brother

29. The High Risk Consent Form has been marked as "Not Applicable", however the anaesthesia consent form was filled up and was duly signed by the patient that is on record.

30. The pre-anaesthetic check-up was also carried out with all endorsements indicating that there was no abnormality and the patient was fit to undergo surgery.

31. A cardiogram report was also on record assessing the status of the patient and the Echo report was also on record which indicates that everything was normal. The Ultrasonography was also carried out which recorded an evidence of Obstructed Umbilical Hernia. The USG report is extracted hereinunder:



Sector-16A, Faridabad (Delhi-NCR) - 121 002
Tel: 0129-4277777 Fax: 0129-4277799
Ambulance Mobile: 9811561000, 9999714000



DEPARTMENT OF RADIO-DIAGNOSIS & IMAGING

File No.	UR13-25610	Date	25/MAR/2014
Name	MR. DAKSH KUMAR	Age/Sex	39 YRS / M
Referred By	DR. B. D. PATHAK / V. S. CHAUHAN	Regn. No.	OR13143462
Panel	CASH	Add. Ref. By	

USG WHOLE ABDOMEN

Liver is normal in size and diffusely increased in echotexture. No focal lesion seen.

Gall bladder is well distended and is normal in wall thickness and contents. The common duct and I.H.B.R are not dilated.

Spleen is normal in size and echotexture. No focal lesion seen.
The spleno-portal axis is normal.

Pancreas is normal in size and echotexture with well maintained peri-pancreatic fat planes. No focal lesion seen.

Both kidneys are normal in size and echotexture with well maintained cortico-medullary differentiation.

There is echogenic focus approx 4.3mm size in upper calyx of left kidney.
No hydronephrosis seen.

There is evidence of obstructed umbilical hernia with approx 1cm peritoneal defect with edematous omentum and mild fluid in the hernial sac.

No evidence of retroperitoneal lymphadenopathy seen.
There is no free fluid seen in the peritoneal cavity.

Urinary bladder is normal in contour, capacity, wall thickness and contents.
Prostate is normal size and echotexture. No focal lesion seen.

IMPRESSION: Findings are s/o grade II fatty liver with small left renal calculus with obstructed umbilical hernia.
Please correlate clinically

Dr. Kamal Aggarwal
M.D. Radiologist

This is professional opinion & not to be used for medico-legal purpose

Email: info@metrohospitalfaridabad.com
Facebook: facebook.com/metrohospitalfaridabad

Website: www.metrohospitalfaridabad.com
Twitter: twitter.com/metro_hospital

32. However, after the surgery, the ECG report records inferior ischemia and abnormal ECG. This ECG is post-surgery dated 26.03.2014 at about 12:40 am.

33. The hospital notes have been read out by the learned counsel for the parties and the learned counsel for the complainant has emphasized that the complications had already set in, yet no appropriate steps were taken for correcting the parameters of the patient who was losing life and the condition was deteriorating for which the progress notes have been read out. The Death Summary has been recorded on 26.03.2014 which is extracted hereinunder:



ACCREDITED

Sector-15A, D-2, 2nd Floor, Durgam Chaudhary
Phone: 0185-2777777 Fax: 0120-2777555
Ambulance Mob: 9811561000 999-714000

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DEATH SUMMARY

Name	Mr. Daksh Kumar	Age/Sex	39 M
IPD No	3700317	UHID	38165
Admission Date	25-Mar-2014	Date	26-Mar-2014
Consultant	Dr. B.D Pathak, V.S. Chauhan	Room	SP-31A1
Panel	Family Health Plan		

Diagnosis:

- Sudden Cardiac Arrest / ? Pulmonary Embolism
- Obstructed Umbilical Hernia
- Post Op. Laparoscopic Mesh Hernioplasty

Mr. Daksh Kumar, 39 yrs old male, was admitted with complaint of swelling and pain in umbilical region since 1 day. At admission patient was haemodynamically stable, BP 120/80 mmHg, PR - 88/min, SPO₂ - 96%, Chest - Bilateral clear, P/A - Swelling (+). Patient admitted in ward and evaluated. Blood investigation showed within normal limits. 2-D Echo showed LVEF=65% and rest normal. Patient taken in OT for Laparoscopic Mesh Hernioplasty and post operatively patient shifted to SICU. After 2 hours of stay in SICU patient shifted to ward, where he developed chest pain, so ECG was done which was normal and cardiac markers was normal on 26-03-2014 at 05:00 AM. Patient became uneasiness and collapsed. Pulse / BP not recorded so urgent shifted to MICU where he was intubated and show fresh blood from ET tube. Urgent CPR done for 1 hour but not revived and declared dead at 6:00 AM on 26-03-2014.

Dr. B.D Pathak
MS, FAIS, FMASTFOLS, FIAGES
Senior Consultant
Dept. of Surgery
Minimal Invasive Surgery

Dr. V.S. Chauhan
MS, MRCS (Glasgow), FAIS
Dept. of Surgery
Minimal Invasive Surgery

Email: info@metrohospitalandabad.com

Website: www.metrohospitalandabad.com

Twitter: twitter.com/metro_hospital

Facebook

www.facebook.com/metrohospitalandabad

34. On considering the submissions raised as well as the written arguments filed on record, coupled with the pleadings and evidence, one of the preliminary allegations on negligence is about conducting the surgery in haste in spite of the fact that it was a case of simple Hernia and did not require an emergent surgery. For this, reference be had to the ultrasonography report of Dr. Kamal Aggarwal already extracted hereinabove which categorically records the diagnosis of Obstructed Umbilical Hernia. The aforesaid ultrasonography test has not been rebutted or even commented upon nor the expert evidence of Dr. Batwara relied on by the complainant indicates a contrary view. As to what is Obstructed Umbilical Hernia was indicated by the learned counsel for the complainant in the arguments already recorded on 06.07.2024. However, this was a case of Obstructed Umbilical Hernia that was clinically examined by the surgeon opposite party no.2 who planned the surgery on the same day. The surgery was admittedly done after taking informed consent which is also corroborated by the fact that the patient's real brother was also a doctor namely, Dr. Lokesh Khandelwal, who participated in the planning of the surgery and is also a witness to the consent that is on record. No objection or any alternative suggestion was made and, according to the opposite parties, there was acute inflammation that evidenced Obstructed Umbilical Hernia that was required to be immediately attended to as it would cause complications. It is also stated in the written

statement that Dr. Meenakshi Gupta had recorded the detail history of the patient and after medical clearance for surgery was given by the physician, the surgery was proposed keeping in view the redness and pain in the Umbilical region of the patient. Learned counsel for the opposite parties have appropriately relied on the literature contained in Bailey & Love's Short Practice of Surgery where under Chapter-62 relating to Umbilical Hernia, the diagnosis has been explained with the help of a diagram stating that obstruction more often culminates in strangulation. The literature also states that there is no clear distinction clinically between obstruction and strangulation and therefore the safe course is to assume that a strangulation is imminent and should be treated accordingly. Under the heading of treatment, it has also been stated that the same should be treated by emergency operation as any delay may cause development of Gangrene and other complications, as such the same deserves immediate attention. In another article from a book published by Springer Publications titled "Abdominal Wall Hernias Principles and Management" it has been recited that any procrastination turns a simple operation into a major reparative procedure associated with morbidity and mortality. Such a condition is potentially lethal and requires a fast and decisive action. Other literatures have also been relied on which indicate that prompt surgery may be required in cases of Obstructed Umbilical Hernia. We therefore do not find any error of judgment in the conduct of the surgery

that was planned on the same day, and therefore the contention that it was an undesirable emergent surgery, does not appear to be an act of negligence on the part of the Surgeon, Dr. Pathak.

35. The next noticeable feature is that the surgery was conducted successfully and there is no complaint regarding the process of surgery. It was conducted after taking consent and a pre-operative clearance from the physician and after a pre-anesthetic check-up. The choice of getting the surgery conducted by the opposite party no.2 was also that of the patient and his family, including his brother Dr. Lokesh Khandelwal. In the absence of any such valid contest on the issue of the surgery itself, we see no reason to delve into this issue any further. The parameters of the patient prior to the surgery were normal and the patient was fit for surgery when he was admitted on 25.03.2014. The admission notings also confirm the same. We therefore hold that the opposite party no. 2, Dr. Pathak cannot be held to have been negligent in conducting the surgery.

36. The contention which has been predominantly raised commences with the allegations immediately post-surgery, the first being the shifting of the patient after surgery. The surgery had been conducted as per the opposite parties between 7.40 p.m. and 8.30 p.m. on 25.03.2014 whereafter the patient was retained in the Surgical ICU for about 2 hours from 9.00 p.m. to 11.00 p.m. The nursing sheets that have been filed on record at 9.00 p.m. states that the patient complained of pain and this recording

has been made by Nurse Anesh. The recording also indicates that Intravenous Analgesics were given and the patient was provided a comfortable positioning. The outcome column records that the pain was reduced. It may be noted that the said pain was not a chest pain for which Analgesics seem to have been given that might have reduced the pain. The Vitals' Chart that has already been extracted hereinabove indicates that the vitals were normal which also has been recorded by the same Nurse Anesh. The BP recorded at 9.30 p.m. was 130/80 and at 11.00 p.m. 130/70; the Pulse Rate was 74 and 78 per minute respectively; the temperature was normal and so was the respiration rate. The Doctors' notes and medication orders at 10.00 p.m. in the Surgical ICU records that the patient is conscious and oriented and his general condition is fair. The vitals recorded were stable with no fresh complaints.

- 37.** The patient was advised thereafter by the consultant to be shifted to the room. It is necessary to mention this fact as an issue has been raised on behalf of the complainant on shifting urging that the shifting has been done against protocols and hurriedly. For this, reliance has also been placed by the complainant once again on the affidavit of Dr. Batwara where he has stated that the patient was shifted from the Surgical ICU to the Private Deluxe Room in just 2 hours in spite of the Anesthetist having advised close monitoring. An inference has been drawn that this led to a deficient follow-up and monitoring of the patient. On this issue, we find

that the opposite parties have brought on record the Surgical ICU Manual of the Hospital, which, according to them, is as per NABH standards and the Hospital was possessed of a Certificate of Accreditation during the said period. The said Certificate along with the Manual has been filed as Annexure R-2. The same prescribes the criteria for shifting of patients and the responsibility of shifting is on the consultant in-charge. The relevant extract of the Manual is reproduced hereunder:

Name of The Document : SICU MANUAL	Issue No : 03	Page No.: 12 out of 98
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SHIFTING CRITERIA

- Substantial resolution of the problems responsible for admission
- Anticipation of prolonged medical stability
- Establishment of status (e.g. DNR) such that intensive care supervision or intervention is not required even if the patient remains critically ill
- Elimination of need for mechanical ventilation/airway protection
- Elimination of the need for invasive haemodynamic monitoring
- Discontinuation of medications/treatments requiring haemodynamic monitoring

SHIFTING DECISIONS

- Discharge decisions are the responsibility of the Consultant in charge for the SICU so discharges are decided in the morning.
- Whenever possible discharges are anticipated and arrangements are made in good time, with the medical and nursing staff who will be taking over the patient's care.
- There is always direct verbal contact with a member of the team taking over the patient prior to transfer.
- There is always liaison with the ward nurses and they are informed in advance to make necessary arrangements to receive patients.
- The patient's relatives are informed about the shifting & that they are informed about the shifting and that they are told that one attendant will always accompany the patient in ward.
- If further SICU admission would be considered inappropriate this is recorded in the patient's case notes. Such a decision is discussed with the team taking over the patient's care.

Name of The Document : SICU MANUAL	Issue No : 03	Page No.: 13 out of 98
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Nurse: Patient Ratio:: 2:1

Two ICU bed is managed by a Nurse who is dedicated to take care of those bed only.

When the patient is on ventilator or having ionotropic support, then this ratio is kept 1:1

 Prepared By: Dr. Seema Mohindra DMS & NABH Co-ordinator	[13]	 Approved By: Dr. S.S. Bansal Managing Director
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38. We also find that there is a noting in the Daily Plan Care Progress Note dated 25.03.2014 at 10.00 p.m. giving instructions in writing by one

Dr. Anuj to shift the patient to the room as the patient's general condition was fair and vitals were stable. The endorsement in brackets also states "As per consultant order". Learned counsel for the complainant has doubted the said endorsement as having been inserted later on but there is no proof or evidence to believe the same except the allegations. The said document has been filed by the complainant and, in the absence of any evidence to the contrary, the endorsement has to be accepted as the shifting has been carried out on the instructions of the consultant, namely, the opposite party no.2.

39. In addition thereto it is categorically asserted in the written statement in paragraph-3 (xii) as follows:

*"(xii) Thereafter, at 11:10 pm the patient was wheeled into the Deluxe **Room No. 214 located on the 2nd floor of the hospital and next to Medical ICU.** The said room is **having the facilities** of Central Oxygen Supply, Central Suction Facility and Multi-para cardiac Monitor of vitals including heart rate, blood pressure, continuous ECG etc. It may be noted that the condition of the patient at 11:10 pm was normal i.e. specifically, heart rate & blood pressure."*

40. This fact has not been rebutted by any further evidence by the complainant. Upon being received in the room which is stated to be adjacent to the Medical ICU, as noted above, the condition of the patient was once again recorded by the attending Dr. Shally as fair and afebrile. The patient

was conscious and oriented and the vitals were reported normal. This noting at 11.10 p.m. is on record of the progress notes.

41. The shifting being the obligation of the consultant, the same seems to be in accordance with the protocol as per the Manual referred to above and therefore we do not find any element of negligence in the shifting of the patient from the Surgical ICU to the Deluxe Room and there is no indication of any objection either by the patient or the attendants to the aforesaid shifting.

42. It may be also pointed out that Injection Dynapar which is for pain has also been issued as per the Indoor Drug Chart at 9.10. p.m.

43. Moving forward while the patient was inside the room in the midnight of 25/26.03.2014, Dr. Shally again examined the patient at 12.40 a.m. when the vitals were again normal but at that moment the patient appears to have complained of chest pain which is recorded in the progress note. Urgent test of CPK MB and Trop-1 was done and Injection Dynapar was administered. The investigations further recorded an ECG that was shown to the attending Dr. Bhanwar. Dr. Bhanwar is the Intensivist who was attending the patient. The Nurses' notes also indicate the shifting of the patient at about 11.00 p.m. and sleeping well. The chest pain referred to above was also noted in the Nurses' notes and the ECG was done that was shown to the Doctor. These notes are recorded by Nurse Gopika who has also recorded the administration of Injection Dynapar as per Doctor's order. At about 12.50 a.m. the Oxygen

saturation level has been reported and recorded as 98% and the investigation reports at 1.45 a.m. were also stated as normal.

44. Dr. Shally after having shown the ECG report once again recorded her notes at 12.46 a.m. that the general condition was fair, the vitals were normal and there were no fresh complaints.

45. The ECG report has also been relied on by the complainant and also referred to by the opposite parties. According to the complainant, the said ECG report that was recorded at 12.40 a.m. on 26.03.2014 indicated some abnormality and was not a normal ECG. On the other hand, the opposite parties contend that all the markings were normal and consequently the said ECG report did not indicate any serious problem as all the other pathological reports did not indicate any abnormality.

46. At 12.50 a.m. Dr. Bhanwar had recorded his notes where the Oxygen saturation level was recorded at 96% but there was a complaint of chest pain and some breathlessness. Injection Dynapar was administered and repeat ECG after 6 hours was also suggested.

47. From the Nurses' notes, it is evident that at 1.45 a.m. the investigation reports were collected and stated to be normal. These notings are once again by Nurse Gopika who changed the Intravenous fluid at about 2.00 a.m. and reported that the patient was normal. The said Nurses' investigation sheet also records that the same nurse went to the patient's room to check the Intravenous fluid flow when the patient asked for sips of water that were

given at 3.30 a.m. The next noting of the same nurse is at 4.15 a.m. which records that the nurse went to the patient's room and the patient intimated that the chest pain was reduced.

48. Simultaneously, the progress notes of the Doctors' sheets indicate that Dr. Shally saw the patient at 2.00 a.m. and found the vitals to be normal with no fresh complaint and was sleeping.

49. The aforesaid narratives emerging from the Doctors' and Nurses' sheets indicate that even though the patient had complained of chest pain at about 12.40-50 a.m., ECG had been taken, Trop-1 test was done and Injection Dynapar was also administered. The Nurses' sheets indicate that the patient was observed as normal during this period and sips of water were also given at about 3.30 a.m. The 4.15 a.m. note indicates that there was some reduction in the chest pain. The Oxygen saturation levels between 96% to 98% also did not give rise to any apprehension of Pulmonary Embolism.

50. There is therefore no evidence of any emergency or alarm noted either by the Nurse or the attending Dr. Bhanwar or Dr. Shally.

51. The fact remains that the notings of Dr. Bhanwar after 12.50 a.m. for the first time are available at 4.00 a.m. and that of Dr. Shally after 2 a.m. at 4.50 a.m. We have not been able to find the attendance of any Doctor particularly between this gap of 2.00 a.m. and 4.00 a.m. even though the Nurses' notes at 2.00 a.m., 3.30 a.m. and 4.15 a.m. indicate as if the patient

was normal and the chest pain had reduced and the patient had had sips of water.

52. Learned counsel for the complainant has urged that when the chest pain had been complained of and even noted, neither any x-ray was conducted nor any scan carried out in spite of the ECG showing abnormality. It is also urged that none of the tests like ABG or other proper investigations were done and no Cardiologist or Specialist was consulted. Dr. Bhanwar was a simple MBBS Doctor who could not gauge the seriousness of the status of the patient which was fast-deteriorating and he did not even call for a Cardiologist nor was the Cardiologist available. It is also urged that no Specialist attempted to diagnose and treat these early symptoms of Pulmonary Embolism and therefore this was a clear act of negligence. On the other hand, learned counsel Mr. Sharma and Mr. Kapoor have urged that chest radiography is no conclusive diagnosis for the exclusion of Pulmonary Embolism and is almost non-specific and, according to the medical literature in Chapter-52 of Irwin and Rippe's Intensive Care Medicine, it is abnormal in more than 80% of the patients. The electrogram is commonly abnormal but findings are usually non-specific regarding Pulmonary Embolism and, deviations in the segments are common. It is also urged on the basis of the said article that the D-Dimer test does not have a positive predictive value and therefore it should not be used in isolation for evaluation.

53. The condition of the patient suddenly was noted as having dropped and deteriorated at 4.50 a.m. by Dr. Shally as the patient was unconscious and unresponsive with his BP at 70/50 and Pulse Rate at 136 per minute. This critical condition of the patient in all probability happened approximately between 4:00 am and 4:50 am. The note also indicates that Dr. Bhanwar was informed and the patient was immediately shifted to the Medical ICU. This shifting is also indicated in the Chart after the recording of the Vitals. This is once again evidenced by the notings of Dr. Bhanwar at 5.00 a.m. on 26.03.2014 who has recorded that the patient was unconscious and unresponsive with irregular breathing and therefore was shifted on ventilation. The recording of the physical appearance and neurological assessment leaves no room for doubt that the patient had plunged into an unconscious state and which according to the Glasgow Coma Scale had been reduced to a score of E-1 (Eyes), M-1 (Motor Response) and V-1 (Verbal). The literature on neurological disorders as explained by Dr. William P. Howlett explains the aforesaid scale through scores contained in a Glasgow Coma Scale Chart which is extracted hereunder:

"Table 9.3

	Best response	Score
Eye opening (E)	spontaneously	4
	to speech	3
	to pain	2
	nil	1
Motor response (M)	obeys commands	6
	localizes stimulus	5
	flexes withdrawal	4

	flexes weak	3
	extension	2
	nil	1
Best verbal (V)	oriented fully	5
	confused	4
	inappropriate	3
	incomprehensible (sounds only)	2
	nil	1
Maximum score		15"

54. According to the said chart and the article referred to, if the score is 1, then the response is nil. We therefore find the argument of the learned counsel for the complainant on this count to be correct that with the aforesaid recording by the attending Doctor himself at 5.00 a.m., there is hardly any doubt that the patient had already sunk to a very low level had practically collapsed. The bleeding in the E.T. tube was also noticed. The opposite parties have taken a defence that with this bleeding it was not possible to give any coagulant at that stage. Learned counsel for the complainant pointed out that it is for the first time that it is at 5.00 a.m. that the Doctors' sheet records suspected Pulmonary Embolism. At 5.20 a.m. Bradycardia is recorded and the patient continued on ventilation with severe Hypoxia being noted. The vitals were poor even at 5.20 a.m. with no further vitals being recorded as normal. It notes that the patient also had Bradycardia at 5.50 a.m. and CPR was done. A 2-D Echo also has been stated to be carried out ruling out the possibility of thrombolytic therapy. Heparin had been directed to be administered but was kept on hold and call was sent to the surgeon opposite party no.2 at that stage.

55. The Hospital notes indicate recording the death of the patient at 6.00 a.m.

56. This is the entire sequence of events and the complainant alleges that in fact neither any proper tests were done nor any diagnosis made once the patient had reported chest pain at mid night, and breathing trouble as well, and neither any Specialist was called nor an appropriate cardiac or pulmonary treatment was either advised or undertaken. This was therefore a clear act of negligence as the patient was attended by somebody who was not qualified to deal with it and in fact the patient was left unattended for a fairly long time.

57. Having taken note of the submissions and notings of the Hospital sheets, particularly after the shifting of the patient at about 11 pm to the room where he continued till 4:50 am on 26.03.2014, it appears that the pain was complained of at about 12:50 am as noted in the progress sheets. However that was dealt with by an ECG and a Trop one test but with no further investigations or consultations with any other doctor. It was Dr. Bhanwar who is stated to be an intensivist on attendance. Mr. Kapoor, learned counsel for the opposite party Hospital and Dr. Bhanwar has urged that he is experienced and qualified. For that reliance has been placed on the certification of experience of Dr. Bhanwar. We find that the certifications do indicate an experience as a resident of ICU at the Fortis Escorts Hospital for some period and then also at the S. D. Memorial Hospital as a junior resident. He is also stated to be an advanced cardiovascular life support provider

certified from the American Heart Association. Even though his experience certificates are on record, but we find that he is not possessed of any speciality or higher qualification beyond MBBS even though his experience has been indicated for having functioned in an ICU for a period of more than three years which according to the learned counsel for the opposite parties is within the medical protocols.

58. Be that as it may, even assuming that he was qualified, we find that the procedure for carrying out the confirmatory tests for pulmonary embolism do not seem to have been attempted at all. This issue relating to the diagnosis and confirmation of pulmonary embolism has been dealt with by this Commission in the case of Inscot Hospital v. Inderjit Arora, (Supra), the decision whereof was assailed before the Apex Court and the SLP has been dismissed. The said decision refers to the 'Brounwalds Heart Disease' text and explains the symptoms, the diagnosis and the treatment in cases of pulmonary embolism. Paragraph 33 of the said decision is extracted herein under:

33. "Brounwalds Heart Disease", A Textbook of Cardiovascular Medicine 7th edition defines Pulmonary Embolism, the "Diagnosis" and the "Investigations" to be conducted for its treatment:

<i>"TABLE 66-6 SIX Syndrome of Acute Pulmonary Embolism"</i>			
<i>Syndrome</i>	<i>Presentation</i>	<i>Right Ventricular dysfunction</i>	<i>Therapy</i>
<i>Massive</i>	<i>Breathlessness, syncope, and</i>	<i>Present</i>	<i>Heparin plus</i>

	cyanosis with persistent systemic arterial hypotension; typically >50 percent obstruction of pulmonary vasculature		thrombolytic therapy or mechanical intervention
Moderate to large ("submassive")	Normal systemic arterial blood pressure; typically >30 percent perfusion defect on lung scan	Absent	Heparin plus or minus thrombolytic therapy or mechanical intervention
Small to moderate	Normal arterial blood pressure	Rare	Heparin
Pulmonary infarction	Pleuritic chest pain, hemoptysis, pleural rub, or evidence of lung consolidation; typically small peripheral emboli	Rare	Heparin and nonsteroidal anti-inflammatory drugs
Paradoxical embolism	Sudden systemic embolic event such as stroke	Rare	Anticoagulation + closure of right-to-left cardiac shunt
Nonthrombotic embolism	Most commonly air, fat, tumor fragments, or amniotic fluid	Rare	Supportive

**therapy depends on degree of impairment of right ventricular function and presence or absence of contraindications to thrombolysis or heparin. Adapted from Goldhaber SZ: Treatment of acute pulmonary embolism. In Goldhaber SZ(ed): Cardiopulmonary Diseases and Cardiac Tumors. In Braunwald E (series ed): Atlas of Heart Diseases. Vol3. Philadelphia, Current Medicine, 1995 pp 7.1-7.12.*

Nonimaging Diagnostic Methods

To establish the diagnosis of PE, the astute clinician must first suspect this illness. Establishing the clinical probability of PE is important to help decide which patients should undergo further work-up. Many patients in whom PE is a theoretical possibility are exceedingly unlikely to have PE.

PLASMA D-DIMER ELISA. *This blood-screening test relies on the principle that most patients with PE have ongoing endogenous fibrinolysis that is not affective enough to prevent PE but that does break down some of the fibrin clot to D-Dimers. Although elevated plasma concentration of D-dimers are sensitive for the presence of PE, they are not specific. Levels are elevated in patients for at least*

one week postoperatively and are also increased in patient with myocardial infarction, sepsis, cancer, or almost any other systemic illness, therefore, the plasma D-dimer ELISA is ideally suited for outpatients or Emergency Department patients who have suspected PE but no coexisting acute systemic illness. This test is not useful for hospitalized inpatients.

CHEST COMPUTED TOMOGRAPHY. Chest CT has supplanted pulmonary radionuclide perfusion scintigraphy of the initial imaging test in most patients with suspected PE (Fig. 66-7).^{53a} For patients with intrinsic lung disease and abnormal chest radiograph results. The chest CT scan can suggest an alternative or concomitant pulmonary disease to explain the clinical presentation. For the evaluation of suspected PE, the CT examination can include scanning of the venous system from the popliteal veins to the sub segmental pulmonary arteries. The CT examination can also provide valuable information about the size and function of the right ventricle relative to the left and can alert the clinician to the presence of right ventricular dysfunction. The latest generation of multidetector-row CT scanners permits image acquisition of the entire chest with 1mm or submillimeter resolution with a breath-hold of less than 10 seconds.⁵⁴ **With a properly performed CT scan on a multidetector row machine, it is likely that CT scanning supplants pulmonary angiography as the gold standards for PE imaging.**

We obtain an electrocardiogram and chest radiograph. To screen for PE in the Emergency Department, we obtain a rapid turn-around plasma D-dimer ELISA if normal, then PE is exceedingly unlikely, and that point. If elevated, we ordinarily pursue the diagnosis of PE with chest CT scanning. For the occasional equivocal result, we next

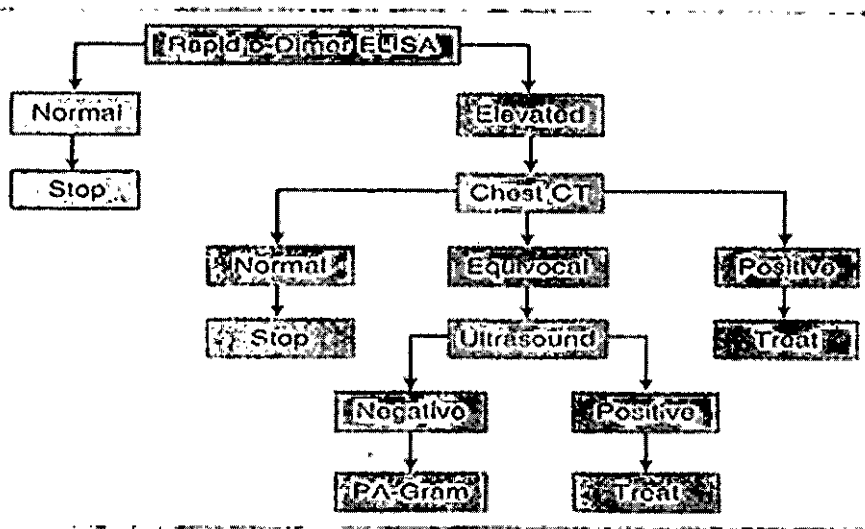


TABLE 66-8 Advantages and Disadvantages of Diagnostic Tests for Suspected Pulmonary Embolism

Diagnostic Test	Advantages	Disadvantages
Plasma D-dimer Elisa	A normal result in this rapid turnaround blood test makes PE exceedingly unlikely.	Level is elevated in patients with many systemic illnesses that mimic PE, such as pneumonia and myocardial infraction. Level is elevated in patients with sepsis, cancer, postoperative state, and pregnancy.
Electrocardiograms	Universally available; may indicate ominous acute corpulmonale or benign pericarditis	Acute corpulmonale on electrocardiogram is not specific for PE; not a sensitive test.
Chest radiograph	Usually has minor abnormalities but occasionally pathognomic; may indicate alternative diagnoses such as pneumothorax.	Not specific
Chest computed tomography	New-generation scanners constitute the new gold standard for diagnosis	Older generation scanners are insensitive of important but distal PE.
Lung Scanning	High-probability scans are reliable for detecting PE; normal/near normal scans	Most scans are neither high probability nor normal/near-normal; lung scans are falling out of favor; most test results are

	are reliable for excluding PE.	equivocal.
<i>Magnetic resonance imaging</i>	<i>Excellent for anatomy and cardiac function; the contrast agent does not cause renal failure</i>	<i>In preliminary use; not widely available; experience very limited</i>
<i>Echocardiography</i>	<i>Excellent for identifying right ventricular dilation and dysfunction that is not obvious clinically, thus providing an early warning of potentially adverse outcome.</i>	<i>Not specific; many patients with PE have normal echocardiograms; the test cannot reliably differentiate causes of right ventricular dysfunction.</i>
<i>Pulmonary angiography</i>	<i>Necessary for catheter-based interventions.</i>	<i>Invasive, costly, uncomfortable.</i>
<i>Venous ultrasonography</i>	<i>Excellent for detecting symptomatic proximal DVT; surrogate for PE.</i>	<i>Cannot image iliac vein thrombosis; imaging of calf is operator dependent; DVT may have embolized completely, resulting in normal finding.</i>
<i>Contrast venography</i>	<i>Used to be gold standard; excellent for calf veins; necessary for catheter-based interventions</i>	<i>Can cause chemical phlebitis; uncomfortable; costly; may fail to diagnose massive DVT because veins are filled with thrombus and cannot be opacified.</i>

DVT+ deep venous thrombosis; ELISA enzyme-linked immunosorbent assay; PE = pulmonary embolism.

Proceed to venous ultrasonography of the legs. If the ultra sonographic examination is normal and high clinical suspicion persists, a diagnostic pulmonary angiogram is obtained. An integrated diagnostic strategy that includes clinical probability assessment, chest CT, and venous ultrasonography will usually provide a noninvasive diagnosis or exclusion of PE. This approach is safe, is validated, and requires pulmonary angiography in at most 10 percent of patients.

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59. The complainants have also relied on the same literature in the present case as well. In the instant case the issue of chest pain as well as symptoms

of breathlessness was also noted, but none of the tests as referred to in the said literature seem to have been carried out between 12:45 am when the symptom of chest pain was noted first up to 4:50 am when the patient had virtually collapsed. In the absence of any such material to indicate that the complete protocol of confirmatory tests for pulmonary embolism were followed, the only inference that can be drawn is that attending doctors were negligent. Not only this, there is no indication of any facility of cardiologist or attending specialist including the pulmonologist to detect and confirm the symptoms of pulmonary embolism that was crucial and essential in the present case, when the patient became critical due to his deteriorating conditions noted above.

60. It also appears that Dr. Bhanwar after 2 am arrived at 4 am to visit the patient. This is a gap of almost two hours and the patient immediately dropped suddenly with his low vitals at about 4:45 am. The notings of the nurses that the patient took sips of water and had somewhat reduced pain is not corroborated by any visit by any of the doctors. Dr. Shally had also visited at about 2 am and then at 4:50 am it was noted by her that the patient was unconscious. The aforesaid entire critical period of almost two hours therefore seems to have led to the deterioration of the patient with practically no medical attendance. The notings do indicate that Dr. Bhanwar had visited at 4 am. But the visits are not supported by any evidence of any

tests having been undertaken, resulting in the sudden drop of the patient, who had almost collapsed at 4:50 am.

61. At this stage we may discuss the evidence relied on by the Complainant, namely that of Dr. Batwara. Dr. Batwara seems to have only given his opinion on the basis of documents indicated, but the fact remains that he held a post graduate degree in hospital management from the University of New England Australia that has been shown by the opposite parties to be a qualification which is not recognised in India at all. Dr. Batwara is not a cardiologist nor a specialist of the said area and therefore the learned counsel for the opposite parties are somewhat correct in their contention that the evidence of Dr. Batwara cannot be relied on as an expert evidence, keeping in view of the ratio of the judgment of the Apex Court in the case of **Ramesh Chandra Agrawal** (Supra). We therefore do not propose to place any credible reliance on the affidavit of Dr. Batwara as he is not an expert of the said field.

62. But the fact remains that after the ECG which was conducted at 12:40 am, no further tests or monitoring seems to have been done, nor recorded either in the doctor's note or in the nurses sheet in spite of specific instructions of anaesthetist. The patient was treated in a routine way with practically no attendance between 2 am and 4 am on the presumption that everything was normal. In fact the deterioration of the patient crystallized into his collapse at about 4:50 am, which may have happened between 4 am

when Dr. Bhanwar visited and 4:50 am when Dr. Shally recorded unconsciousness. This was a vital and a critical period when the patient ought to have been attended. No cardiologist or pulmonologist was either called or attended on the patient. This was certainly lacking on the part of the Hospital. There is no indication as to who was the cardiologist or pulmonologist available in the Hospital who could have been called upon to attend on the patient with the symptoms of chest pain and growing concerns. This deficiency on the part of the Hospital also touches upon the negligence with due to the patient appears to have suffered.

63. We would however like to add another note, namely, that the patient's real brother Dr. Lokesh Khandelwal being a doctor does not seem to have been attending on the patient during this critical hours and as a matter of fact he could have also contributed in arousing any concern during the early hours when there is a possibility that the attending doctors were also taking rest. There is however no evidence to that effect, but the fact remains that the patient's condition plummeted during these critical hours.

64. With this background we are of the opinion that there was no deficiency or negligence on the part of the treating surgeon who had carried out the surgery to the best of his ability and the skills possessed by him for which no negligence can be attributed to the opposite party no. 2.

65. In our opinion it is only the post-surgical care that has come under cloud as discussed above, where the hospital seems to be mainly responsible

for not providing appropriate specialists and available at the critical moments of the patients. The attending doctor namely, Dr. Bhanwar does not seem to have been equipped with any such special qualification to deal with such a critical situation and therefore the hospital could not have left the patient only to the care of Dr. Bhanwar who had no special qualifications of either cardiology or pulmonology. Such a qualified personnel was essential for the purpose of attending to the patient in such a critical state.

66. The other negligence on the part of Dr. Bhanwar is that he failed to take appropriate steps for investigations and diagnosis for the symptoms of pulmonary embolism that ultimately took away the life of the patient. Once there were symptoms of chest pain as also the other symptoms related to pulmonary embolism, then it was his obligation to carry out the appropriate tests as referred to in the literature and discussed by us hereinabove for ruling out the possibility of pulmonary embolism. No such steps were taken and as a matter of fact it was ultimately confirmed that the patient died due to pulmonary embolism. Dr. Bhanwar was therefore negligent to that effect in performing his duties as an attending doctor.

67. There is substance in the arguments raised on behalf of the complainant that after the patient had almost collapsed the conducting of tests after 5 am seems to have been done which were of no avail. The CPR could not have been for an hour as per the discharge summary and therefore the learned counsel for the complainant is correct in her submissions that the

CPR timing has not been reflected correctly. Not only this the 2D echo test was also an empty formality as the timing recorded on the said test report as pointed out by the learned counsel for the complainant is almost four minutes before the patient was recorded as dead by the opposite parties when in fact the patient had already passed away long before. This pleading again therefore also confirms our doubts about the negligent treatment of the patient.

68. Accordingly in the background above, we hold the opposite party no. 1 Hospital and the doctor, namely Dr. Bhanwar (Dr. Bhanwar Lal Kamawat) to be negligent in treating the deceased patient for all the reasons stated hereinabove.

69. Looking to the claim of compensation the contentions raised on behalf of the complainants needs to be moderated keeping in view the income claimed as per the Income Tax Return and the age of the deceased at the time of his death which was 39 years. He had liabilities at the time of his death, namely, two daughters and a son. The claim made by the complainant in paragraph 52 to 57 as follows:

"52. That as per the latest Income Tax return for the assessment year 2014-2015, the gross total income of the deceased was Rs. 7,12,250 p.a. and the total income of the deceased for the assessment year 2013-2014 was Rs. 5,84,223 which clearly indicates that the business of the deceased was on the rise and had potential of greater profits and earnings in the future years. Copy of the Income Tax Return for

the assessment years 2014-2015 and 2013-2014 are collectively annexed and marked herewith as ANNEXURE P/8(COLLY).

53. That since the Complainant's husband expired at a young age of 39 years, many of his working years have been taken away from him. The deceased was a young and fit man and did not suffer from any medical diseases and as such had the potential to work for profit for atleast another 31 years.

54. That the deceased has three minor children (two daughters and one son) namely Ayushi Khandelwal aged 15 years, Vaibhavi Khandelwal aged 11 years and Rudransh Khandelwal aged 5 years and now after his demise the responsibility of their education, upbringing and marriage falls upon the Complainant who was financially dependent on her deceased husband.

55. That in view of the aforementioned, the Claimant herein is praying for compensation of Rs. 2,20,79,750/- (Rupees Two Crores Twenty Lakhs Seventy Nine Thousand Seven Hundred and Fifty Only) only with 18% interest p.a. in addition to medical expenses incurred for the hernia repair treatment amounting to Rs. 1,31,564/- (Rupees One Lakh Thirty One Thousand Five Hundred Sixty Four Only).

56. That the basis of calculation of compensation of Rs. 2,20,79,750/- is that if the deceased earned annually Rs. 7,12,250 for the next 31 years, he would have earned Rs. 2,20,79,750/-.

57. That the Complainant is further praying for Rs. 50,00,000/- (Rupees Fifty Lakhs Only) for the education and marriage of her minor children, Rs. 50,00,000/- (Rupees Fifty Lakhs Only) towards loss of

consortium and mental pain and agony of the Complainant along with cost of this petition."

- 70.** In our considered opinion the calculation of the income is based on a business earning of a cement agency situate in Haryana. A business cannot be assumed to be a profitable business throughout one's life and it may have its ups and downs keeping in view the nature of the commodity for which the business was being run. The income therefore can be fluctuating and cannot be taken in a standardised way to assume a profit making business throughout the life of the person concerned.
- 71.** In the circumstances keeping in view the age of the deceased, we find that the complainant would be justified in claiming at the rate of Rs.5,00,000/- per annum for 30 years which would be approximately 1.50 crores as against all the opposite parties. We have however found that there was no negligence on the part of the surgeon or in the surgery and therefore a moderation on that count can be made with the responsibility of the post-surgical complications that has led to the death of the patient. We have no other method except to gauge this calculation in the background that the deceased's real brother was also a doctor and could have participated more effectively during the critical period.
- 72.** Nonetheless, we find that a net lump sum amount of Rs.20,00,000/- be awarded as compensation, out of which Rs.15,00,000/- be borne by the Hospital and Rs.5,00,000/- by Dr. Bhanwar. The same shall be paid

within three months from today or else will invite interest @ 6% p.a. from
the date of default till the date of actual payment.

Sd/-

.....
(A.P. SAHI, J.)
PRESIDENT

Sd/-

Pramod/Satish/ Jyotsana/ Mukesh/ Brahm

.....
(BHARATKUMAR PANDYA)
MEMBER