Thomas Chacko Vs. the Managing Director, Sree Uthradam Thirunal Hospital

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Court : Kerala State Consumer Disputes Redressal Commission SCDRC Thiruvananthapuram

Decided On : Feb-28-2012

Judge : The Honourable Shri. Justice K.R. Udayabhanu President &Amp; the Honourable Mr. M.K. Abdulla Sona Member

Appeal No. : First Appeal No. A/10/505 (Arisen out of Order Dated 16/04/2010 in Case No. cc274/2006 of District Thiruvananthapuram)

Appellant : Thomas Chacko

Respondent : The Managing Director, Sree Uthradam Thirunal Hospital

Judgement :

JUSTICE SHRI.K.R. UDAYABHANU: PRESIDENT

The appellant is the complainant in CC.274/06 in the file of CDRF, Thiruvananthapuram. The complaint stands dismissed.

The case of the complainant then aged 54 years is that he was admitted at the opposite party hospital on 16.4.2006 on account of severe chest pain and underwent by-pass surgery on 21.4.2006. He was kept in the ICU for 4 days out of the 9 days package. He has paid Rs.99,000/- for the surgery and a sum of Rs.11,382/- for the treatment charges up to the date of surgery. After surgery he was having severe pain on the back side, buttocks, thighs, elbows etc was told by the hospital staff that he had blanket allergy and will recover soon. On account of

severe pain and uneasiness he requested for a water bed but instead was given water filled rubber hand gloves from which water spilled over which increased the pain. He has sustained serious burn injuries over the backside. According to him he was remained in the hospital for a period of 50 days till 9.6.2006. He would have been normally discharged within 9 days after the heart surgery. He has alleged that it was on account of the negligence of the opposite parties in properly operating the thermal blanket over which he had to be laid for surgery that he sustained the injuries. The medicines administered subsequent to the burn injury were all for treatment of deep burns. According to him he is still having considerable difficulties and pain. His entire backside is disfigured. Further the opposite parties charged an additional amount of Rs.28,944/- for the treatment which was occasioned solely due to the negligence on the part of the opposite parties. According to him he is still under treatment and has not recovered so far.

The opposite parties filed version pointing out that a very complicated coronary by pass surgery in which 3 bypasses were done on the complainant on 21.4.2006. In the version the opposite parties have explained the details of the surgery. After surgery he was transferred to ICU and put a ventilator as is the usual practice. At about 1.45 am on the next day the nurses noticed a few small blisters on the back side and the antiseptic ointment was applied in consultation with the duty doctor. By 9.30 am he was weaned off from the ventilator. The blisters were initially thought to be due to allergy reactions to the thermal blanket used as some patients used to get blisters even on application of skin plasters. However the blisters became bigger on the next day with the peeling of skin. It was thought that the allergic reaction was aggravated by the heat. The lesions were of a superficial nature except the ones over the interscapular areas and the sacrum. The same were managed with local antiseptic dressings and later on with the involvement of plastic surgeon. Though not deep, because the blisters enlarged and broke down leaving large raw areas, it took some time for healing. The patient was well looked after by the team consisting of doctors and nurses under the supervision of a plastic surgeon. The complainant was discharged when all lesions were healed. The opposite parties had shared additional expenses by giving a discount of Rs.47,968/-. The opposite parties have denied any negligence on their side.

Evidence adduced consisted of the testimony of PWs 1 and 2, DWs 1 to 3, Exts.P1 to P9, D1 and D2.

The Forum has dismissed the complaint on the ground that the complainant has failed to produce expert evidence in support of the case that the burn injury sustained was not on account of the allergic reaction from the thermal blanket.

The complainant and his son who took the photographs of the complainant that showed the intensity of the burn injuries were examined as PWs 1 and 2 respectively. DW1 is the cardiac surgeon who performed the Coronary Artery Bypass Graft Surgery (CABG).

It is the case of the complainant that it was on account of the carelessness on the part of the staff of the opposite party hospital who operated the thermal blanket unit while he was lying over the same during the bypass surgery that the burn injuries were occasioned. DW3 is the Perfusion Scientist who operated the equipment. He has stated that he having diploma in the Perfusion Science. It is seen from Ext.D1 case sheet that the complainant was shifted to the operation theatre at 9.30 am. The surgery started at 10.55 am and the surgery was over by 1.33 pm. The literature produced downloaded from the Net ie Nursing Procedures, 4th Edition, edited by Mills, Elizabeth Jacqueline etc maintain that a blanket -sized aquathermia pad, the hyperthermia-hypothermia blanket raises, lowers, or maintains body temperature through conductive heat or cold transfer between the blanket and the patient. It can be operated manually or automatically. It is the adjunct to anesthesia in heart surgery. The purpose is to decrease the metabolic activity. It is so mentioned by DW3 as well. It has been stated by DW1, the cardiac Surgeon that the thermal blanket consisted of 2 parts. One is the blanket itself which consisted of small channels inside the blanket through which warm water is circulated. Another part is for heating the water where there is temperature controls. According to the opposite parties the temperature can be set between 37C to 45C. It is the case that in the instant case the temperature was set so as that will not raise beyond 42C . At the time of surgery; as stated by DW3, the Perfusion Scientist is in charge of the thermal blanket as well as the heart lung machine. The surgeon requires stand still blood free heart to operate. Hence body

temperature is brought down. In the instant case at page 235 of Ext.D1 case sheet contains the record of the temperature of the body of the patient during the surgery. He has stated that in the instant case the temperature was brought down to 29.7C and that after surgery the temperature was brought up to the normal body temperature ie up to 36.9C,. At the time he was brought to the operation theatre the body temperature was 34C.

The case of the complainant is that due to the negligence on the part of DW3 the auto stop mechanism did not function and the temperature continued to rise or remained at the highest level which resulted in the serious burns that was sustained on the back of the complainant. Evidently at the time the complainant was anesthetized and unconscious and unable to feel the pain. It is the case of the complainant that during re-warming after surgery the thermal blanket heats the patients back portion and when the temperature reaches to the said level the control unit stops the heat process. The remaining portions of the body could be still in a cool state. The temperature raised on the patients back spreads gradient heat to the cooler areas of the body and the probe senses the temperature drop and this feedback causes the system to restart the heat process of the thermal blanket. It is the probe that makes sense of the heat. The probe/thermistor is affixed at the patients rectum and taped it to the patients body to prevent accidental dislodgment. If rectal insertion is contra indicated the probe is tucked deep into the axilla and secured with tape. If the patient is anesthetized an esophageal probe is also inserted (Nursing Procedures (supra) at page 15). It is the essence of the argument of the complainant that this probe got dislodged and the same was not noticed by DW3 who was in charge of the thermal blanket and hence the heating process in the thermal blanket continued to restart. The probe after dislodging would not have sensed the temperature of the operation theatre which is kept very low ie 20C only and hence the auto control device ie the circuit breaker did not cut off the electric supply to the heater as the temperature never reached 37C which should have sensed by the probe, incase the probe remained affixed to the body of the patient. The complainant has compared the function of the probe with that of a float ball in a flush tank. If the float ball is dislodged it cannot control the water and the same would result in the continuous over flow of water from the flush tank. According to him the same has happened in his case

also. The thermal blanket continued to emanate heat and the same resulted in very deep injuries. It is also pointed out that as per Ext.D2, the technical data of the thermal blanket produced by the opposite parties the power consumption of the thermal blanket is 1500 watts which is more than sufficient to boil water. According to him the total area of burn was more than 45% of the total body surface area. It is also pointed out that all the treatments provided which is evident from Ext.D1 case sheet is for the treatment for burns and not for allergy slough cutting was done a number of times, the white and brown deep burn marks on the body would show that the skin re-producing cells and flush were damaged on vast areas.

The complainant/appellant was present in person and his backside appeared considerably disfigured. As stated by him the injury marks are in a net work pattern that reflects the small channels through which warm water is circulated. The same is highlighted by the counsel for the appellant. The above also disprove the case of the opposite parties that the injuries sustained were allergic reaction to the latex the material that cover the channels through which warm water is circulated. There are also keloid formations.

Evidently the technicalities of the working of the thermal blanket and particularly the case that the probe was dislodged was not brought out properly in the cross-examination of DW3 the perfusion scientist or DW1 the Cardiac Surgeon. It was the complainant himself in person who conducted the case before the Forum.

The counsel for the appellant has highlighted the statement of DW1 the Cardiac Surgeon in her testimony that at first she thought that it was allergic reaction then only later it was realized that it was burns. She has denied that the injuries were 3 rd degree burns. She has admitted that at the pressure points what were some 2nd degree burns. According to her the case was of superficial burns. Blisters got ruptured easily. It is stated she has explained that slough cutting hass nothing to do with the severity of the burns as slough cutting was done to quicken the healing process. It is seen from Ext.D1 case sheet that slough cutting was done more than once ie on 26.5.06, 29.5.06 and 31.5.06. Ext.D1 case sheet would also show as noted on 7.8.2006 that the complainant was unable to abduct both arms fully and

that he was referred to Physiotherapy for shoulder contracture.

It has to be noted that 42C which is the highest temperature set in the thermal blanket is much more than 100F. The contention of the opposite parties that it is latex allergy that the complainant had appears not established as the literature produced by the opposite party (downloaded from Net) would show that only rashes etc are produced by latex allergy. In the instant case DW1 as well as DW3 has stated that there will be the disposable cover over the thermal blanket and also the patient is covered drapes ie cloth sheet. Hence the possibility of the patient coming into direct contact with the rubberised material does not arise and even if there was such a contact it is unlikely that such serious burn injuries would have resulted on account of the contact with the latex.

As noted above during the cross-examination of DW1 and DW3 the matter of affixing the probe was not properly brought out and DW3 has answered evasively to some of the material questions in this regard. It is also pertinent to note as pointed out by the counsel for the appellant that the opposite parties have not produced the manual of instructions of the thermal blanket. Only Ext.D2 technical data is produced which is not helpful as to the manner of operation of the equipment. It was also put to DW3 in the cross-examination that one of the surgeons blamed him (the word used is cursed) showing the burned area the answer is that he dont know and that he did not remember. When questioned as to the working of the probe he has answered that it is very difficult to explain. The answers are evasive as to the direct questions that the burn marks are in the same pattern of the water channels. He has stated that he cannot say. As noted above as the complainant has conducted the case in person. Many aspects were not properly brought out. But the evidence as such would clearly indicate that the serious burn injuries sustained by the complainant for which he had remain in the hospital for a further period of 40 days in addition was not on account of the allergic reaction to the latex as contended. Further the opposite parties could not produce any similar instances recorded/reported as having happened on account of the use of the thermal blanket which was being used for every bypass surgery. We find that the evidence adduced clearly disclosed that the injuries sustained to the complainant and the difficulties that he had to undergo and the problems that

he is still having was on account of the lapse from the part of the staff of the opposite party hospital particularly DW3 the perfusion scientist. Hence the order of the Forum is set aside in this regard.

So far as the compensation is concerned the complainant has not produced in details of the expenses that he had to spend for further treatment. As to the exact disability apart from the disfiguration that he is having no objective evidence has been adduced. Admittedly he was filled for a sum of Rs.76,912/- for the treatment undergone subsequent to the bypass surgery. According to him as he objected the discount was given and he was made to pay Rs.28944/-. He has also produced the records that would show that he has undertaken Ayurvedic treatment and treatment by a skin specialist.

In the circumstances the opposite parties are ordered to refund the amount of Rs.28,944/- paid by the complainant with interest at 9% from the date of complaint. The opposite parties are also directed to pay a sum of Rs.75,000/- as compensation. The complainant will also be entitled for cost of Rs.7500/-. The opposite party/respondent will make the payment within 3 months from the date of receipt of this order failing which the complainant will be entitled for interest at 9% on the amount of compensation as well from 28.2.12 the date of this order.

In the result the appeal is allowed as above.

The office will forward the LCR along with a copy of this order to the Forum.