(2016) 08 NCDRC CK 0030

In the National Consumer Disputes Redressal Commission

Case No : 589 of 2016

FAZAL-E-ILAHY Vs SRI JAYADEVA INSTITUTE OF CARDIOVASCULAR? SCIENCES & RESEARCH

Date of Decision : 10-08-2016

Acts Referred:
Consumer Protection Act, 1986, Section 21(a)(i) - Jurisdiction of the National Commission

Citation : 2016 3 CPR 377

Hon'ble Judges : Ajit Bharihoke,?S.M. Kantikar

Advocate : PAWAN KUMAR RAY

Judgement

1. The instant complaint is filed by Shri Fazal-E-Ilahy, the complainant, against Sri Jayadeva Institute of Cardiovascular Sciences & Research, Bangalore/OP, for alleged medical negligence causing death of complainant''s father because of not providing proper treatment. There was negligence during handling critical stage of the patient.

2. Brief facts relevant in this complaint are that on 12.8.2015, Mr. M. K. Jameel, father of the complainant, (since deceased, hereinafter referred as ''the patient'') suffered urinary retention with pain and respiratory distress. He approached OPD at OP/Hospital. He was investigated and diagnosed as fluid in both the lungs, with urinary retention due to BPH. He was admitted in ICU-3 of OP/hospital. The emergency measure, Foley''s Catheterization, was advised for passage of urine. It was alleged that despite the critical condition of the patient, the doctors at OP-Hospital gave only insulin dose, no catheter was placed and left the patient unattended. The patient was restless and unable to sleep throughout that night. The blood investigations revealed reduction in Platelet Count (Thrombocytopenia) and increase in potassium (k) level + (Hyperkalemia). The patient was unattended by senior doctors, only untrained medical students attended him. It is further alleged that the doctors did not bother to do a simple procedure of

Foley''s catherization to remove patient''s urine. The platelet count was decreasing but no platelet transfusion was given, therefore, patient''s vital

organs got damaged. Thus, it was a negligent behavior of the OP doctors. Therefore, for proper treatment, the complainant decided to shift the patient to Fortis Hospital, but OP did not allow for shift till 11.30 a.m. of the next day, because there was no billing staff and other official to sign the medical file of the patient. Also the doctors at OP informed the complainant that, the hospital is Cardiac hospital, hence, nothing can be done for the patient. After a long delay, on 13.8.2015, the patient was discharged and thereafter he was shifted to Fortis Hospital for further treatment. In the Fortis Hospital, immediate Foley Catherization, blood tests, platelet transfusion and dialysis were performed but the patient could not be saved. Therefore, the complainant filed the complaint under Section 21(A)(i) of the Consumer Protection Act, 1986 before this Commission and prayed for compensation to the tune of Rs.1,18,76,656/- under different heads.

3. We have heard Mr. Pawan Kumar Ray, learned counsel for the complainant at the stage of admission. Learned counsel reiterated the facts mentioned in the complaint. We have put specific question to the counsel regarding the treatment and diagnosis of the patient. Counsel brought our attention towards OPD and IPD sheets of OP-hospital. We have perused the entire medical record submitted along with complaint. It is clearly mentioned in the OPD slip that patient approached the OP/hospital on 12.8.2015 and initial diagnosis made was "DM II, HTN, p/w ACCHTN, LVF, CKD, Hyperkalemia, Thrombocytopenia." The patient''s age was 74 years. The admission sheet shows that the patient was admitted at 9.29 p.m. On 12.8.2015, the investigations reveal bilateral plural effusion. The Discharge summary also clearly reveals, the patient was discharged against medical advice (DAMA) with the final diagnosis as, "Accelerated Hypertension

With Left ventricular Failure,

With CKD with Hyper kalemda with thrombocytopenia

DM type 2

Hypertension."

4. The medical record reveals of OP-Hospital, the patient was investigated properly. The emergency treatment given was Inj. NTG 0.6 ml for IV, Inj Lasix 40 mg IV (40-40-20), Inj. ? Insulin according to sugar level. It is pertinent to note that, the discharge note is clearly mentioned as: "Pt. has been advised for further treatment but pt. attender wants to discharge against medical advise. Prognosis has been explained."

5. In furtherance, we have perused the medical record of Fortis Hospital. It revealed that the patient was shifted to Fortis Hospital at 12.21 on 13.8.2015. The discharge summary of OP/hospital is relevant. It is reproduced as under:-

"Mr. Jameel K, 74 years old male admitted with c/o fever with dyspnea since 3 days. On arrival to Emergency, creatinine was 8 mg/dl with base creat. Of 2.2. mg/dl. Chest x-ray showed bilateral infiltrations, ABG showed metabolic acidosis

& hyperkalemia. He was shifted to MICU for further management. Patient was drowsy * arousable on arrival. The CBC showed low platelet count and he was diagnosed as Dengue NS1 positive. The patient was given emergency dialysis and further treatment. The X-ray revealed signs of pulmonary Oedema. Despite all the treatment, the patient did not recover. There was persistently hypotensive and acidotic. In spite of all supportive measures, the patient died at 1.05 a.m.

6. Considering medical records of OP/hospital and Fortis Hospital, correctness of which is not challenged in the complaint, it is clear that the patient is of 74 years old suffering from multiple ailments like DIA 2 dialysis and known hypertensive. He was already known case of CKD. Initially, he approached OP-hospital wherein he was investigated and admitted in ICU. For urinary retention, Inj. Lasix 60 mg, IV was given. Also for hypertension, he was given Inj. NTG 0.6 ml. per hour IV. The patient was kept under observation to stabilize, but the relatives of patient took discharge against medical advise. The doctors at OP-hospital clearly recorded that the patient was advised for further treatment and prognosis was explained. At the time of discharge also, the patient was critical, which is clearly evident from the medical record of Fortis Hospital. The death of patient was due to multi-organ dysfunction syndrome because of pre-existing diseases including suspected dengue fever. In our view, the doctors have done their entire efforts to treat the patient. Therefore, we do not find any lapse or any short comings in the treatment given by OP-hospital. It is well settled that ''no cure is no negligence''.

7. Therefore, on the basis of foregoing discussion, we do not find any reason to admit this complaint. Hence, it is dismissed at the admission stage.

