**REPORTABLE**

**IN THE SUPREME COURT OF INDIA**
**CIVIL APPELLATE JURISDICTION**

**CIVIL APPEAL NO.6168 OF 2008**

Dr. C.P. Sreekumar, M.S. (Ortho) .....Appellant

Versus

S. Ramanujam ..... Respondent

**WITH C.A.No.6167 of 2008**

**J U D G M E N T**

**HARJIT SINGH BEDI, J.**

1. This judgment will dispose of C.A. No.6168 of 2008, and C.A.No.6167/2008 as they arise out of the same order. The facts are being taken from C.A. No.6168 of 2008.

2. These appeals are directed against the order of the National Consumer Disputes Redressal Commission

(hereinafter called the "Commission") whereby a sum of Rs.5.50 Lac alongwith interest on a part of the aforesaid amount and costs of Rs.25000/- has been awarded to the complainant – respondent. The facts leading to this appeal are as under:

3. The respondent, who was then employed in the Indian Overseas Bank, Chennai was going on his bicycle at about 8:20 a.m. on 31st December 1991 when he was hit by a motorcycle leading to an injury to his leg. He was admitted to the Surya Hospital, of which the appellant, Dr. C.P. Sreekumar was the Managing Director, at about 9.45 a.m. An X-ray of the leg revealed a hairline fracture of the neck of the right femur. The appellant, as the attending doctor, chose a conservative line of treatment and put the respondent's leg in a plaster of paris bandage known as 'derotation boots' in order to immobilize the leg. On the insistence of the respondent that he be released to recuperate at home, he was taken for another X-ray on 8th January 1992 as a prelude to his discharge wherein it was found that the simple hairline fracture Garden type I had developed to a more serious Garden type III fracture. The

appellant thereupon decided that an operation be performed on the injured leg. Pre-operative evaluations were made on 9th January 1992 and the appellant, on considering the various options available, decided to perform a hemiarthroplasty instead of going in for the internal fixation procedure. The respondent consented to the choice of the surgery after the various options had been explained to him. The surgery was performed on the next day. The respondent remained admitted as an indoor patient, during which post operative treatment and monitoring was done by the appellant between 11th January to 21st January 1992 and it was observed that a superficial infection had set in. The sutures were actually removed on 21st January 1992. The respondent was thereafter made to undergo physiotherapy and was finally discharged on 5th February 1992. On 6th March 1992, the respondent appeared in the hospital and his condition was reviewed and he was instructed to go in for physiotherapy on a daily basis and to return for a subsequent review two weeks later but he neglected the advice. It is the case of the respondent that on account of lingering pain, he had consulted

various doctors, including Dr. Mohandas of Tamil Nadu hospital on 27th May 1992 who gave his opinion on the matter. The appellant has however pleaded that the respondent, in the meanwhile, continued to make a nuisance of himself with frequent visits to and unbecoming behaviour in the hospital on which the appellant gave a sum of Rs.50,000/- as an ex-gratia payment in order to pacify him. It appears however, that notwithstanding the aforesaid payment the respondent sent an Advocate's notice on 19th November 1992 alleging negligence and deficiency in service as the simple fracture had got displaced to a more complicated one, on account of mishandling by the hospital staff as also in the choice and the manner of the surgery and calling for compensation of Rs.3 Lac of which Rs.50,000/- had (statedly) already been paid as an advance. The appellant in his reply dated 15th December 1992, denied any negligence in the surgery and further pointed out that the displacement of the fracture had come about on account of natural causes i.e. a muscular spasm and that respondent after being informed about the various lines of treatment available had consented to the hemiarthroplasty.

Dissatisfied with the reply given by the appellant, the respondent in May, 1993 filed a complaint before the State Commission alleging that his consent had not been taken for the hemiarthroplasty and that this procedure was not justified as the bone was in good condition. The appellant in his reply denied the allegations and prayed for the dismissal of the complaint. It appears that while the complaint was yet pending, the respondent underwent a total hip replacement on 24th April 1995 at the Tamil Nadu hospital performed by Dr. Mohandas, on which he moved an application before the State Commission seeking to amend the complaint whereby the claim was increased from Rs.3 to Rs.12 Lac. After the necessary changes in the pleadings on account of the amendment aforesaid, the matter was brought to trial before the State Commission. The appellant appeared as a witness and was examined and cross-examined over several days. Several documents were also filed by the respective parties. By its order dated 29th January 1999, the State Commission dismissed the complaint holding that there had been no negligence or deficiency in service on the part of the appellant

and that the respondent had not been able to prove mishandling by the hospital staff. The State Commission, inter alia, noted that the complainant had not appeared as a witness and further that no witness had been examined by him in support of his case.

4. Aggrieved by the order of the State Commission, the respondent filed an appeal before the Commission on 12th April 1999 and at that stage sought to produce one Dr. David, the duty doctor at the relevant time, as a witness, but thereafter took no steps to secure his presence. Vide its order of 15th November 2006, the Commission, however, allowed the appeal but limited the respondent's claim to Rs.2.5 Lac, ( being the balance amount after deducting Rs.50,000/- allegedly paid as an advance) but, in addition granted a further sum of Rs.3 Lac to cover the contingency that he might have to undergo yet another surgery at some later stage. Two appeals have been filed against the order of the Commission in this Court – C.A. No.6168 of 2008 by Dr. C.P. Sreekumar seeking a dismissal of the complaint and the second, C.A.No.6167 of 2008 by the respondent, S.Ramanujam, seeking an enhancement of the

compensation to Rs.12 Lac. Both matters are being disposed off by this judgment.

5. The Commission in its order noted that the respondent had suffered only a hairline fracture (described as Garden type I fracture) for which he had been admitted in the hospital and had been immobilized by being put in a plaster with a suggestion of six weeks bed rest so that the fracture could heal on its own, and as such there was no occasion for the respondent to be taken for another X-ray on the 8th January 1992 as there was absolutely no complaint from him and it was at that stage that it was discovered that the simple hairline fracture had developed into a displaced Garden type III fracture. The Commission concluded that this complication had happened when the respondent had been moved from the first to the ground floor of the hospital for the purpose of X-ray by a ward boy, Elango, assisted by some laborers, who were not qualified to handle a patient. The Commission also observed that there was no warrant for the stand of the appellant that the hairline fracture had been displaced due to a muscular spasm and for that reason the averments made in the

complaint could not be disregarded. The Commission emphasized that within 2 days of the X-ray on 10th January 1992 the respondent had undergone a hemiarthroplasty, a surgical procedure whereby half of the hip joint had been replaced leaving the other half in its natural state and relied heavily on several medical texts placed by the parties to hold that this procedure was performed only on patients of the age of 60 years and above and as the respondent was, at the relevant time, 42 years of age, the open reduction procedure, whereby the bones are brought together and clamped by metal screws etc., was the appropriate one. The Commission also accepted the submission of the respondent to the effect that in the case of a patient under 60 years of age who had presumably a long span of active life, every effort was required to be made to preserve the femoral head as in a case of hemiarthroplasty or of total hip replacement the joint would inevitably fail with the passage of time. The Commission further observed that the respondent had approached Dr. Mohandas on 16th March 1992 with a complaint of pain in the right leg and inability to walk and Dr. Mohandas had recorded that the respondent had some

kind of infection and had advised for the removal of the prosthetic and further advised for a total hip replacement. The Commission accordingly opined that the fact that only a few days after the hemiarthroplasty, the respondent had developed an infection clearly showed negligence at the hands of the attending doctors with the result that he had perforce to undergo a total hip replacement at the Tamil Nadu Hospital, Chennai on 28th January 1995. In conclusion, the Commission observed as under:

> "It is thus clear that: (i) a hairline fracture developed into displaced fracture due to wrong handling in the opposite party's hospital; (ii) the opposite party performed a Hemi-arthroplasty on a young patient of 42 years without consideration open reduction and internal fixation and against established medical practices; (iii) the post-operative infection was not properly conducted with the result that prosthesis got loosened within a period of two months. There is thus a clear case of negligence and deficiency in service rendered by the opposite party."

6. The Commission then came to the question of the payment of Rs.50,000/- by the appellant to the respondent and observed that there were strong reasons to believe the respondent's

plea that it was a part payment towards a compromise for the larger sum of Rs.3 Lac that had been promised. The Commission further observed that from the certificate issued by Dr. N.K. Sundaram of Tamil Nadu Hospital it was clear that a total hip replacement would fail over a period of time and would need to be revised again with a new artificial joint, which would cost Rs.3 Lac and that this amount too was payable to the respondent. A total sum of Rs.5.50 Lac was, thus, computed and awarded.

7. Mr. Ranjit Kumar, the learned senior counsel for the appellant, has first and foremost pointed out that the Commission had proceeded on the basis that all that had been pleaded by the respondent in his complaint was the gospel truth despite the fact that all the allegations had been controverted and in the background that no ocular evidence had been led by the respondent and neither he himself, nor his wife, who appeared to be well informed about the procedures that had been adopted, had appeared to give evidence, there was no warrant for believing the entire story on his mere ipse dixit. It has also been pleaded that there was

neither any mishandling of the respondent by Elango and the others nor any misjudgment in the choice of the surgery as at the very initial stage the Doctor had chosen a conservative line of treatment as the fracture was a simple Garden type I, but which had been later transformed into a Garden type III fracture on account of a muscular spasm which required a hemiarthoplasty and that this line of treatment had been chosen as it would make for quicker recovery so that patient's ambulation could be restored. It has also been argued that the mere fact that a complete hip replacement had been made on 28th April 1995 i.e. three long years after the hemiarthroplasty showed that this procedure was in fact the correct one. It has also been submitted that there was no warrant for the very broad proposition that the only procedure in the given circumstances to be performed on a 42 year old patient was internal fixation and that hemiarthroplasty had to be completely ruled out unless the patient was beyond 60 years of age. He has reiterated that as per the evidence of the appellant doctor, the nature of the fracture had changed from Garden type I to Garden type III on account of a

muscular spasm and the condition of the bone had also deteriorated and as this statement had not been challenged or controverted by the respondent by adducing evidence, there was no justification in disbelieving the statement as he was the best judge in selecting the appropriate procedure in the given circumstances. It has finally been submitted that there is no basis for the conclusion that the payment of Rs.50,000/- to the respondent was a part payment towards a compromise involving a total settlement of Rs.3 Lac, as this amount had been paid to mollify the respondent who was creating a nuisance in the hospital premises and the appellant's residence and causing inconvenience to the other patients. It has, thus, been prayed that in the light of this background, there was no justification for the award and that no compensation whatsoever was called for.

8. Mr. Ranjit Kumar's stand has been strongly controverted by the respondent, who appeared in person. As a matter of fact, owing to the limitations of untrained litigants who appear in person, we had asked the respondent if he wished to engage a lawyer or we could even arrange one to represent him as an

amicus curiae. He brusquely declined the offer and on the contrary vehemently suggested that he had no faith in members of the legal profession as he had been cheated by his lawyer before the State Commission as he had connived with the opposite party and had deliberately dissuaded him from producing any substantive evidence which had led to the dismissal of his complaint at the first instance. During the course of his arguments and in his affidavit dated 19th June 2007 as also in his written submissions given to this Court, the respondent repeatedly requested that the matter be remanded to the State Commission for recording his evidence, that of his wife and some expert witnesses and also to produce some additional objects as evidence. We, however, questioned the respondent as to whether he had made any such prayer or complaint in writing before the State Commission or the Commission and he admitted that he had not done so. In this background, and the fact that the incident had happened some 18 years ago, we feel that it would be inappropriate to remand the matter to the State Commission for additional evidence at this stage.

9. We find that three basic issues arise in the present case, (1) whether Dr. C.P. Sreekumar, the appellant herein, had the competence to perform a hemiarthroplasty and whether he had chosen this procedure as he was not qualified for the internal fixation procedure; (2) whether it was the negligence of the Surya Hospital of which Dr. C.P. Sreekumar appellant was the Director and of the ward boy Elango and three labourers, who are said to have removed the respondent from his room for X-ray department on 8th January 1992 that had resulted in the aggravation of the Garden type I fracture to Garden III type fracture necessitating more radical treatment and (3) even assuming that some radical procedure was necessary, whether hemiarthroplasty was the appropriate one in the light of the fact that the respondent was at the relevant time 42 years of age.

10. The basic principles under which a case of medical negligence as a criminal offence as also a tort has to be evaluated has been succinctly laid down in **Jacob Mathew vs. State of Punjab & Anr**. (2005) 6 SCC 1. One of the primary arguments raised by the respondent herein is that the appellant Dr. C. P. Sreekumar, though qualified in

Orthopedics, did not have the basic skill to carry out a hemiarthroplasty or an internal fixation and for that reason was not competent to perform the procedure. In Jacob Mathew's case, this Court adopted the test laid down in **Bolam vs. Friern Hospital Management Committee** (1957) 2 All ER 118 (QBD) in which it has been observed as under :

> "[W]here you get a situation which involves the use of some special skill or competence, then the test as to whether there has been negligence or not is not the test of the man on the top of a Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and profession to have that special skill. A man need not possess the highest expert skill…It is well-established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art."

11. This Court then observed that this judgment had been followed repeatedly not only in India but in other jurisdictions as well and that it was the statement of law as commonly understood today. In paragraphs 24 and 32 of Jacob Mathew's case it has been observed thus:

"The classical statement of law in Bolam's case has been widely accepted as decisive of the standard of care required both of professional men generally and medical practitioners in particular. It has been invariably cited with approval before the courts in India and applied as a touchstone to test the pleas of medical negligence. In tort, it is enough for the defendant to show that the standard of care and the skill attained was that of the ordinary competent medical practitioner exercising an ordinary degree of professional skill. The fact that a defendant charged with negligence acted in accord with the general and approved practice is enough to clear him of the charge. Two things are pertinent to be noted. Firstly, the standard of care, when assessing the practice as adopted, is judged in the light of knowledge available at the time (of the incident), and not at the date of trial. Secondly, when the charge of negligence arises out of failure to use some particular equipment, the charge would fail if the equipment was not generally available at that point of time on which it is suggested as should have been used.

32. At least three weighty considerations can be pointed out which any forum trying the issue of medical negligence in any jurisdiction must keep in mind. These are: (i) that legal and disciplinary procedures should be properly founded on firm, moral and scientific grounds; (ii) that patients will be better served if the real causes of harm are properly identified and appropriately acted upon; and (iii) that many incidents involve a contribution from more than one person, and the tendency is to blame the last identifiable element in the

> chain of causation, the person holding the "smoking gun".

12. These observations postulate the underlying principle that too much suspicion about the negligence of attending Doctors and frequent interference by Courts would be a very dangerous proposition as it would prevent Doctors from taking decisions which could result in complications and in this situation the patient would be the ultimate sufferer. **Jacob Mathew's case** was followed in **State of Punjab v. Shiv Ram & Ors.** (2005) 7 SCC 1 which was a case of a failed tubectomy leading to a plea of medical negligence. This is what this Court had to say in paragraph 33:

> "A Doctor, in essence, needs to be inventive and has to take snap decisions especially in the course of performing surgery when some unexpected problems crop up or complication sets in. If the medical profession, as a whole, is hemmed in by threat of action, criminal and civil, the consequence will be loss to the patients. No doctor would take a risk, a justifiable risk in the circumstances of a given case, and try to save his patient from a complicated disease or in the face of an unexpected problem that confronts him during the treatment or the surgery. It is in this background that this Court

> has cautioned that the setting in motion of the criminal law against the medical profession should be done cautiously and on the basis of reasonably sure grounds. In criminal prosecutions or claims in tort, the burden always rests with the prosecution or the claimant. No doubt, in a given case, a doctor may be obliged to explain his conduct depending on the evidence adduced by the prosecution or by the claimant. That position does not change merely because of the caution advocated in Jacob Mathew in fixing liability for negligence, on doctors."

13. In **Samira Kohli vs. Dr.Prabha Manchanda & Anr (2008) 2 SCC 1** the basic issue was as to the principle governing "consent" to be taken from a patient prior to any invasive procedure. We find, however, that in the present case, the question of consent has not been raised by the respondent and on the contrary the case seems to be that the consent had, in fact, been taken. Even in his arguments the respondent did not deny lack of consent and on the contrary (as Mr. Ranjit Kumar has pointed out) in the Advocate's notice issued to Dr. C.P. Sreekumar appellant, on 19th November 1992, the fact that the respondent had agreed to the operation, has been admitted.

14. Before we embark on an evaluation of the three issues it bears reiteration that the respondent did not produce any evidence in court and did not even appear as a witness in support of his own case. Realizing the consequences of this omission, the respondent had requested that the matter be remitted to the State Commission for recording additional evidence, which request has been declined by us.

15. The first issue is with regard to the doctor's expertise in his field of orthopaedics, as it is the respondent's plea that he had chosen hemiarthroplasty as he was not qualified to go in for the internal fixation procedure and that he lacked the elementary knowledge of hemiarthroplasty as well. We have considered this argument and find that there is absolutely no evidence to back up this wide claim. On the contrary, we have gone through the evidence of the appellant who deposed that he was an M.B.B.S. from the Tanjore Medical College and had thereafter done his Masters in General Surgical Science from the University of Madras in the year 1983 and his Masters in Orthopaedic Sciences from the University of London in the year 1985 and that on the day of the operation he had about 15

years of experience in the field of Orthopaedics. We have also gone through the very lengthy cross-examination of the appellant spread (intermittently) over several days and find not the slightest suggestion that the appellant was unable to perform an internal fixation. The bald statement of the respondent (in the course of his arguments and in his written submissions) with respect to the lack of expertise in performing the internal fixation procedure on which the appellant had chosen to go in for hemiarthroplasty, cannot thus, be accepted.

16. Admittedly the respondent had suffered a simple Garden Type I hairline fracture in the course of the accident on 31st December 1991 and after he had been examined by the appellant on that day, his leg had been immobilized with the help of derotation boots. It is the case of the respondent that when he was taken for an X-ray on 8th January 1992 it was found that the simple Garden I type fracture had developed into a complicated Garden III type fracture, and that this happened on account of rough handling by Elango and the other attendants who were mere labourers whereas it is the case of the appellant that this had occurred due to a muscular spasm.

We find from a reading of the order of the Commission that it proceeded on the basis that whatever had been alleged in the complaint by the respondent was in fact the inviolable truth even though it remained unsupported by any evidence. As already observed in **Jacob Mathew's case** the onus to prove medical negligence lies largely on the claimant and that this onus can be discharged by leading cogent evidence. A mere averment in a complaint which is denied by the other side can, by no stretch of imagination, be said to be evidence by which the case of the complainant can be said to be proved. It is the obligation of the complainant to provide the *facta probanda* as well as the *facta probantia*.

17. The Commission has, further, relied on the cross-examination of the appellant with regard to the speculation about the defective lift as being the reason for the shift of the respondent on a stretcher to the X-ray room. This is on the face of it misplaced, as no inference can flow that the displacement had occurred on account of rough handling by the staff. The appellant, on the contrary, in the course of his evidence, pointed out that as the respondent's smoking over a

period of 15 years had resulted in chronic bronchitis, that he was obese and had taken hormonal treatment for sterility and in this context re-emphasized that the displacement had occurred due to a strong muscular spasm. When cross-examined on 7th April 1998 he pointed out that in order to immobilize the leg he had used de-rotation boots which extend below the navel and to the injured leg to half of the uninjured leg and that such a cast would normally immobilize the hip by 75% but notwithstanding this fact a muscular spasm could still happen. It will be seen from the cross-examination that there was no suggestion whatsoever that a simple hairline fracture of the femur could not be transformed to a Garden type III fracture due to a muscular spasm. We thus find from the appellant's reply to the complaint and also in the course of his evidence that the fracture had been displaced on account of muscular spasm and that this point has gone unrebutted as no contrary evidence has been produced. It cannot therefore be said with any certitude that the displacement had occurred on account of the rough handling by Elango and the others on the

8th January 1992. In its order, while referring to the radical change in the fracture, the Commission has observed:

> "There is no way to ascertain the reason for this development but one cannot disregard the averment made by the complainant that it is due to rough handling of the staff of the hospital."

We are of the opinion that in the face of this observation, no case of negligence can be spelt out.

18. The question as to whether hemiarthroplasty or internal fixation was the proper procedure in the background that the respondent was 42 years of age at the relevant time, has been hotly debated. It is the case of the appellant that on evaluation of the respondent's condition he had thought it fit to carry out a hemiarthroplasty whereas it is the case of the respondent that as per the various text books which have been placed on record, this procedure was invariably carried out on a patient who was 60 years of age or above and hemiarthroplasty was thus not the favoured option for him. Mr. Ranjit Kumar has taken us through several passages from various text books, most of which have in fact been produced by the respondent, and it does appear that ordinarily in the case of a patient of less

than 60 years of age, hemiarthroplasty is not the preferred option and internal fixation involving the use of a clamp with screws was the more acceptable one. In **Subcapital Fractures of the femur, A Prospective Review by R.Barnes, J.T.Brown, Glasoow, Scotland, R.S.Garden, Priston,and E.A.Nicoll, Mansfield, England. With a statistical analysis by D.F.Goda, Edinburgh, Scotland,** it has been pointed out that the choice between the internal fixation and immediate prosthetic replacement is often difficult to make and no full proof criteria exists for assessing which of the two procedures is the proper one in the facts of the particular case. Likewise, in the Article **"The displaced femoral neck fracture internal fixation versus Bipolar Endoprosthesis : Results of a Prospective Randomised Comparsion (Bray – TJ ; Smith Hoefer.E, Hooper.A, Timmerman.L. University of California, Davis Medical Center, Sacramento Clin Orthop.1988 May (230) 127-40** wherein the dilemma as to the procedure to be adopted has again been highlighted, it does appear that in the case of a young patient, internal fixation is the favoured procedure. **In**

**Practical Fracture Treatment (Third Edition) by Ronald Mcrae** it has been observed as under:

> "**Alternative treatments of intracapsular fractures(1): Non-operative management:** All impacted fractures (Garden I and some Garden 2) may be treated conservatively, and this is an important consideration, especially wherein an ageing population these fractures are on the increase, and where surgical time is in heavy demand. Overall a lower mortality rate has been claimed in those treated conservatively as opposed to surgically. Method:(1)The leg is rested in a gutter splint until pain settles (usually after about a week).(2)Partial weight bearing with crutches is then commenced, and continued for 8 weeks, after which full unsupported weight bearing may be allowed.(3)Check radiographs are taken 2 days after the start of mobilisation, and thereafter every 2 weeks until the eight week.(4) If the fracture disimpacts and becomes unstable (a 14% incidence only is claimed) then active treatment becomes necessary, when a hemi-or total arthroplasty may be performed. Disimpaction is seen most often in those over 70 especially those in poor general health, or in the younger patient with a low life expectancy. The problems of prolonged recumbency in the elderly may nevertheless follow this line of treatment."

This basic principle has been repeated again **in Emergency Orthopaedics and Trauma by Andrew Unwin and Kirsten Jones** in which it has been observed as under:

> "**Subcapital fractures of the neck of the femur**:
>
> These common fractures have been classified according to the Garden classification.
>
> Garden I
>
> Impacted fractures with an incomplete facture line.
>
> Trabeculae through fracture angulated as the head is abducted.
>
> Garden 2
>
> Impacted fracture with a complete fracture line.
>
> The trabeculae appear interrupted but not angulated.
>
> Garden 3
>
> Femoral head is displaced.
>
> The trabeculaeare interrupted and angulated.
>
> Garden 4
>
> Femoral head is more displaced (fallen off).
>
> Trabeculae may appear parallel as the head may not be abducted.
>
> This classification system corresponds with increasing insult

to the blood supply of the femoral head. Grades 1and 2 are relatively undisplaced fractures with a lower risk of avascular necrosis than the more displaced Grades 3and 4. The system also allows a treatment strategy(see below).

Subcapital fractures are prone, in addition to other complications associated with all femoral neck fractures, to two particular problems:

(a) avascular necrosis of the femoral head – this is unpredictable, but generally the prognosis is worse with greater displacement and with proximal fractures; and

(b)non-union of the fracture.

The treatment of these fractures is controversial. Many centres now adopt the following protocol:

1. All young patients undergo internal fixation as a surgical emergency in an attempt to reduce the fracture, decompress the intracapsular haematoma and fix the fragments. Subsequent avascular necrosis or non-union is treated on its merits, often with a total hip replacement.(Primary total hip replacement as an emergency treatment is regarded by many to have an unacceptable complication rate,although this policy is adopted by some).

2. In older patients:-

Garden 1 and 2 fractures are internally fixed.

Garden 3 and 4 fractures are assumed to have a high risk of complication with internal fixation, and so as to avoid multiple operations, undergo a hemi-arthroplasty, replacing the head of the femur whilst leaving the acetabulum intact (Fig.20.9). A risk of hemiarthroplasty is that the metallic femoral head may 'bore' its way into the acetabulum, causing pain and erosion. For this reason, with their softer bone, hemiarthroplasty should be avoided in patients with rheumatoid arthritis.

3. In the very old or frail patient,all femoral neck fractures are recommended to undergo hemiarthroplasty."

In **Intracapsular Fractures of the Neck of the Femur By C.E.Ackroyd.G.C.Bannister and V.G.Langkamer,** it has been observed as under:

Indications for internal fixation

If undisplaced fractures are managed without fixation, 12 per cent displace and are therefore less likely to unite. The trabecular bone is already impacted and fixation with two screws is sufficient to maintain stability.

British and Danish controlled trials suggest that in patients over 70 years of age with displaced fractures, primary prosthetic replacement results in lower morbidity, fewer reoperations and comparable mortality over 6 months when compared with internal fixation. However,femoral head replacement results in progressive acetabular erosion and after 5 years 20 per cent of survivors have undergone total hip replacement.

Internal fixation may reasonably be offered to mentally alert, independent and fully mobile patients, whose life expectancy is likely to exceed 5 years provided that the fracture can be accurately reduced in patients under 60 years of age every effort must be made to preserve the femoral head. Prosthetic replacement will inevitably fail with the passage of time.

Fixation devices

The profusion of fixation devices is testimony to the poor union rate of intracapsular fractures and the endeavours to improve this by more secure fixation.The literature is confused by reports quoting wide differences in results between individual authors and from different institutions but when randomized prospective controlled trials have been carried out by some authors, results are all very similar.

The evidence suggests that displaced subcapital fractures unite better with adequate internal fixation.

Two implants are better than one, and a screw can be inserted with less trauma than a nail and is less likely to disturb the reduction.

In Standard Orthopaedic Operations, Third Ediction by J.Crawford Adams

Comment

Efficient internal fixation of femoral neck fractures is not always simple and it demands considerable precision. The slogan should be: "Get it right first time". All too often the operator accepts an inferior reduction, an imperfect position of the nail or screw, or incorrect length of the fixation devices. Defeat must not be accepted perseverance is well rewarded.

Trouble is often experienced with the radiographic control. Unless the setting up of the apparatus is supervised by the surgeon himself films that are virtually useless may be produced. In particular, they often fail to show the femoral head adequately in the lateral projection. The reason for this is usually that the cassette is not pushed firmly enough into the loin, or that the beam is wrongly directed. These points must be checked every time a film is exposed. The same remarks apply to the use of the image intensifier.

If the correct rotational position of the limb is not insisted upon it often happens that the lateral radiographs show the femur semi-obliquely rather

than in the true lateral projection. Acceptance of such an incorrect position makes accurate insertion of the nail and screw unnecessary difficult.

Choosing the correct length of the nail and of the screw should not present any special problem because the length of the guide wire within the bone can be determined accurately by measuring the amount still protruding, and to this may be added or from it subtracted an amount as measured on the check radiographs. One necessary precaution needs to be mentioned, however, that is, to measure the length of the nail directly with a ruler before it is inserted, and not to rely simply on the figure engraved upon it: the length as engraved is not always the effective length that will enter the bone, for it may include the head of the nail.

A hazard that needs further mention is that of inadvertently driving the guide wire forwards with the nail. This can present a very serious difficulty if the wire is driven across the hip joint into the iliacfossa, for the guide wire may be broken off by repeated hammer blows upon the nail. In such a case the only way of retrieving the broken-off part of the guide wire is by exposing the iliac fossa and locating the tip of the wire from within the pelvis. This dilemma is, however, easily avoided if the precaution is taken of examining the guide wire repeatedly while the nail is being driven in. This entails removal of the cannulated

punch and measurement of the protruding part of the guide wire to see whether it is being driven on. At the same time is wise to grip the guide wire in a hand chuck and to rotate it to and fro: if the wire is being gripped dangerously by the point of the nail it will not rotate freely, and at this danger signal the wire should be promptly withdrawn.

All these points of detail are important: neglect of any one of them may easily lead to failure.

Alternative Techniques

It is not universally accepted that fixation by a nail and a screw is the most effective method. The compression hip screw, the use of which is described."

In **Watson-Jones Fractures and Joint Injuries, Edited by J.N.Wilson, Sixth Edition, Vol.I** it has been observed as under:

**Treatment**

The choice of treatment for femoral neck fractures depends upon three factors:

1.The age and fitness of the patient
2.The type of fracture
3.The degree of displacement

Undisplaced fractures are treated by protected weight bearing until union occurs or by internal fixation in situ to prevent displacement. If it is decided not to operate, regular radiographs are

needed to be sure that the position does not change.

Displaced fractures can be treated by internal fixation or prosthetic replacement.

Internal Fixation. The fracture can be held with several fine pins, a pair of crossed nails or a dynamic compression screw and plate. This device compresses the fracture site and is the preferred treatment in most centres. All of these are inserted under image intensifier control. Internal fixation is particularly suitable for the larger fragments caused by basal fractures. Accurate reduction and fixation is more difficult in severely displaced fractures and those with small fragments.

**Indications.**

**Internal fixation:** fit; young, little displacement

Prosthesis: unfit, old, displaced fractures

**Results**

Internal fixation: better long term result. More complications. May need second operation. Slow rehabilitation.

Prosthesis: early mobilization. Long-term complications are rarer but more serious. A good guideline is to fix the fractures of fit patients under 65 and replace the rest.

The fracture must be protected from full weigh bearing after fixation, which is difficult in the elderly patient.

If successful, internal fixation of the fracture produces an almost perfect hip if the fracture is complicated by aseptic necrosis or non-union, a second operation will be required to replace the head with a prosthesis. The femoral head may also collapse onto the pins, damaging the acetabulum.

Prosthetic replacement. Immediate replacement of the head with a Thompson or Austin-Moore prosthesis avoids the complications of non-union and aseptic necrosis and allows immediate full weight bearing.

Early mobilization has many advantages, but the prosthesis may loosen or the femoral head may erode the floor of the acetabulum. If either complication occurs, a total hip replacement will be needed. The wound may also become infected, making excision arthroplasty necessary.

As always with prosthetic replacement, the results are better than other techniques t when they are successful but far worse when they are not."

19. Mr. Ranjit Kumar and the respondent have filed some additional texts alongwith their written submissions but as they are largely repetitive they need not be referred to. In view of the aforesaid decisions, we find that no firm conclusion as to the preference of one or the other procedure can be drawn but for a Garden type III fracture on a young person, internal fixation is ordinarily the favoured but not the only option as some of the texts afore-referred also proceed on a school of thought which prescribe that in order to avoid long drawn out recovery and other complications, it is advisable to go in for a hemiarthroplasty notwithstanding the age factor. It has also been observed that condition of the patient and of the bone would be relevant determining factors in the choice which the doctor wishes to make. The appellant, in his evidence, explained as to why he had chosen hemiarthroplasty over internal fixation in the following words:

> "During the surgery I was assisted by Dr. Naivasivayam who was a Surgeon for 20 years of experience attached to Government General Hospital, Madras. One Dr. Gopinath was a stand-by during the Surgery. He was the Doctor who had treated him for infertility. From the 1st X-

> ray it was found that the fracture was garden type I. From the second X-ray it was found that the fracture was garden type III. During the operation I found the head of femur to be unhealthy. The size of the prosthesis is a measure from the head of the femur removed from the patient during the course of surgery by a special measuring device. I was satisfied with my whole procedures."

20. In cross-examination, he further stated that due to deterioration of the fracture site, he had decided to go in for surgery instead of internal fixation. It is also relevant that though the respondent had sought the opinion of Dr. Ajit Yadav of the Tamil Nadu Hospitals on 30th May 1992, he produced no evidence to off-set the appellant's evidence as to why he had chosen hemiarthroplasty over internal fixation. It is equally significant that the respondent had taken the advice of several renowned doctors including Dr. Mohan Das and Dr. Nand Kumar, but none of them in their treatment notes observed adversely about the choice of treatment nor any negligence in the actual operation. In the light of the fact that there is some divergence of opinion as to the proper procedure to be adopted, it cannot be said with certainty that

the appellant, Dr. Sreekumar was grossly remiss in going in for hemiarthroplasty. In **Jacob Mathew case** (supra) it has observed as under:

> "48(*1*) Negligence is the breach of a duty caused by omission to do something which a reasonable man guided by those considerations which ordinarily regulate the conduct of human affairs would do, or doing something which a prudent and reasonable man would not do. The definition of negligence as given in *Law of Torts*, Ratanlal & Dhirajlal (edited by Justice G.P. Singh), referred to hereinabove, holds good. Negligence becomes actionable on account of injury resulting from the act or omission amounting to negligence attributable to the person sued. The essential components of negligence are three: "duty", "breach" and "resulting damage".
>
> (*2*) Negligence in the context of the medical profession necessarily calls for a treatment with a difference. To infer rashness or negligence on the part of a professional, in particular a doctor, additional considerations apply. A case of occupational negligence is different from one of professional negligence. A simple lack of care, an error of judgment or an accident, is not proof of negligence on the part of a medical professional. So long as a doctor follows a practice acceptable to the medical profession of that day, he cannot be held liable for negligence merely because a better alternative course or method of treatment was also available or simply because a more skilled doctor would not have chosen to follow or resort to that practice or procedure which the accused followed."

21. It would, thus, be seen that the appellant's decision in choosing hemiarthroplasty with respect to a patient of 42 years of age was not so palpably erroneous or unacceptable as to dub it as a case of professional negligence.

22. We thus, allow Civil Appeal No. 6168 of 2008 and dismiss the respondent's complaint. Ipso facto Civil Appeal No.6167 of 2008 is dismissed. In the light of the fact that the respondent had appeared in person and is physically handicapped, we direct that a copy of this judgment be sent to him free of cost to his address under Registered cover.

**.....J.**
(**DALVEER BHANDARI**)

**.....J.**
( **HARJIT SINGH BEDI** )

**New Delhi,**
**Dated: May 1, 2009**