
(2015) 05 NCDRC CK 0115

In the National Consumer Disputes Redressal Commission

Case No : 372 of 2001

MRS. JYOTI CHOPRA

APPELLANT

Vs

M/s. Indraprastha Medical Corporation Limited.

RESPONDENT

Date of Decision : 12-05-2015

Acts Referred:

Constitution of India, Article 226 -
Power of High Courts to Issue certain writs

Citation : 2015 3 CPJ 394

Hon'ble Judges : J.M. Malik, S.M. Kantikar

Advocate : S.K. Mishra, Lalit Bhasin, Sanjay Gupta, Ravi Tyagi, Gaurav Seth

Final Decision : Complaint dismissed

Judgement

"Careful pre-operative work-up of every transplant candidate is mandatory to improve post-transplant organ and patient survival. The workup should be tailored according to patients` specific conditions, by a multidisciplinary approach before proceeding to transplantation".

This is a peculiar complaint, before this Commission, that two distinct grounds of negligence were advanced on behalf of the complainant, Smt.Jyoti Chopra The first one is concerned with removal of both kidneys (bilateral nephrectomy), whereas the second arm of the complaint is concerned with the management of patient after nephrectomy. It was contended that the OP doctors failed to perform a renal transplant despite availability of kidney donor. The facts:

1. The complainant Smt. Jyoti Chopra"s husband named Mr. Praveen Kumar Chopra, (since deceased- herein referred as "Patient") consulted Dr. Vijay Kher, a Nephrologist of Indraprastha Apollo Hospital i.e. OP-1 on 13.2.1998. The patient was diagnosed as a case of Chronic Renal Failure (CRF) with bilateral Nephrolithiasis (stone). But, further, Dr.Kler neither investigated the patient nor advised any treatment or dialysis. As a mandatory requirement of OP hospital, patient was asked to sign authorization for operation, complainant alleged that, it was contrary to the principles enshrined in the Code of Medical Ethics.

2. In the month of September, 1999, patient consulted Dr. Ramesh Kumar, Head of Department of Nephrology, at Batra Hospital, New Delhi, wherein he was diagnosed as B/L obstructive Uropathy with CRF and advised urgent kidney transplant. The expenditure was informed as Rs.3,00,000/-. Thereafter, on 17.09.1999, patient approached Dr. M.R. Rajasekar, (OP-3) at OP-1 hospital, who advised urine Culture and Sensitivity(C/S) for Urinary Tract Infection (UTI). Same day, the OP-3 told that patient's condition, as per C/S report, Norflox, was sensitive. It came as a surprise to the complainant that, how OP-3 decided without report of C/S, because, C/S test reporting will usually take three days. Therefore, it was negligence and dereliction of duty by OP-3. On the same day, Dr. A.S.Soin, Sr. Consultant, Department of Multi-Organ Transplant/Hepato Biliary Surgery, issued a certificate that the patient was suffering from Chronic Renal failure (End Stage Renal Disease (ESRD))

3. On 30.09.1999, Dr. Rajasekar, issued another certificate that "patient is being treated under my care" and before the kidney transplant, he must undergo laparoscopic Bilateral Nephrectomy operation and the additional cost will be around Rs. 2.00 lakhs. It was further informed that, after removing both the kidneys, patient will need dialysis, thrice a week, until the transplantation. Therefore, it was alleged by the complainant that, that Dr. Rajsekar made a diagnosis on the basis of old records, without conducting any tests. Thereafter, the patient was forced to be admitted to OP-2 hospital on 17.09.1999 for B/L laparoscopic nephrectomy. The evaluation of the patient was normal, there was no severe UTI, and hence there was no pyelonephritis.

4. OP-3 removed both the kidneys on 08.10.1999, whereas the confirmatory test was done on 11.10.1999 and patient was discharged, but the patient was readmitted for 2 nd time, from 24.10.1999 to 6.11.1999, and again on 3 rd time, on 15.11.1999, for various complications and infections in various parts of body. Therefore, it was wrong on part of OP that, soon after the B/L nephrectomy, OP should have transplanted the kidneys. It was alleged that, dialysis was carried only from 28.09.1999 to 05.11.1999 and thereafter no dialysis was done for the reasons best known to OP-3.

5. It was alleged that, with malafide intention, the OP-3 removed both kidneys, before receiving report of serum oxalate. The patient was kept 51 days waiting for transplantation, without dialysis. Subsequently, patient died on 26.12.1999. Therefore, the OPs indulged in series of mal-practice and negligence. The OPs have neither investigated nor treated the patient properly, but, unnecessarily delayed the treatment for 20 months, which caused death of patient. The OPs treated patient in most haphazard and very casual manner. The complainant spent approximately Rs.12.00 lakhs, while the initial estimate was given only for Rs.3.25 lakhs. Hence, complainant filed complaint before this Commission and prayed to grant the compensation as claimed i.e. Rs. 2.35 Crore, with interest @ 18% p.a.

6. The complainant produced medical records and literature. Complainant relied

upon a number of judgments of Hon'ble Supreme Court, and that this Commission namely; i. III (2004) CPJ 744 - Dr. M.L. Deb Vs. Rose Mary Lingdoh

ii. III (2005) CPJ 9(SC) - Jacob Mathew (Dr.) VS. State of Punjab & Anr.

iii. III (1995) CPJ 1(SC) - Indian Medical Association Vs. V.P. Santha & Ors.

iv. III (2004) CPJ 29(NC) - Dr. Kaligownden Vs. N. Thanga Muthu

v. (2004) CPJ 17 (SC) - Malay Kumar Gangoly Vs. Sukhmar Mukherjee (Dr.) & Ors.

vi. (2004) 8 SCC 56 - Savita Garg (Smt) Vs. Director, National Heart Institute.

vii. AIR 1969 SC 128 - Dr. Laxman Balkrishna Joshi Vs. Dr. Trimbak Babu Gadbole Defense:

7. The OPs resisted the complaint by filing the written version, The Medical Superintendent, Dr.Ritu Rawat filed an affidavit on behalf of OP-1 hospital, and Dr. M.N. Rajasekar, the OP-3 filed his affidavit evidence. As per the affidavits of OPs, the patient came to the hospital, for the first time, on 13.02.1998, with advanced and untreated CRF caused by Obstructive Uropathy (recurrent stones in both kidneys) for which he had undergone multiple operations in the past, in other Hospitals, on both, right and left kidneys. Dr. Vijay Kher, who attended to the patient at the Apollo Hospital on 13.02.1998, had noted that the patient had serum creatinine of 4.8 mg/dl with history of weakness and fever in August, 1997. The patient was diagnosed as having CRF due to bilateral nephrolithiasis (stones in both kidneys). Thereafter, the patient was brought to the OP Hospital, only on 17.09.1999, i.e. approximately, after 1 year and 7 months after the patient was diagnosed to be suffering from CRF with frank UTI caused by organisms E. Coili and Klebsiella. Patient was managed appropriately by expert team of doctors in OP hospital, who are experienced and specialized in their respective fields. However, in spite of appropriate and timely treatment, the patient died due to severe infection .The patient's infection was more resistant to the treatment. The patient was also detected to have lung infection due to tuberculosis. Also, the patient was found to be infected with Acinobacter and had bleeding disorder causing upper gastrointestinal bleed and bleed in the left pleural cavity. As a result of combination of above factors, patient suffered seizures also. Submissions and Findings:

8. We have heard the learned counsel for the parties, perused the affidavits, interrogatories and the answers given by both the parties. Also, perused medical records and relevant medical literatures.

9. The counsel for complainant vehemently argued that the instant case is rarest of the rare case, where negligence on the part of the OP is writ large and OPs preferred to keep silent on legal notice, served on them, on 15/09/2001. The counsel also raised objection against the opinion received from the board, AIIMS, because it's devoid of treatment details. The counsel reiterated the facts

mentioned in the complaint. The counsel's arguments were advanced on following main points:

- a. Why a laparoscopic bilateral nephrectomy operation was a precondition to a kidney transplant? Why not the total cost of the operation was indicated at the first instance.
- b. Why the patient was discharged uneventfully and without most urgently kidney transplant?
- c. Why more than six operations were performed on the patient during the stay in the Hospital, which ultimately resulted into death of the patient on 26.12.1999.
- d. The consent was given under duress
- e. The opposite parties have departed from excepted line of treatment.

10. The counsel further submitted that, the family members of the patient kept silent in the fear of threats and inherent danger of causing damage to the patient. Taking benefit of it, the opposite parties had carried out as many as six more different types of operative/invasive processes during the period from 15.11.1999 to 26.12.1999, on the patient, besides innumerable pathological and other tests, including dialysis, were also carried out, but the much needed and most urgently required lifesaving process of kidney transplant for which the patient had initially gone to much hyped hi-tech institute i.e. OP- 2, was never ever carried out. Ultimately, pushing the ill-fated husband of the complainant into the domain of death.

11. The rival arguments advanced by counsel for OP, that the patient had severe malnutrition and advanced renal failure which precluded the patient from recovering after removal of infected kidney. The facts of medical expenses and consequences were explained to the patient's relatives. The counsel further submitted that it is imperative to wait for a few weeks, after performing a bilateral nephrectomy, because healing and recovery is needed before undertaking the kidney transplant operation. The patient was needed to surgical explorations for removal of fluid collected in the spaces from nephrectomy bed. The fluid culture was taken and appropriate medicines were given. To treat respiratory distress, the cardio-thoracic surgery team led by Dr. B. N. Das performed chest operation to remove the blood stained fluid in the pleural cavity and to place intercostal drainage tubes. It was performed after taking informed consent. A tracheostomy (tube in the breathing pipe) was performed by a consultant ENT Surgeon to alleviate breathing difficulty. OP doctors performed procedures like endoscopy to control bleeding from the stomach, aspiration of fluid collection in the nephrectomy bed by ultrasound or CT guidance. Since, the immunity in the patient was decreased; there was platelet dysfunction, which was the cause of delayed healing. The patient was suffering from respiratory distress due to superadded lung infection. Polymerase chain reaction (PCR) test for Tuberculosis was positive. Thus, with all those ailments, the patient suffered

cardiac arrest.

12. Counsel for OP further submitted that, the provisionally transplant was decided on 29.09.1999, subject to, only if the patient would be cleared of all infections and after doing blood oxalic acid level test to rule out Primary Oxalosis. The OPs informed the future course of treatment to the patient and his relatives. As per the affidavit of Dr. Rajasekar (OP-3), the patient visited the OP-1 hospital in February, 1998, he was diagnosed as advanced and untreated CRF caused by obstructive uropathy. Thereafter, the patient took consultation from various doctors and again came to OP-2 hospital, for treatment, in September, 1999.

13. It is pertinent to note that, the complainant herself in para 6 of her complaint averred that, the patient had never undergone dialysis, till he was advised by the OP-3 on 28.09.1999. Thus, it clearly indicates that patient did not follow a systematic line of medication which resulted in deterioration of the health of the patient. Thus, since very time of inception, the patient was not in good health.

14. OP-3 categorically stated that, transplant will only be started, once investigation is treated effectively and accordingly, he referred the patient to Nephrologist, Dr. A. Mishra, for appropriate medical therapy, dialysis etc., but the patient did not follow the advice, immediately, but consulted the Nephrologist, after a long period. The B/L nephrectomy was performed as both the kidneys were totally infected and failed. Thereafter, the patient was given regular dialysis. Therefore, we do not find any negligence.

15. The patient, even after 2 weeks, continued to have fever and evidence of UTI because of long standing persistent kidney stone disease. Hence, he was further diagnosed as "chronic pyelonephritis" As both the kidneys were badly infected and nonfunctioning, therefore, Dr. A. S. Soin performed Bilateral Nephrectomy, on 07.10.1999 . OP did not give any assurance to the family members of patient, about the kidney transplant and that it should be carried out, within a week of removing the kidneys. Therefore, the OP had properly investigated the patient and appropriate medical treatment was given, under supervision of Senior Consultants. The counsel further submitted that on humanitarian ground, the consultants offered their services free of cost, from 25.11.1999. Despite this, the patient could not be saved. Therefore, we are of considered view that, the OP had properly investigated the patient and appropriate medical treatment was given under supervision of Senior Consultants.

16. We have perused the Expert Opinion given by AIIMS Medical Board dated 29.10.2013. The Board consisted of Dr. Bhowmik - Chairperson, Professor of Nephrology, Dr. Sandeep Aggarwal - Member, Professor of Surgery, Dr. Naval K. Vikram - Member, Addl. Professor of Medicine and Dr. Shweta - Member Secretary, Department of Hospital Administration. They reviewed medical record and investigations of the patient Late Mr. Praveen Kumar Chopra and opined as following; " the renal transplantation is never an emergency life-saving surgery, since patients of End-stage Renal Disease can be sustained indefinitely on hemo-

dialysis; and the mere presence of a kidney donor does not mean that renal transplantation should necessarily be performed in a hurry. This patient had an infected urinary tract with residual renal stone and bilateral hydronephrosis. Hence, it was completely justified to perform pre-transplant bilateral nephrectomy. In fact not investigating for causes of recurrent stone disease, and not performing bilateral nephrectomy would be considered deviation from standard clinical practice.

Dialysis patients are always at high risk of intra and peri-operative surgical complication. It is our considered opinion that multiple interventions were necessary and per se there is no evidence of medical negligence."

17. It is also pertinent to note that, as per prescription note (Annexure -P1) dated 14.9.1999, only three days prior to coming to the OP Hospital, the patient took a consultation from Dr. Ramesh Kumar, Nephrologist at Batra Hospital. He also confirmed that, the patient was indeed suffering from bilateral obstructive uropathy which was a cause of persistent UTI, hence advised for urgent kidney transplant. The prescriptions and clinical notes entered by OP-3 (on page no. 78, Vol. I) show us, that OP-3 advised urine analysis and informed to stop Norflox after the days' therapy and get urine C&S after 48 hours and also requested Dr. A. Mishra to review the files and follow up, in his absence. Conclusion:

18. To know the indications for bilateral nephrectomy, we have perused an article published in British Journal of Surgery "Bilateral nephrectomy before transplantation: indications, surgical approach, morbidity and mortality" of Nuffield Department of Surgery, John Radcliffe Hospital, Oxford, UK (Br J Surg 1991 Mar;78(3):305-7). The main indications for bilateral nephrectomy are hypertension resistant to medical therapy, persistent symptomatic renal infection, severe renal protein loss and occasionally polycystic kidneys or bilateral renal tumors.

19. We have perused the medical records and noted that, after 9 days", after discharge, the patient was brought to the OP hospital, on 15.11.1999, with history of mental obtundation /seizures and respiratory distress. The consultation note of Dr. Sanjeev Jasuja, clearly mentioned that the patient had persistent infection prior to removal of native kidneys by two notorious bacteria-E Coli and Klebsiella. The patient had low grade fever in spite of removal of the source of infection and he

was treated extensively with broad spectrum intravenous antibiotics, followed by oral antibiotics. He advised for X-ray chest, CT scan and ultrasound of abdomen.

20. In our view, availability of a suitable donor alone was not enough to proceed with the major operation of a kidney transplant. The patient's USG dated 20.10.09 again showed collection of fluid in the kidney-bed, infected with Klebsiella. The fluid was removed by surgical exploration of both the kidney-beds. Again, on 1.11.1999, he had ultrasound guided aspiration of fluid collection. Therefore; kidney transplantation is not a miracle therapy for kidney

failure. It could be done only when the condition of the patient is fit for transplantation and in the meanwhile, the patient can be treated properly by medical therapy and regular dialysis.

21. The clinical notes made by Dr. V. Kher, (Exhibit OP-1/A-1) are as follows:
Annexure 1: B/L renal stone nephron-lithotomy and pylo-lithotomy done at AIIMS in 1981

- A symptomatic till 1995
- Seen from plural thickening in 1995
- Again in AIIMS found to have chronic renal failure without any significant obstruction
- Seen also at Bombay - S. Creatine 4.8 mg in August, 1997 Hb 10.2 gm

Occasional fever and weaknesses.

Annexure 3 showed-PCR report as MTD DNA positive Annexure 4- revealed UTI and E. Coli 2 ++ Post on Norfox advise culture sensitivity and follow up.
Annexure 5- The clinical biochemistry report dated 25.9.1999,

S. Urea : 220

S. Creatinine : 12.9

S. sodium (Na) : 142

S. Potassium(K) : 3.8"

In the Discharge summary from OP hospital, the diagnosis mentioned, was;

- CRF
- HTN
- ESRD
- Chronic pyelonephritis.

The operative procedure: B/L Laproscopic nephrectomy under GA on 08/10/1999 & kidneys were sent for histopathology, Path report Chr. Pyelonephritis Post-operative Period .

Post-operatively, he continued to have fever, which was treated with vancomycin amikacin & Fortum.

22. After the discharge from the OP hospital following nephrectomy of the infected kidneys, hemodialysis was duly carried out on the patient. The kidney transplantation was never an urgent requirement, since absence of kidney function can be managed medically, on dialysis, even for years" together. Availability of a willing and suitable kidney donor is, by no means, an indication to proceed with kidney transplant. Since the patient had developed fever after

discharge from the hospital, he was advised admission to hospital to evaluate the cause of fever. Thereafter, on 25/11/1999, the patient was transferred to the free patient's ICU. Hence, there was no financial implication to the family. Since the patient further, deteriorated due to poor general health, he was never found fit, at any stage, for a kidney transplant.

23. In this context to know about Pre transplant evaluation of patient, the indications and contraindications of transplant, we have gone through the medical text book on Kidney Transplantation -Principles and Practice by Peter Morris. We found that, Indications for Kidney Transplantation are;

- i) End Stage Renal Disease
- ii) Estimated renal function
- iii) Significant symptoms or signs of uremia such as nausea, loss of appetite, insomnia, or chronic fatigue; or acid-base or electrolyte irregularities unresponsive to oral treatment.

The Absolute Contraindications to Kidney Transplantation are;

- i) Active infection
- ii) Active malignancy
- iii) Active use of drugs of abuse, alcoholism, or psychosis
- iv) Medical noncompliance
- v) BMI > 40.
- vi) High probability of peri-operative mortality
- vii) Anatomy that makes transplantation technically impossible

24. One article "The candidate for renal transplantation work-up: medical, urological and oncological evaluation." Arch Esp Urol Jun;64(5):441-60; which revealed us that; Renal transplantation prolongs life, reduces morbidity, improves quality of life, and enables social rehabilitation of patients with end stage renal disease (ESRD). In ESRD patients medical background and comorbidities are crucial at the time of considering a renal transplant candidate because they can determine the procedure success. Pre transplant medical evaluation aims to diagnose, treat, and optimize any preexisting disease, and how these can interfere with patient and graft survival. It is important to consider age, cardiovascular disease, presence of diabetes mellitus, coagulation disorders, obesity, gastrointestinal diseases, ESRD situation and associated complications, active infection and noncompliance with treatment and follow up. A thorough clinical history must be compiled, Urological requirements for successful renal transplantation are the absence of urinary infections, a compliant and continent reservoir, and a reliable method of achieving complete bladder evacuation. Thus, pretransplant urological evaluation aims to diagnose, treat, and optimize any preexisting urological disease that can jeopardize transplant evolution.

Each case must be evaluated on an individualized basis, and the decision relating to treatment is to be taken in the context of a multidiscipline team. The urinary tract of the candidate for renal grafting must be sterile and have an efficient reservoir. It is not always possible to predict when a patient will become a candidate for transplant. Many of these more urgently listed transplant candidates are hospitalized in an intensive care unit where they may be colonized or infected with multidrug resistant organisms (MDROs).

25. We put reliance upon, the ratio laid down by the Hon"ble Supreme Court in the Appeal (Civil) 1949 of 2004 dated 16.01.2008 in the case of Sameera Kohli Vs. Dr. Prabha Manchanda & Anr . It states that, "it is for the doctor to decide, with reference to the condition of the patient, nature of the illness and the prevailing established practices as to how much information regarding the risk and consequences should be given and how they should be couched in the best interest of the patient. A doctor acting accordingly with normal care and in accordance with a recognized medical practice cannot be said to be negligent merely because body of opinion taken a contrary view. In modern medicine and surgery dissection of the various thing a doctor has to do in the exercise of his whole duty of care owed to his patient is neither legally meaningful nor medically practicable. In this instant case the OP-3 decided the mode of treatment on the basis of condition of patient. The act of OP-3 was a standard duty of care.

26. In Achutrao Harbhau Khodwa Vs. State of Maharashtra 1996 Vol 2 643 the Hon"ble Supreme Court has held "The skill of medical practitioner differs from doctor to doctor. The nature of the profession is such that there may be more than one course of treatment which may be advisable for treating a patient. Courts would indeed be slow in attributing negligence on the part of a doctor if he has performed his duties to the best of his ability and with due care and caution. Medical opinion may differ with regard to the course of action to be taken by a doctor treating a patient, but as long as a doctor acts in a manner which is acceptable to the medical profession and a court finds that he has attended on the patient with due care skill and diligence and if the patient still does not survive or suffers a permanent ailment, it would be difficult to hold the doctor to be guilty of negligence. In the instant case the OP-3 and Dr,Soin attended the patient with due care and diligence.

27. In spite of every effort, the patient"s fever and infection continued, hence transplantation was not possible, therefore unfortunately the patient died. In our view, OPs are not responsible. This view dovetails from the case " Martin F. D" souza vs. Mohd. Ishfaq ", 2009 CTJ 352 (Supreme Court) (CP) in which the Hon"ble Supreme Court was pleased to observe as under:- " 41. A medical practitioner is not liable to be held negligent simply because things went wrong from mischance or misadventure or through an error of judgment in choosing one reasonable course of treatment in preference to another."

" 49. when a patient dies of suffers some mishap; there is a tendency to blame

the doctor for this. Things have gone wrong and, therefore, somebody must be punished for it. However, it is well known that even the best professionals what to say of the average professional, sometimes have failures. A lawyer cannot win every case in his professional career but surely he cannot be penalized for losing a case provided he appeared in it and made his submissions."

28. Therefore, on the basis of forgoing discussion we are of considered view that the OPs treated the patient as per standard of practice. There was neighter deficiency in service nor any negligence in diagnosis and treatment of the patient. The complainant failed to establish negligence on the part of OPs, therefore we, dismiss the complaint. There shall be no order as to costs.