KOVAI MEDICAL CENTER AND HOSPITAL LIMITED
NABH Accredited Hospital Excellence in Healthcare
99, Avanashi Road, Coimbatore - 641 014. INDIA | Phone : (0422) 4323800, 4324000, 6803000
Web : www.kmchhospitals.com | CIN No : L85110TZ1985PLC001659

15.10.2025

Ref: KMCH/SEC/SE/2025-26/ 2486

To
Corporate Relationship Department
BSE Limited
1st Floor, New Trading Ring
Rotunda Building, P.J.Towers
Dalal Street, Fort
Mumbai - 400 001

Dear Sirs,

Sub: Disclosure under Regulation 30(2) of the Securities and Exchange Board of India (Listing Obligations and Disclosure Requirements) Regulations, 2015.

Ref: Security ID: KOVAI, Security Code: 523323

Pursuant to regulation 30(2) of the Securities and Exchange Board of India (Listing Obligations and Disclosure Requirements) Regulations, 2015 (LODR Regulations) read with clause 20 of Para A of Part A of Schedule III of the LODR Regulations, we enclose herewith the details of Order for the Settlement of Proceedings received by the Company from the Tamilnadu State Consumer Disputes Redressal Commission, Chennai.

The disclosure as required under Regulation 30 of SEBI(LODR) Regulations,2015 is enclosed as Annexure-A.

We request you to kindly take the above intimation on record.

Thanking you,

Yours truly
For Kovai Medical Center and Hospital Limited

R.Ponmanikandan
Company Secretary

Kovai Medical Center And Hospital Limited CBE-14

EXCELLENCE IN HEALTH CARE 35th 1990 - 2025

Annexure-A

Name of the authority	Tamilnadu State Consumer Disputes Redressal Commission, Chennai
Nature and details of the action(s) taken, initiated or order(s) passed	Court Order for the Settlement of Proceedings
Date of receipt of direction or order, including any ad-interim or interim orders or any other communication from the authority.	Official Order Copy received on 14.10.2025
Details of the Violation(s)/ contravention(s) committed or alleged to be Committed	Alleging Medical Negligence
Impact on financial, operation or other activities of the listed entity, quantifiable in monetary terms to the extent possible	Rs.15,00,000/-. The Company is planning to file an appeal.

Date of filing : 02.11.2009.

IN THE TAMIL NADU STATE CONSUMER DISPUTES REDRESSAL COMMISSION, CHENNAI.

Present: **Hon'ble Thiru Justice R.SUBBIAH ... PRESIDENT**

C.C. No.1 of 2011

Orders pronounced on: 29.08.2025

K.S.Muralidharan,
A6, Shree Durga Apartments,
No.186, R.K. Mutt Road,
Chennai-28. ... Complainant

vs.

1.The Chairman,
Kovai Medical Center and Hospital,
Avinashi Road,
Coimbatore 641 014.

2.Dr.Vivek Pathak,
Nephrologist,
Kovai Medical Centre and Hospital,
Avinashi Road,
Coimbatore 641 014.

3.Dr.Devadas Madhavan,
Surgeon,
Kovai Medical Center and Hospital,
Avinashi Road,
Coimbatore 641 014. ... Opposite Parties.

For Complainant : Mr.V.Balaji
For Opp. Parties : M/s.Iyer & Thomas

This Complaint came up for final hearing on 30.08.2023 and, after hearing the arguments of the counsels for the parties and perusing the materials on record and having

stood over for consideration till this day, this Commission passes the following:-

ORDER

R.Subbiah, J. – President.

Alleging, in nutshell, that the death of his wife was due to medical negligence on the part of the OPs by their failure to do a proper diagnosis & a meaningful clinical evaluation regarding her extent of ailments before the procedure/Bilateral Nephrectomy and to give adequate information under the informed consent regarding the known post-operative complications in the given clinical condition, the complainant seeks this Commission to hold the opponents liable under the consumer law and to direct them to pay to him Rs.10 lakh each under two heads viz., compensation towards deficiency in service and damages towards mental agony and repay the excess amount to the tune of Rs.3.25 lakh with interest @ 18% p.a., besides costs.

2. It is the crux of the complainant's case that his wife was suffering from renal failure, for which, she was

taking treatment at Malar Hospital where, the consultant/Nephrologist advised her for kidney transplantation; that, after a second opinion from one more Nephrologist, on 13.02.2008, the patient was taken, along with her entire medical reports, to the 1st OP/Hospital which instructed them to arrange for a kidney donor and one Mrs.M.Kumari volunteered to donate a kidney; that, after obtaining the consent for removal of kidneys, the patient had undergone the procedure/nephrectomy at the hands of OP Nos.2 and 3 on the scheduled date/19.02.2008, however, the said OPs removed only one kidney and stated that the patient can survive with the remaining kidney and also assured that 6 weeks after healing of the wound, transplantation would be carried out; that, while the patient was in the ICU, the dialysis scheduled on 08.03.2008 could not be done due to dip in the BP level and it was performed only on 10.03.2008; that on 11.03.2008, the condition of the patient was said to be critical and she was declared dead on that date at 11.15 PM. and a certificate was issued that the death was due to cardiac arrest; that the 1st OP transplanted

the donated kidney to some other patient without the knowledge of the complainant; that the plea of the complainant to furnish discharge summary ended in vain; and that the death of the patient was due to gross negligence of the OPs and the act of the 1st OP in having transplanted the donated kidney without the knowledge of the complainant amounts to unfair trade practice and hence, the present complaint.

3. The 1st OP resisted the complaint by filing a written version, which is adopted by the rest of the OPs/Doctors, and it is inter alia stated therein thus:-

The patient not only had the renal failure issue but, her medical records, as a whole, revealed that she was suffering from

> **Bilateral** Autosomal Dominant Polycystic Kidney disease-chronic;

> Kidney failure on maintenance hemodialysis;

> Severe Left Ventricular Dysfuncion; and

> Recto Vaginal Fistula.

Considering the patient's overall condition and in confirmation of the advice for a kidney transplant given by the doctors at Chennai, the patient was advised to go in for kidney transplant. Bleeding of the cysts coupled with infection and the abnormally large size of the kidney did not permit the retention of the old kidney and there was every possibility that the infected kidneys could affect the transplanted (fresh) kidney also. The best option and treatment process in the circumstances was to remove the infected kidneys prior to transplant because the bleeding from the cysts showed that the patient was endangered and there was also no possibility to postpone the procedure. It was, after a proper explanation, due written consent was obtained for removal of the kidneys by way of bilateral nephrectomy which was scheduled on 19.02.2008.

It was only after a complete evaluation, the surgery was planned on the aforesaid date and, during the course of the procedure, it was found that the right kidney was severely affected with pus coming out there-from and also,

the patient's heart rate was slowing down along with a dip in the BP level and hence, it was decided to remove the severely infected kidney and to remove the other one at a later stage, since the removal of the 2nd kidney was not an emergency especially in the given clinical condition of the patient.

As pus was leaking from the right kidney, the patient had developed sepsis which had driven the patient to suffer multiple organ failure, due to which, despite all resuscitating measures, she had fallen into bradycardia followed by respiratory arrest and was declared dead at around 11.15 PM on 11.03.2008.

No assurance was given by the OPs that transplantation could be carried out after six weeks or that it was told that the patient would recover in the meantime. The death of the patient was only due to the complications arising from sepsis which is not an unexpected complication but an anticipated risk that was weighed even prior to surgery by the doctors.

Since the transplantation could not be done to the patient on account of the complication that had set in, with

due permission from the authorities, the kidney of the intended donor was used for another patient and hence, the complainant cannot have any grievance in that segment nor he can demand reimbursement of the charges incurred for the mandatory tests performed on the donor before transplantation; as such, there is no scope to allege any unfair trade practice.

By denying all other allegations, the OPs ultimately sought for dismissal of the complaint along with costs.

4. In order to substantiate the claim and counter-claim, both sides filed their respective proof affidavits and, while 45 documents have been marked at the instance of the complainant as Exs.A1 to A45, the OPs have filed 9 documents as Exs.B1 to B9.

5. Learned counsel for the complainant would primarily present his points as a preview by stating that the OPs failed to do a full-fledged diagnosis before proceeding to perform the procedure said to be involving REMOVAL OF

BOTH THE SEVERELY INFECTED KIDNEYS; that the informed consent is a ceremonial one since it is not signed by the professional/Doctor or Surgeon concerned, who is claimed to have explained the consequences of the surgery; that the post-operative infection suffered by the patient was nosocomial or hospital-borne in nature and that there is a clear unfair trade practice in diverting the donated organ to some other patient without even intimation to the complainant or refunding him the unnecessary charges received from him.

While elaborating the points, learned counsel states that the OPs themselves consistently admit that both the kidneys had become so large due to multiple abnormal cysts expelling blood and pus, yet, they speak rather in a very low pitch of volume or in a mute manner when it comes to the serious allegation of inadequate diagnosis at the 1st OP and their medical records also do not even show that, during the period in between the first day of admission and the date of surgery, the patient was kept under an antibiotic umbrella to contain the infection in the event of unilateral

nephrectomy especially when the procedure was elective in nature which means it was not performed on the same day of admission. It is the own claim and case of the OPs that the patient had urgently required removal of both kidneys and that is the reason, the complainant was forced to search for a donor and, after some herculean efforts, he succeeded in bringing a donor with a fond hope that his wife would get a successful transplantation. While so, the clinical action to advise a 'BILATERAL NEPHRECTOMY' meaning removal of both kidneys ought to have been preceded by a full-fledged examination of the patient through CT or MRI that would have given the current image regarding the size and infectious burden of the polycystic kidneys as well as the extent of pus formation or oozing of pus from the large polycysts, influencing the clinical mind to rightly plan the surgery or to manage the infection before hand and, more importantly, to get a meaningful informed consent by adequately apprising the patient that one of the imminent complications would be sepsis if the surgery atmosphere do not permit removal of both kidneys due to sudden eruption

of bradycardia or dip in BP Level since she is a cardiac-compromised patient. But, from the written arguments filed by the OPs, it could be well discerned that they did not order any such essential radiological tests except some routine lab examinations and, by largely relying upon the previous history, they proceeded to drive a big vehicle on tiny tyres – too heavy, too fast, never anticipating it might burst; as a result, they got stuck halfway by restricting the surgery to unilateral nephrectomy instead of bilateral nephrectomy and conveniently, they now attempt to wriggle away by citing the issue of sepsis, which occurred in the patient only due to the wrong planning of surgery and its impact that ultimately took away the valuable life of the complainant's wife.

Further, the attempt of the OPs to justify their action in getting a ceremonial informed consent, which is not valid either as per medical ethics or law, by citing Regulation 7.16 of the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002 and by stating that the possible complications are clearly highlighted in the informed consent, has to be repelled right

away for the reason that simply because the regulation does not explicitly speaks about Doctor's signature, in practice and as repeatedly held in the precedents, it is implicit and understood always that absence of signature or endorsement by the Doctor means that the professional duty on his part to explain the proposed treatment as well the possible complications arising there-from to the patient is not fulfilled; or, in other words, such signature is a critical part of the consent form that protects both the patient and the physician. The very same regulation relied upon by the OPs, with the very wordings contained therein '***before performing an operation, the physician should obtain in writing the consent***....", by itself imposes a clear obligation on the physician to get the consent and the compliance by him is understandable only if he endorses the consent form with his own signature; therefore, it is so absurd to whimsically interpret the said regulation to mean that it does not at all mandate signature by the physician. Secondly, while the consent form is in a printed format and a specific space is left therein to serve the purpose of

mentioning the details of possible outcome or complications in a particular surgery on individual basis, everything mentioned in a random manner in the printed format cannot be blindly borrowed to justify the lapse on the part of the OPs in not giving adequate details regarding a potential complication viz., sepsis, which led to cardiac failure. As such, there is a serious lapse on the part of the OPs in getting a proper and valid informed consent.

The OPs also failed to file the drug or nursing charts to prove the factum that, in order to treat the bacterial infection sustained through IV Cannula, Drug – Amphotericin B, which is the gold standard in treating such infection, was ever administered. In the face of the details surfacing from records, especially Ex.B3 Report regarding Culture & Sensitivity, dated 25.02.2008, carrying the finding 'Klebsiella SPS – Pseudomonas Aeruginosa', it is abundantly clear now that that the complainant suffered sepsis only subsequently during the course of her post-surgery treatment at the 1st OP.

Similarly, when the donor was brought by the complainant, if really the donated organ was used for some other patient, nothing prevented the OPs from specifically stating in their written version that they obtained necessary permission from the authority concerned and they could have filed a supporting document to that effect. By not doing so, by mere lip service, the OPs cannot justify their conduct of unfair trade practice in having utilized the donated organ at their whims and fancies.

By ultimately stating that the very medical records of the OPs highly militate against their own defence and the same are also sufficient to substantiate the case of the complainant, learned counsel pleads to hold the OPs jointly liable and to grant the relief sought for, in its entirety, by doing substantial justice.

6. Countering the above submissions, learned counsel for the OPs primarily contend that, from the averments made in the complaint, it is quite fathomable that the main grievance of the complainant revolves around the

alleged exorbitant costs charged at the 1st OP for the treatment of the patient and the complaint lacks solid pleadings nor it is supported by documents of substantive nature regarding medical negligence against the OPs and hence, there being no scope at all to demonstrate or sustain a case of negligence or deficiency, the complainant cannot seek for any consequential reliefs.

At the time of the patient's admission in the 1st OP, her medical condition was –

- She had multiple clusters of cysts in both the kidneys that were already swollen with great level of infection and removal of such infected kidneys had become a necessity to carry out transplantation;
- She was at the end-stage renal disease, for which, she was on hemodialysis, which is a life-sustaining medical procedure acting as an artificial kidney;

- She was at the verge of heart-failure owing to Severe Left Ventricular Dysfunction;
- Also, she had a Recto Vaginal Fistula (RVF), an abnormal connection between the rectum and the vagina and it is a condition by itself which is extremely debilitating since the fecal escape through the vagina was causing repeated infection of the urinary tract, for which, she was attempted a repair in the year 1986, but in vain;
- She was on anti T.B. Treatment since July-2007; and
- She used to pass bloody urine/hematuria which is indicative of the scenario that, in the given clinical condition, the cysts in the kidneys had begun to bleed;

- She also had fever which means that the fluid in the cysts of the kidneys were infected, resulting in pus formation.

While so, as could be seen from Ex.B2, pre-operative tests were conducted at the 1st OP to record that the patient had multiple cysts - in the liver, Ascites, Gall bladder, Spleen and Pancreas; Right Kidney was measuring about 17.4 CMs. while the left kidney 16.7 CMs. along with urea level at 122 mg/dL and Creatinine level-4.4 mg/dL. Similarly, Ex.B3 would go to show that wide range of lab tests were taken to further assess the condition of the patient. Ex.B9/Progress Record would evidence that the patient was monitored routinely for the scheduled bilateral nephrectomy. All the above documents would go to show that, at the time of admission, the patient was examined thoroughly by the Doctors, various tests including whole blood test – blood urea level, creatinine level were conducted at the 1st OP and, based on the reports, medications were prescribed for the patient to control various pre-existing medical conditions and only thereafter,

the surgery took place and hence, it is a quite absurd and mala fide allegation to say that proper pre-procedure medical protocol was not adhered to by the OPs.

Secondly, Ex.B3 Lab Test Report, dated 13.02.2008, revealed – CMV IGG-SERUM Positive, which means the patient was infected with Cytomegalovirus that usually causes asymptomatic infection after which it remains latent in patients and the said virus is a significant cause of morbidity and mortality among organ transplant recipients and it also leads to multi organ failure. As such, when the patient had infection even prior to the surgery, citing the latter reports to build up a point regarding hospital-borne infection would in no way help the already fragile and dooming case of the complainant.

Thirdly, Regulation 7.16 of the Indian Medical Council does not stipulate that doctor's signature is mandatory for the consent form to be valid. The very consent form self-speaks that the complications mentioned therein had been explained to the patient by the Physician and therefore, it is unassailably a valid document in the eye

of law, especially when the patient herself had signed it after understanding what was explained to her by the physicians. By overstretching the scope of the above Regulation with his own interpretation, the complainant cannot succeed to gain anything.

Fourthly, in the face of the fact and position that neither the donor nor any other person has ever raised any complaint before the appropriate authority under the Transplantation of Human Organs and Tissues Act, 1994, there cannot be any grievance for the complainant over the organ utilized for some other patient and there is no reason or basis for him to seek refund of the charges paid for the tests conducted on the donor since those tests were mandatorily required to be conducted on her prior to transplantation.

By referring to a couple of decisions reported in ***2008 (17) SCC 491 (Bachhaj Nahar vs. Nilima Mandal & another)*** for the proposition that without pleading, no amount of evidence can be looked into for granting any relief and the other one in ***2021 (10) SCC 291 (Dr.Harish***

Kumar Khurana vs. Joginder Singh & others) for the ratio that Doctors shall not be held liable on the basis of mere legal principles and general standard of assessment sans medical evidence on highly technical medical issues, learned counsel ultimately adds that the allegations made here without any medical literature or expert opinion are so bald and blunt that they do not even give rise to any cause of action for any sort of negligence or deficiency on the part of any of the OPs especially when the patient, who was suffering from multiple diseases, unfortunately died owing to her fragile system susceptible to infection and sepsis, despite the best medical care and treatment given by the OPs and he re-states ultimately that, there being no case made out against the OPs, the complaint may have to be dismissed at the threshold, holding it frivolous, malicious and vexatious in nature.

7. The logical trajectory of these arguments by both sides culminates in the stemming of the following core issues for consideration:-

a) Can the Hospital and its Doctors' Team that proceeded to perform a really major surgery of bilateral nephrectomy or removal of both kidneys on a patient, who admittedly had serious co-morbid issues of severe left ventricle dysfunction which admittedly had the potentials to produce bradycardia / slowed heart rate that may reduce the scope of surgery into a unilateral removal and also RVF which may cause fecal contamination to independently cause sepsis,

without any proof to show that she was subjected to CT or MRI scans in order to be clinically sure about the feasibility to remove both the infected kidneys and also to show that a Cardiologist was consulted regarding her cardio fitness for bilateral removal or that a collective opinion of Colorectal Specialist / Uro-gynaecolgist & an Infectious Disease Specialist was ever obtained regarding sepsis, and eventually encountered during surgery the issues of

'slowing down of the heart rate and a dip in the BP level', justify the deviation from bilateral to unilateral nephrectomy on the premise that the right kidney alone was severely infected and that removal of the other kidney was not an emergency which justification is a glaring contradiction to the very own version of the OPs that both the kidneys were having large polycysts and excreting blood and pus which clinical condition had admittedly / ultimately

necessitated bilateral removal and that is why the complainant had arranged for the donor of the organ; that too, without adequate risk information under the consent form that there may also be prospects for a unilateral removal which may, in turn, lead to sepsis, a commonly known post-surgery complication in the given clinical condition of the patient?

b) Whether the decision to perform the surgery was

based on a limited review of previous medical reports & some current lab tests rather than a comprehensive or updated pre-procedure evaluation of the high-risk category patient, by a multidisciplinary team of Specialists?

c) Whether the argument of the OPs that, in the light of the Regulation of the Medical Council cited by them, the informed consent sans the signature of the Physician cannot be said to

be invalid, is hectic enough to downplay the grievance projected in that regard by the complainant?

d) Is there any substance in the grievance of the complainant against the 1st OP/Hospital in having utilized the donor's organ for some other patient, after extracting charges for the pre-transplantation tests conducted on the donor?

e) To what relief, the complainant is entitled to?

8. Before proceeding to deal with the points, let us advert to a core aspect that what a consumer, who is said to be a victim of medical negligence, particularly in a scenario like the present set of facts, requires to express in the pleadings is –

> Existence of a relationship of patient and doctor/medical care provider that would denote a duty of care,

> Specific acts of omission on the part of the Doctor or Hospital that amounted to breach of duty, and

> Proximate causal link between the breach of duty and the injury resulted there-from to the patient and the consequential damages sustained.

If those details are accounted for in the pleadings, there cannot be any basis for the opponents to argue that the pleadings are sparse or not broadly detailed to bring home

any negligence, especially when the medical records of the OPs themselves bring to surface some serious nature of glaring lapses that defy their defence. Secondly, while expert opinion is a valuable material in medical negligence cases connected to complex procedures where professional judgment is involved and in cases where differing medical opinion exists regarding what constitutes the standard of care, it is not a rigid or mandatory pre-condition or a straitjacket requirement in cases where negligence is per se apparent in the light of the facts borne out by records or where the facts are non-technical in nature and things can be understood even by laypersons.

The reason why these points are relevant to be mentioned beforehand is – one of the main/primary lines of attack by the OPs against the complainant is that the latter had concentrated in the pleadings mainly the issue of exorbitant charging by the 1st OP and that the narrative is lacking in respect of negligence, however, a perusal of the pleadings in the complaint, on the contrary, shows that it pointedly mentions about the existence of relationship

between the parties as patient and medical care providers and also the surgery plan informed to the patient viz., removal of both kidneys and the deviation during the procedure viz., removal of one infected organ alone instead of bilateral removal, as well as the consequences that had flown there-from, etc. which are solid factual pleadings that revolve around medical negligence and, of course, the narrative regarding the exorbitant charging by the 1st OP is broader in extent and that does not mean, it diluted the facts and the factum regarding negligence and secondly, the present facts and circumstances covering the alleged negligence are so simple and straightforward that the same fall within the realm of ordinary understanding and common prudence and the nature of the grievance/issue is such that it does not involve any intricate or specialized medical procedure, diagnosis or judgment that would otherwise demand a cumbersome professional interpretation. In other words, in a case of this nature where the standard of care is so apparent that there is no expert opinion needed to explain what a reasonable and

competent medical practitioner or hospital would have done, the contrary argument that absence of expert evidence is fatal to the case would not hold water before this Commission.

9. Now, coming to main discussion, inasmuch as issues-a & b are intertwined, they are dealt with and answered together.

At the first instance, let us point out that, although the written version filed by the 1st OP/Hospital is adopted by the rest of the OPs, while dealing with the core spectrum of surgery, the said document does not even speak about the specific role played by each of them, in terms of ordering diagnosis, doing pre-surgery follow up and also surgery. It appears, in an endeavor to frustrate the process of drawing any adverse inference, the written version is seemed to have been drafted in a lavishly generalized terms that it does not even mention the name of the physician or surgeon who explained the details of surgery and prognosis and also the names and respective roles of the Doctors

comprising the Team which ought to have had a Heart Specialist especially when the patient had a serious cardiac problem making the cardiologist's involvement non-negotiable and requiring his direct or on-call presence during the perioperative period a critically safety measure. The reason to highlight this aspect is, no records of the 1st OP including Ex.B8-Operation Notes, which is an obscure writing and giving the names of two surgeons viz., Dr.Devadas, probably the 3rd OP/Dr.Devadas Madhavan and the name of the other Doctor which is not legible to be read out, carry anything to suggest that the patient, who suffered the ordeal of bradycardia and low BP level during the course of surgery, was perioperatively evaluated, especially by a Cardiologist.

Having said so, in the face of the plain but solid averment of the complainant that, after stating that removal of both kidneys was inevitably necessary to save the life of the patient and also to facilitate the transplant, what was done with the haphazard clinical proceedings of the OPs is that they deviated from the planned course and

removed only a part of the infected organ, it is now apt to deal with the stand of the OPs, especially regarding the condition of the patient at the time of her admission, as could be seen from their written version -

- The patient had "BILATERAL autosomal Dominant POLYCYSTIC Kidney Disease' and the description is thus given at **paragraph-d**.

  "The patient also had blood in the urine which is indicative of the fact that the cysts in the kidney begun to bleed. The patient had fever which meant that the fluid in the cysts of the kidney were infected resulting in pus formation."

- As per **paragraph-f** –

  'there was every possibility that the INFECTED KIDNEYS could affect transplanted (fresh) kidney also."

- As per **paragraph No.g**

"The best option and treatment process in the circumstances <u>was to remove the INFECTED KIDNEYS</u> prior to transplant because the bleeding from the cysts showed that the condition of the patient was endangered. There was also no possibility of also postponing the procedure. <u>In these extreme circumstances only, the patient was referred to the first Opposite Party hospital by the Doctors at Chennai</u>. The patient was a high risk category patient."

In terms of the given clinical condition as detailed by the OPs, who obviously classified her as a high risk category patient for the reason of infected kidneys coupled with other severe co-morbid conditions, this Commission toiled to browse through the medical records exhibited by them to find out as to what are the examinations done on the patient at the 1st OP that had enabled them to

independently give the clinical estimation, upon the patient's admission there. But unfortunately, there is no single radiology report of the 1st OP available to show that the above details given in the written version are from the independent diagnosis done by the OPs, rather, what was entered in Ex.B2 appears to be based on Ex.B4 of the previous year/2007 showing the size of the right kidney, which is later removed, as 17.9 x 10.06 cms. and the left one as 16.7 x 8.8 cms. In Ex.B4, it is further noted –

> " Both the kidneys are enlarged and studded with multiple cysts 0.5 To 11.0 cms. The cysts are clear. Few cysts have wall calcification. Multiple calculi are also seen in both kidneys.
>
> Impression : ....
>
> Adult polycstic kidneys. ..."

As such, except the above old scan report, in the absence of any independent CT or MRT Report secured at the 1st OP

regarding the current condition of both the kidneys upon admission at the pre-surgery stage in the 1st OP, this Commission posed a query as to how they could conclude so as elaborated in the written arguments and it is replied thus by the OPs in their written arguments:-

> " 31. All new allegations made by the Complainant Counsel during his oral arguments and in the Complainant's Written Arguments dated 08.03.2023 that ..... cardiac evaluation is mandatory prior to surgery and the same was not done, no cardiologist examined the patient prior to surgery and fitness certificate was not given, CT-Scan or MRI Scan ought to have been taken prior to the surgery and the same would

have given a clear image of the functions of the kidney – ***all these allegations are baseless. No pleading of these allegations have been made in the Complaint or the Proof Affidavit.*** The Complainant is raising all these issues for the first time during his arguments and the same are liable to be rejected in limine."

The OPs must know that once the complainant raised substantial pleadings, however minimum they are in text and contents, in his endeavour to discharge the burden of initial proof, he shall have to, in the light of the medical records, elaborate the points that root from the pleadings and, while countering the same, the OPs cannot play a hide and seek game with a vain reply that what is elaborated by way of arguments does not find place in the pleadings or that some new allegations are made. In every medical

negligence case, the opponent is legally bound to responsibly respond to the complainant's claims and arguments, especially when the medical records are held by the Hospital/Doctors. While so, downplaying the crucial arguments as not a part of the pleadings is legally an ineffective strategy. It is sufficient for the consumer to formally present a claim outlining the facts but it is the responsibility of the doctor to address those claims directly, with the case history held by him, for, the doctor's arguments are always a response to the complainant's case, not an independent/unrelated set of claims. Consequently, what could be inferred here is that the OPs' plan to do the removal of both kidneys was substantially based on previous case history and not based on any full-fledged current evaluation by way of any meaningful examination in the form of CT or MRI or at least by way of an ultrasound imaging. It is a fundamental principle of patient care and a key component of the standard of care in medicine that a Hospital or Doctors shall have to conduct their own current evaluation of a patient and they cannot

simply rely on previously recorded case history. The reason is - health condition of a patient is not static and it can change rapidly. Conditions of the kidneys can worsen, new complications can arise and the patient's response to treatment can also evolve. Co-morbid conditions, which are pre-existed, like severe left ventricle dysfunction may have progressed making the planned surgery too risky now and RVF could be a potential source of an active/smoldering infection that might not have been present or was not even noted in previous records. Apart from that, an independent evaluation aids the medical team to confirm the patient's fitness for the surgery and anesthesia, identify any new or missed risks and to develop a safe and effective surgical plan. In some cases, previous records may also be incomplete, outdated or even erroneous, whereas, current evaluation provides a chance to correct any inaccuracies and ensure that the team of doctors has the recent and accurate information. Such an evaluation would also necessarily affect the informed consent since the patient needs to understand the current risks of the procedure

based on the present evaluation. Therefore, the duty of care lying on the part of the Hospitals, which assume legal liability for the care they offer and provide, mandates them a fresh and independent assessment to ensure patient's safety and to provide treatment that meets his/her existing situation and current medical protocol. It is by conducting its own assessment, the Hospital fulfills its duty of care and exhibits due diligence thereby. By not doing so, the Hospital paves the way to sustain the allegation that the ethical principles of beneficence/doing good for the patient and non-malfeasance/doing no harm, which are so central to healthcare, are flagrantly violated. That being the crucial corner, it is because of the reason that the OPs deliberately failed to do a meaningful pre-procedure diagnosis especially regarding the current condition of the kidneys, they abruptly planned and proceeded to remove both the pus-expelling kidneys but suffered a setback to stop the surgery with the removal of one infected organ and leaving the other untouched for the reason that no complete pre-surgery evaluation was done, as required in

the case of the patient. If the following texts, extracted at the risk of repetition from the written version viz.,

> " f. .... There was every possibility that the ***infected kidneys*** could affect the transplanted (fresh) kidney also.
>
> g. The best option and treatment process in the circumstances was to remove the ***infected kidneys*** prior to transplant because the bleeding from the cysts showed that the condition of the patient was endangered. ..."

is contrasted with the OPs' stand taken in the same written version to the following effect -

> "7. ... on account of the excessive puss formation in the right kidney which had resulted in sepsis, there was a

drop in the heart rate and BP. Though this was not an unexpected complication but an anticipated risk ...."

it can be well discerned that the pre-operative diagnosis of equal infection in both kidneys did not meet the standard of care; as otherwise, after being clinically satisfied and expressed that the infected kidneys, if left to remain, would affect the organ that is going to be transplanted, it is highly illogical and irrational to say that the infection was only in the right kidney and that the patient was manageable with the other kidney, which is also recorded to be expelling pus. Secondly, after stating thus at para No.30 of their written arguments:-

"30. (c) Further, based upon the results of the tests, medications were prescribed for the patient to control various pre-existing medical conditions ***only after which Bilateral***

Nephrectomy surgery took place"

which means, their claim is, before surgery, the patient who was suffering from a debilitating condition due to pus expelling kidneys was clinically prepared by containing the infection, facilitating her to undergo the bilateral removal; while so, to claim now, in the written version, that the OPs anticipated the drop in heart rate and BP owing to sepsis that drove them to limit the scope of the surgery with removal of only one organ, is nothing but an oxymoron; as otherwise, it would have been conveyed to the patient under the informed consent that the scope of bilateral removal might also be limited to unilateral one owing to the anticipated impact of sepsis. Thirdly, the other claim of the OPs at para-i "the removal of the second kidney was not an emergency" is a deliberately misleading statement for the simple reason that, in the face of the consistent stand of the OPs that both the kidneys were excreting pus, leaving one to remain would naturally produce the issue of sepsis.

Therefore, had the OPs been at least average enough in their diligence at the pre-surgery stage, they would not have been driven now to present diametrically opposite statements in the written version by stating at one place that both the kidneys, which were expelling pus, needed immediate removal by way of bilateral nephrectomy to save the patient and prepare her for transplant and, quite contrary to such stand, they conversely state that removal of the other kidney was not an emergency, conveniently forgetting the factum that it is of common knowledge, presence of a pus expelling kidney would produce sepsis and eventually lead to death due to cardiac or multi organ failure. It is not the case of the OPs nor their defence that removal of one kidney might have saved the patient if it successfully eliminates the primary source of pus and if the other kidney could be managed. But, here, it is the consistent and admitted case of none else than the OPs themselves that the other kidney was also actively expelling pus. Therefore, when even the decision to perform a bilateral nephrectomy in a patient with bilateral

polycyst kidney disease is quite complex and difficult in nature, only a consciously negligent professional alone would proceed without holding in hand the updated details of ailments & its virulence especially the extent of infection in each kidney. By performing a unilateral nephrectomy and leaving a kidney that was still expelling pus, the OPs concerned failed to achieve the goal and their action was not in the patient's interest and likely contributed directly to the patient's continued septic state. In the given dire situation, if at all the cardiac-compromised and immune-compromised patient could have been managed with one kidney especially when it is admittedly anticipated that removal of both kidneys is not feasible, nothing prevented the OPs from identifying the completely dead kidney and the manageable one, however, having failed to do their own full-fledged evaluation by way of CT or MRI which ought to have been done, the OPs go on giving one reason or the other as if it was an emergency surgery to save the life of the patient, yet, the patient was prepared for almost a week time to undergo the surgery.

Further, when it is admitted by the OPs that the obstacle in the way of completing the removal of the other infected kidney was bradycardia and dip in BP level, any prudent mind would pose a question – whether clearance was given by a Cardiologist or proper risk-benefit valuation was done, but, once again, it is the illogical and quite absurd reply from the OPs that such query is irrelevant in the absence of a detailed pleading in the complaint. The OPs must be knowing that when it is a known factor in medical parlance that LVD plus RVF by itself is a high-risk factor, if surgery was not cleared by the opinion of a Cardiologist or no meaningful risk-benefit evaluation was done, it is a glaring instance of breach of duty. That being so, when the patient is recorded to have suffered bradycardia/slow rate of heart and dip in BP level during the course of surgery, the OPs are duty-bound to show that they proceeded to lay the surgical hands on the patient only after a due fitness from a Cardiologist. Similarly, having claimed that removal of both the kidneys are absolutely inevitable for saving the life and to enable transplantation,

once again, the OPs shall have to explain as to why they did not inform the patient or her relatives at the time of getting the consent that there were prospects of removing only a single kidney owing to the fragile heart condition and thereby, the patient may be exposed to sepsis due to the presence of the other kidney, especially when there is a clear admission in the written version, as extracted above, that the Doctors anticipated the risk and such transparent information would have influenced the decision of the patient to seek for alternative courses or even to avoid the exercise of searching for and fetching a donor. In our considered opinion, the OPs shall have to be held deficient and negligent on the following core grounds:-

- **Lack of proper pre-procedure evaluation**:- Standard medical protocol and practice mandates for ordering a CT Scan or MRI to independently assess the size and condition of the kidneys before the surgery and this would have given a

precise imaging and allowed the OPs to plan the surgery accordingly, however, conscious failure to do a pre-operative workup in a multidiscipline manner having regard to the other co-morbid conditions ultimately resulted in deviation from the planned procedure due to eruption of bradycardia and a dip in BP, ultimately producing adverse complications in the patient to the extent of causing her death after cardiac failure as a consequence of sepsis.

- **Misleading Rationale**:- When both the kidneys were recorded to be impaired owing to growth of multiple cysts excreting blood and pus, both were highly infectious and posed a risk to the patient; while so, leaving

one diseased kidney in the body against the very purpose of the planned surgery which was to remove both the diseased organs, the doctors' rationale is absolutely misleading.

- **False justification for emergency**:- The very statement in the written version of the OPs that removal of the other kidney was not an emergency meaning that the patient was manageable with the same directly contradicts their initial rationale for bilateral nephrectomy which was to prepare the patient for a transplant. In other words, such a stand means that a life-threatening emergency was not at all there and it is smartly taken to justify the deviation from the informed plan to remove both the diseased kidneys. It appears, the OPs

may stoop to any level, in order to justify their conduct of negligence ab intio culminating in spread of sepsis due to the left out diseased organ that served as a continuous source of infection and had the potentials to push the patient down into sepsis.

- **Breach of informed consent**:- While the patient gave her consent for a bilateral nephrectomy by keeping the organ donor ready along her side, by performing a unilateral nephrectomy, the OPs, in terms of their admissions in the written version and arguments, consciously breached the consent by doing a different procedure than the one agreed upon and it violates the patient's right to self-determination and makes the surgeons' action a potential battery.

That being so, in the light of the medical records that are in demonstrative nature to depict the serious nature of lapses amounting to conscious negligence on the part of the OPs and validating the statement – ***in the stillness of the operating room, the patient became a monument to the Doctors' Blunder***, issues-a & b are to be necessarily answered against the OPs and in favour of the complainant and, they are answered accordingly.

10. Coming to issue-c, already while dealing with the previous issues, it is pointed out that consent was breached by the acts and conduct of the OPs. Apart from that, the argument of the OPs by citing the Regulation, as extracted above, of the Medical Council, that the consent form even without the signature of the physician is valid is bereft of any logic and rationale for the reason that the regulation itself says that it is the physician who has to secure the signature of the patient or so and it implicitly and logically means that only a counter signature by the Physician or Surgeon concerned would denote

compliance of such obligation. Secondly, of the three consent forms, one contains a written text of the risk on a blank space and the other one remains completely blank and in the consent form pertaining to the surgery, what is written on the blank space is 'Bleeding. Infection." If any other set of complications as already given in the printed text is applicable to the individual patient/procedure, by ticking the particular text or para, it is conveyed that the said risk is also covered apart from what is specifically written down. But here, like the previous form where the risk is specifically mentioned without ticking any text in the printed format, there is no specific marking made against any of the printed risks. As such, the OPs cannot be allowed to find profit in a broken compass. Inasmuch as the informed consent is vitiated and rendered invalid for more than one reason, there is no difficulty to hold that there is a clear breach of duty in that regard as well on the part of the OPs and this issue is answered accordingly against the OPs and in favour of the complainant.

11. Regarding issue No.d, the point is very simple that it was only because of the reason and a nearly 200% assurance that the patient shall have to undergo removal of both kidneys to facilitate transplant, the complainant is seemed to have taken some backbreaking efforts to fetch a donor of organ and if it was even implicitly conveyed to him that there are also prospects to remove only one kidney and the patient could be managed for some time with the remaining organ, he would not have ventured so hurriedly to bring the donor and to spend a considerable sum for doing the matching tests. Like the saying goes ***'no man's harvest shall be sown with another's misdeed'*** which is in line with the maxim ***Nemo Punitur Pro Alieno Delicto (Let one not suffer for the fault of another)***, for the task imposed upon the complainant by the negligent clinical proceedings of the OPs, the former shall not suffer and accordingly, the issue is answered in his favour and against the OPs.

12. Coming to the final issue, it is true that the causal link is visible between the negligence of the OPs and the conditions leading to the patient's death, however, it should not be lost sight of that the patient was already sinking towards what was destined, also due to the poor state of her health; hence, it is just and fair to hold the OPs proportionate only to the extent of their negligence and, in our considered opinion, directing them to pay jointly and severally a sum of Rs.15,00,000/- (Rupees fifteen lakh only) along with a sum of Rs.50,000/- towards litigation expenses, to the complainant, would meet the ends of justice.

13. In the result, the complaint is allowed to the extent of directing the OPs to jointly and severally pay a total compensation of Rs.15,00,000/- (Rupees fifteen lakh only) and also Rs.50,000/- (Rupees fifty thousand only) towards litigation expenses to the complainant, within a period 12 weeks from the date of receipt of a copy of this order, failing which, the said sum shall carry

interest @ 9% p.a. from the date of the complaint till the date of realization.

sd/-
R.SUBBIAH, J.
PRESIDENT.

LIST OF DOCUMENTS MARKED ON THE SIDE OF THE COMPLAINANT

Sl.No.	Date	Description of Documents
Ex.A1	09.02.2008	Copy of receipt issued by Hotel Vinayak, Coimbatore to the complainant
Ex.A2	09.02.2008	Copy of receipt issued by Rubies Garments for purchase of cotton mask
Ex.A3	11.02.2008	Copy of receipt issued by Trivitron Diagnostics P. Ltd. to the complainant's wife for purchase of Dialyser
Ex.A4	12.02.2008	Copy of receipt by Medihauxe Interpational of purchase of injunctions
Ex.A5	12.02.2008	Copy of receipt issued by Renadial (IBMS) Medical Pvt. Ltd. for purchase of Blood tubes
Ex.A6	13.02.2008	Copy of Admission Card issued to the complainant's wife
Ex.A7	13.02.2008	Copy of receipt issued by the opposite parties for payment of an Advance amount of Rs.20,000/-
Ex.A8	14.02.2008	Copy of receipt issued by the opposite parties for payment of an Advance amount of Rs.60,000/-