**IN THE COURT OF ------------------------------------**

**BHADRAVATHI**

M.V.C. ------------------

PETITIONER : ----------------

V/s.

RESPONDENT : ------------------

CHIEF EXAMINATION P.W.2 BY WAY OF AFFIDAVIT

1. Name : Dr. Ramachandra H.M.

2. Father Name : Kamath H.M.

3. Age : 46 yrs.

4. Occupation : Orthopedic Surgeon

5. Address : Madhava Day Care Fracture Surgery

Lower Hutha, Bhadravathi

I am working as Orthopedic Surgeon in Bhadravathi since 1994. I visit various nursing homes as consulting orthopedic surgeon. I examined the petitioner Mr. ------- on ----- in - after receiving a call about him being admitted. He gave history of Road traffic accident on -. He was having following wounds.

1. Abrasion Right mid leg 1 X 2 cm
2. Contused lacerated wound mid calf postr 1 X ! cam bone deep Right side
3. Abrasion on medial malleolus Right side 2 X 2 cam
4. Abrasion R foot plantar aspect 1 X 1 cam
5. Displaced comminuted fracture of tibial shaft right side
6. Displaced fracture of shaft of fibula Right side

Injury no 5 & 6 were grievous and other wounds were simple in nature. No 5 and 6 were confirmed by x ray. Color of blood red and age of wound less than 24 hrs. I have issued a wound certificate in this regard on ---------- and I have noted that in the case sheet also.

Later he was investigated and administered medicines, injections, drips etc. He was operated by me on 30/8/2010. An intramedullary tibia interlocking nail and 4 bolts were inserted to correct his fracture. Autologous bone grafting was also done. He was put on plaster and was discharged on ----------- with advice to continue tablets and exercises were taught to him. Bhadranursing Home authorities have issued receipts for their services on their behalf and my services on my behalf.

He attended my clinic for further treatment till 21/06/2011 during which he was given physiotherapy, sutures were removed, plaster was changed.

Following were his visits

9/9/ 13/9 dressing done. 17/9 dressing and AK POP done, 11/10 xray, 9/11 POP downsizing done, 23/11 xray done, 16/12 POP removed dressing done. 18/12 fiber glass cast applied 27/1/11 xray done. The last plaster was removed on 21/2/2011. He again came for pain on walking on 17/3 and 21/6/2011 when I prescribed medicines.

I have issued prescriptions and receipts for all the services in my OPD.

On 28/12/2012 he came for assessment of physical disabilities and x-rays were done with measuring scale. On 12/01/2013 when he came for assessment, he gave history of pain on walking and standing for longtime, inability to sit cross legged, sit on floor or low stool, carry heavy weights, use Indian type toilet.

Further on physical examination the findings corroborated with history. He walks with a limp on right side. His wounds are healed and anterior nail insertion site scar is tender. This patient has FFD of 5 degree in right knee giving a deformity by itself and a true shortening of 1 “. Total Limb length on Left 34.5” on R side 33.5”. His muscles strength in the right ankle and foot joints was less than on the left side. He had pain in right knee on active movements. He finds difficulty to lie down prone also. X-rays on assessing showed union of fracture with intramedullay nail in situ with a true shortening of tibia of 1 inch. (13.75 R 14.75 L).

His stability scores of right side for walking on plain surface, walking on slope, and standing on both legs, squatting on floor, sitting cross leg and taking turns were less than on the left side.

Above findings were entered in the disabilities assessment score sheet in the proforma suggested by Guidelines for other disabilities No 16-18/97-NI.[http://www.ccdisabilities.nic.in](http://www.ccdisabilities.nic.in/)

Following corroborating documents were also referred case sheet, wound certificate, x-rays.

First mobility loss at hip, knee and foot & ankle was calculated and added. That value was multiplied by 0.3 and was --. Then loss of muscle strength at hip, knee and foot & ankle was calculated and added. The value was multiplied by 0.3 and was --. Out of these value -- being higher was considered a and – was considered b. Both values were combined using combining formula a + (b(90-a)/90) giving a value of – for the total mobility component. Then clinical method was used to calculate loss in the stability component giving a value of --. Out of these mobility and stability loss values, – being higher was considered a and – was considered b. Both values were combined using combining formula a + (b(90-a)/90) giving a value of – for the total loss.

At the end lower limb extra points or additional weightage was calculated and added giving a final value of -.

On the basis of above a disability certificate was issued to the petitioner as he is suffering with permanent disability to the extent of - for lower limb. In this case the impairment due to injury is more than that could have happened with amputation at that level because of involvement of upper joints.

I have also advised him removal of the implants from right leg as early as possible, which would cost around 30000/- including hospital stay for 10 days and follow-up in OPD for next 30 days. In my opinion above disabilities are permanent and can not be corrected.

I have produced

1. Case sheet of IP treatment pages

2. OPD Notes, examination findings 1 page

3. X rays – nos. and X ray report

4. Score sheet of Assessment of permanent physical impairment in lower limb – 3 pages

5. Score sheet Assessment of permanent physical impairment in upper limb – 4 pages.

6. One disability certificate 1 page

I swear to the above contents.

Identified by me:

Advocate

Place: Shimoga DEPONENT   
Date: --------------