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| NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION | |
| NEW DELHI | |
| Consumer Complaint NO. 44 OF 1997 | |
| Baburao Vithal Lohakpure<br>r/o B-22, Vishvalaxmi<br>M.A. Road Andheri (W)<br>Mumbai – 58.<br><br>Siddharth Lohakpure<br>Aged 16 years<br>C/o B.V. Lohakpure<br>r/o B -22, Vishvalaxmi<br>M.A. Road Andheri (W) Mumbai -58<br><br>Yuvraj Lohakpure<br>Aged 13 years<br>C/o B.V. Lohakpure<br>r/o B -22, Vishvalaxmi<br>M.A. Road Andheri (W) Mumbai -58 | ..... Complainant(s) |
| Vs. | |

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| Smt. Suniti Devi Singhania Hospital<br>And Medical Research Center<br>P.O. Jekegram Thane – 400606<br>Maharashtra<br><br>Dr. Prakash Gangadhar Page<br>r/o 205, Swaralata Apartment<br>Opp. To Ice Factory<br>Naupada, Thane<br>Maharashtra<br><br>Dr. Mohan Shankar Chandavarkar<br>r/o 1 A 1, drug Employees Society<br>Pokharan Road No.<br>Opposite J.K. (Samata Nagar)<br>Thane, Maharashtra | ..... Opposite Party(ies) |
| **BEFORE:** | |
| HON'BLE MR. JUSTICE K. S. GUPTA, PRESIDING MEMBER | |
| HON'BLE DR. P.D. SHENOY, MEMBER | |
| | |
| For the Complainant : SHRI SUSHIL BAJAJ, Advocate | |
| | |
| For the Opposite Party 1. : SHRI ASHISH DHOLAKIA, SHRI ARVIND KUMAR AND SHRI ABHISHEK RAO Advocates<br>2. : SHRI RAJIV THAKUR, Advocate<br><br>3. : MS. SHILPA OVALEKAR, Advocate | |
| | |
| **Dated the 16th day of August ,2007** | |
| | |
| **O R D E R** | |

## DR P D SHENOY, MEMBER

A healthy well nourished lady, Mrs. Jayshree Lohakpure aged 38 years was admitted to the hospital on 23.02.1995 for hysterectomy and taken to the operation theatre at 1.40 p.m. on 24.2.1995 and declared dead at 3 p.m. before the commencement of surgery in the presence of anaesthetist, gynaecologist, nurses and lastly a surgeon and a chest specialist who came to the Operation Theatre (OT) a few minutes before her death. Can this be considered as a case of medical negligence? A detailed analysis of the case leaves no room for doubt.

**Case of the complainant :**

Complainant No.1 is the husband of the patient Jayshree Lohakpure who is survived by her two children. Complainant No.2 and No.3 have filed this complaint through their next best friend and guardian, complainant No. 1.

On the recommendations of Dr.Chandavarkar, Opposite Party No. 3 (OP No.3) was admitted to Smt. Suniti Devi Singhania Hospital and Medical Research Center, Thane. She was declared dead around 3 p.m. on 24.2.95 even before the actual surgery was commenced because of the negligent manner in which anaesthesia was administered by Dr. Page and also because of inadequate and negligent emergency medical aid provided by the opposite parties.

Mrs. Lohakpure having menstruation problem for a month, consulted OP No. 3 who recommended hysterectomy. As the test results were satisfactory, surgery

was fixed at 2 p.m. on 24.2.95 and was admitted on the previous day to the hospital. Necessary fees were paid by the complainant. To get best possible treatment, the patient was admitted into the best class as per the booklet printed by the hospital titled **'Patient guide and some useful information'.**

Mrs. Lohakpure was prepared for surgery and taken to the OT at 1.30 p.m. At 1.45 p.m., just 15 minutes before the commencement of surgery Dr. Page, anaesthetist met the patient for the first time. After perfunctorily asking the patient some questions about her health, Dr. Page at 2.15 p.m. started administering her anaesthesia. Dr. Chandavarkar, Gynaecologist arrived at 2 p.m. All her vital organs at that time were normal. Two nurses Mrs. Anni Polas and Mrs. Vatsama Ratankumar were also present. Though Mrs. Lohakpure was admitted to the hospital on 23.3.95 a day prior to the operation, Dr. Page did not examine her nor did he conduct preoperative anaesthetic check up. At 2.15 p.m. Dr. Page and Dr.Chandavarkar OP No. 2 & 3, started preparing her for the operation. Dr. Page tried to insert the endotrachea tube but he was unable to do so. He then removed the tube and put her on artificial respiration. All her vital signs at that time were normal. He mentioned the difficulty in inserting the tube to Dr. Chandavarkar and Nurse Anni Polas heard him say this as well. Despite this difficulty Dr. Page continued his attempts under anaesthesia. The operation was not a vital life saving procedure, which could have been easily postponed. According to Dr. Page the reason that he could not insert the tube was because of the

> "composition (arrangement anatomy) of the physique (body) of the patient and the Swaryantra (throat) the said tube could not go into the swaryantra (throat)"

Dr. Page despite the failed attempt, tried to insert the tube once again in exactly

the same manner. He made no effort whatsoever to make an attempt which would overcome the alleged abnormality which he himself had stated only minutes ago existed nor did he adopt a different method to put her under anaesthesia. Forceful effort to reinsert the endotrachea tube caused laceration on her upper lip. As it was not an emergency procedure and as Dr. Page found an abnormality in the physique, the surgery could have been easily postponed. Instead a second and negligent attempt was made and due to this she was deprived of sufficient oxygen. Consequently, when he finally put her back on artificial respiration her pulse had reduced and her heart completely stopped at 2.30 p.m. Though the situation was demanding prompt and correct medical emergency-aid to save the patient's life, the life saving injection 'Adrenaline' to the heart was only given much later after Mrs. Lohakpure's heart had stopped and that too by Dr. Rupwate who had heard the announcement for help.

A perusal of the statement of Mrs. Anni Polas, the nurse on duty to the police throws light on the fact that the hospital was under- equipped in terms of the medical personnel present to effectively handle an emergency situation.

A chest and lung specialist Dr. Rupwate happened to hear the announcement for a doctor and arrived in the OT at 2.45 p.m. by which time Mrs. Lohakpure's heart had stopped. Dr. Harish another doctor had also arrived at approximately same time. Though Mrs. Lohakpure's heart stopped at 2.30 p.m. till the arrival of Dr. Rupwate at 2.45 the life saving injection was not given either by Dr. Page or by Dr. Chandavarkar. This 15 minute's delay was fatal. By then Mrs.Lohakpure showed no signs of pulse or blood pressure. In fact, by then she was already exhibiting the symptoms of 'cyanoses'

i.e. her nails had turned blue and pupils were not showing any reaction to light. In short she exhibited all signs of death.

Dr. Rupwate injected life saving drug Adrenalin straight into Mrs. Lohakpure's heart twice. She was declared dead at 3 p.m. The resident medical officer arrived at the scene only at 3.30 p.m. **The body was sent for post mortem and the report clearly states that the cause of death as "Cardio respiratory failure due to hypoxia or cardiac arrest due to low oxygen". The supply of oxygen was in fact so low that the brain had also haemorrhaged.**

Mrs. Lohakpure was the sole proprietor of M/s Jaya Intercom Corporation. She has been filing income tax returns since 1991. She has left behind two sons aged 16 and 13 years namely Siddharth Lohakpure and Yuvraj Lohakpure. Complainants have claimed a total compensation of Rs. 72.60 lakhs.

**Reply on behalf of the respondent No.1 – Smt Sunitidevi Singhania Hospital and Medical Research Centre.**

The opposite party No. 1 claims that it is a well established public charitable hospital situated in the city of Thane since six years, consisting of 101 beds including 16 beds in the ICU and 4 Operation Theatres (OT). It has a staff of 315 including 81 nurses. It has qualified Resident physicians/ surgeons who are all post-graduates in their speciality and are available in the hospital to look after the patients to carry out the instructions of the consultants/ doctors treating the patients on a 24-hour basis. **Hospital employs 9 Resident Medical Officers, 5 full time consultants viz., one**

**General Surgeon, one Cardiologist, one Orthopedic Surgeon, one Gynaecologist and one Pathologist who are all on call 24 hours a day and reside in the hospital complex.** Hospital has various injections readily available including injection Adrenalin 20 ampule. Apart from all necessary equipments, OT also provides monitoring equipments, pulse oxymeter and resuscitation equipments.

OP No.1 submits that the unfortunate death of Mrs Lohakpure is not as a result of non-availability of adequate equipment and/ or medicine and/ or staff, nurses or doctors and/ or inefficiency in the service provided by the hospital. OP No. 1 has provided all possible assistance to the doctors to take care of any pertinent emergency. Death of Mrs Lohakpure was unfortunate and was not due to any deficiency in service and/ or any medical negligence on the part of the hospital. **In case of emergency in the OT the staff concerned informs the telephone operator or a general announcement is made on a public announcement system to all the doctors to get in touch with the OT, which is repeated several times.**

Dr Prakash Gangadhar Page – OP No. 2 is a highly qualified and experienced anesthesiologist attached to the hospital as an honorary anesthesiologist. Similarly Dr M S Chandavarkar is a highly qualified and experienced specialist in Obstetrics and Gynaecology. **The hospital is equipped with audio-visual alarms and with one of the best monitors so that last 24 hours' condition of the patient could also be reviewed, if necessary.** Effectiveness of the system is seen from the fact that two doctors attended immediately to render such assistance when called for. Dr Page

commenced Cardio-Pulmonary Resuscitation measures as soon as Dr Rupwate arrived in the theatre. He administered the life saving medicine Adrenaline to Mrs Lohakpure thrice. RMO Dr Usharani Shetty was not required to attend the surgery and if her presence was required, a request would have been made.

**Written statement of OP No. 2 – Dr P G Page :**

Dr Page has given in detail his qualification and experience in his written submissions wherein he has submitted that it has always been his usual practice as an anesthetist to get detailed information in advance about the patient whom he has to anaesthetize and to get acquainted with the case history of the patient through discussions with the surgeon who would be performing the surgery, and by reviewing relevant case records.

In the present case he has followed the standard procedure and satisfied himself whether the required pre-operative investigations had been done and that the results of those investigations were within the normal limits and that the patient was fit to undergo anaesthetic procedure. Subsequently, he also had the patient's clinical examinations as per the standard procedure. He has also ascertained that the patient had given an informed consent to undergo anaesthesia. Before introducing anaesthesia he administered 100% Oxygen (pre-oxygenation) to the patient, as a preventive measure to ensure that her Haemoglobin was fully saturated with oxygen to combat any hypoxia, if any may occur during intubation. This is a standard internationally accepted anaesthetic practice. Every surgical/ anaesthetic procedure is attended by such risks.

**Risks of sudden unforeseeable and unpreventable complications of unknown origin, which fact was explained and conveyed to the patient. The same was conveyed as reflected in the consent form**.

**OP No.3 Dr Chandavarkar had advised the patient Mrs Lohakpure** to **undergo operation for abdominal hysterectomy (removal of uterus) which was to be done on 24th February 1995 at 2 p.m.** She was admitted on the previous night at 11.00 P M. Prior to the admission of the patient, OP No. 2 had a telephonic discussion with the OP No. 3 about the intended operation of the patient, her case history and the pre-operative/ pre-anaesthesia investigation. He was told that the patient was slightly obese, she was fit for surgery and anaesthesia. As per his usual practice, **OP No. 2 wanted to go through the reports of various tests of the said patient. However, he could not do so because the complainant No. 1 got his wife admitted in the hospital at 11.00 P M on the previous night.** OP No. 2 at about 01.30 P M in pre-operative/ recovery room examined the said patient including her mouth, mobility of the cervical spine, any abnormality of the teeth, nasal passage, temporomandibular joint movement, cardiovascular system, respiratory system, blood pressure and pulse and found that all these parameters were normal and **that there was no anatomical abnormality.** At about 01.45 P M the patient was taken to the OT. OP No.2 have carried out a pilot drill and ascertained that all the anaesthesia instruments equipments like Boyle's apparatus, monitoring devices etc., were in perfect working condition and that the oxygen supply line was proper. He checked other equipments, medicines and availability of nursing staff. When the patient was brought for operation, the following steps were taken for administering for anaesthesia :

a. pre-oxygenation i.e. 100% oxygenation for 5 minutes

b. injected intravenous penthal (for inducing sleep)

c. injected intravenous Scoline (for relaxing the muscles)

d. thereafter followed the procedure of laryngoscopy and endotracheal intubations (i.e. to continue anaesthesia for required time for surgery)

According to him the entire procedure of intubation including its connections with the anaesthestic medicine is usually complete within less than a minute. The procedure of anaesthesia commenced at 02.15 P M with the administration of 100% oxygenation. By 02.20 P M on being satisfied that she was adequately oxygenated the OP No. 2 administered the initial dose of 50 mg Pentothal intravenously. As the patient did not develop any untoward reaction the OP No. 2 administered the remaining dose of 250 mg Pentothal making a total dose of 300 mg. This was followed by I V Scoline 100 mg. During this period, the patient was being given 100% oxygen by hand ventilation. One of the nurses then applied cricoid pressure and this OP did laryngoscopy with the normal blades. OP No. 2 could only see the tip of the epiglottis and could not see the vocal cords as the larynx was positioned anteriorly.

Anterior larynx is not an uncommon finding and is often discovered on the operation table for the first time. As the intubation could not be carried out at the first attempt, this opposite party withdrew the tube and continued 100% oxygenation with hand ventilation till the patient recovered from the effect of Scoline and started breathing on her own, in about five minutes. There was no oxygen deficit whatsoever at any stage and all the vital parameters of the said patient were normal.

The passage of the tube into the trachea via the larynx (voice box) is automatic

as the tube follows the normal anatomical curve. **However, at times such intubation may not be possible due to the degree of the anatomical variation being greater than what is normally expected.** In such cases the anesthetist withdraws the tube and if the condition of the patient is stable, makes a second attempt at intubation, with a change to a longer laryngoscope blade. This is a universally accepted standard anaesthetic practice. If the second attempt also does not succeed then the anaesthetist abandons the procedure altogether.

In the instant case, as the patient was stable, her vital parameters like pulse, blood pressure and respiration were normal, the cardiac monitoring indicating normal functioning of the heart and as the tip of the epiglottis could be seen during earlier laryngoscopy, this patient was fit for second attempt at intubations as per the accepted international practice in anaesthesia.

The patient started breathing on her own as the effect of the first dose of Scoline started wearing off. This opposite party thereafter slowly administered well diluted Atropine 0.6 mg. intravenously to prevent any possible side effects like slowing of the heart rate and increased secretions in the respiratory tract, after the proposed second dose of Scoline. Following the administration of Atropine, the patient responded as is normally expected with an increase in the heart rate. Meanwhile, as the patient had started breathing on her own, this opposite party administered 0.5% Halothane alongwith 100% oxygen via the anaesthesia circuit, to keep the patient lightly anaesthetized prior to administration of second dose of Scoline as per the internationally accepted standard practice in anaesthesia. Halothane was discontinued before

administration of the second dose of Scoline. This opposite party then administered second dose of 100 mg. Scoline intravenously for the second Laryngoscopy and continued giving 100% oxygen to the patient.

After this the opposite party noted the desired effect of Scoline, he carried out laryngoscopy for the second time, with a longer laryngoscope blade so as to be able to visualize the vocal cords. However, inspite of the change to longer laryngoscope blade, he could not visualize the vocal cords due to the inherent anatomical variation in the patient. Therefore, this opposite party thought it advisable not to intubate the patient. He put aside the prepared Endotracheal tube and abandoned the procedure altogether in the best interest of the patient and as per the internationally accepted standard practice in anaesthesia. The opposite party continued to give 100% oxygen. He then placed an airway in the patient's mouth to prevent and protect against the possibility of obstruction to her respiration by backward falling of her tongue, a common occurrence in all unconscious patients. It is pertinent to note her that this opposite party was continuously monitoring the patient all throughout.

At about 02.35 P M the opposite party noticed on the cardiac monitor that the pulse rate of the patient, though regular, suddenly started to slow down, even though 100% oxygen was being continuously administered. The patient started developing sinus bradycardia (heart rate slowing down to below 60 beats per minute and regular) and hypotension (fall of blood pressure). The opposite party therefore immediately administered Atropine 0.6 mg, intravenously once again to increase her heart rate to

overcome the sinus bradycardia. Development of sinus bradycardia in a patient who has already been administered Atropine before giving the second dose of Scoline, is a highly unusual occurrence. Therefore, as a matter of abundant caution this opposite party promptly summoned for additional medical assistance.

It is important to note here that this sudden, unexpected and unpredictable complication that had arisen, was noticed immediately because of the intensive monitoring of the patient by the opposite party. The opposite party gave Efcorline 200 mg. intravenously to combat the situation. Further, the opposite party also asked the nurse to fill up a syringe with 1 c c of 1:1000 Adrenaline.

While the above mentioned therapeutic and precautionary measures were being taken, the patient's heart suddenly stopped and she went into a cardiac arrest. The opposite party with the help of the OP No. 3 immediately started the cardio-pulmonary resuscitation, which is the first line of treatment before administration of any drugs like Adrenaline etc.

The most important steps of Cardio-pulmonary Resuscitation (CPR) are as follows :

a. Establish a clear airway by removing the secretions, if any, from the oropharynx.
   This was already done by this opposite party by way of putting airway as stated earlier.
b. Oxygenate the patient with 100% oxygen.
   Administration of oxygen was already on in this case.

(c ) Give external cardiac massage.

This was done by the opposite party No. 3 by thumping the chest once followed by pumping the same with palms of both the hands placed one over the other and pressing and releasing the patient's chest wall at the rate of about 80 times per minute.

a. Simultaneously ventilate the patient's lungs with 100% oxygen at the rate of about 20 bursts per minute that is one burst of oxygen after every fourth pump on the chest wall. This ventilation was done by this opposite party by pressing the reservoir bag of the anaesthesia machine.

b. Administration of Adrenaline. As per the standard practice of C P R procedure Adrenaline is administered only after the heart has failed to respond to the external cardiac massage. If Adrenaline is administered prematurely, that is during bradycardia, it will precipitate the cardiac arrest by itself. Therefore, Adrenaline is administered after the C P R is tried for some time and the patient fails to respond.

   **While the CPR was being done, Dr Rupwate also arrived in response to the SOS call. The opposite party No. 2 & 3 continued the CPR and the opposite party 2 requested Dr Rupwate to administer the said Adrenaline, already filled in the syringe, directly into the patient's heart as she failed to respond to the C P R. The opposite party No. 2 & 3 continued the CPR with the help of others present in the operation theatre. Dr Rupwate administered a second dose of intra-cardiac Adrenaline.**

c. Administer D C Shock to electrically stimulate the heart, if the above measures do not succeed.

   This was done by the opposite party as the patient's heart failed to respond to pumping of the chest wall, ventilation with 100% oxygen, administration of adrenaline intra-cardiac twice. The cardio-pulmonary resuscitation was continued throughout.

Inspite of all these resuscitation measures the patient's heart failed to respond. Her pulse and blood pressure could not be recorded and her pupils became dilated. C P R was further continued for some time but the patient's heart did not show any signs of revival. It was at about 03.00 P M after best of these efforts, that all the doctors present in the operation theatre concluded that the said patient was now dead and declared her so accordingly.

He has denied that there was a 15 minute delay either in dealing with the emergency situation or in arrival of Dr Rupwate. All the resuscitative measures were taken promptly as the bradycardia, preceding the cardiac arrest, was noticed immediately due to the alertness of the opposite party and everyone was mentally alert to cope with any eventuality. There was no delay in administration of Adrenaline even though it was administered by Dr Rupwate who did inject Adrenaline twice directly into the heart after his arrival in response to the SOS Call.

**Written submissions of OP No.3 Dr Chandavarkar :**

It is an admitted fact that surgery on the deceased had not yet commenced when she expired. It is again an admitted fact that not one incision had been made by OP 3 upon the deceased when the death occurred. The opposite party did all that was best possible to revive and resuscitate the deceased under the supervision of OP No. 2., when OP No. 2 informed that the deceased was showing signs of Bradycardia.

Massage was given by OP No. 3 continuously under the supervision of OP No. 2

in an attempt to save the deceased. Just as no anaesthetist can direct or control any surgery performed by the Gynaecologist, similarly no Gynaecologist can control or direct the methods or the means or medicine in the administration of anaesthesia to any patient. In fact OP No. 3's responsibility would have commenced only upon the first incision having being made on the patient signifying the commencement of the surgery which in this case was not done. **A provisional diagnosis of dysfunctional uterine bleeding/ Adenomyosis was made. After the treatment, bleeding had stopped, she had a mild pain in the back and abdomen. She also desired to get the hysterectomy done in the near future.**

During anaesthesia by OP No. 2 when the second attempt of intubations did not succeed, OP No. 2 continued by giving the patient oxygen to bring her out of anaesthesia. Few minutes later the patient developed bradycardia and OP No. 3 immediately washed out of his sterile gown and started helping the resuscitation process. OP NO. 2 asked the OP No. 3 to give external cardiac message. OP No. 2 in the meanwhile was continuously administering oxygen and intravenous medications to the patient. OP No. 2 also instructed the staff nurse to summon for additional personnel to help, if required. Inspite of the resuscitative measures Mrs Lohakpure developed sudden cardiac arrest. **Resuscitative measures continued, then Dr Rupwate (Chest Specialist), Dr Harish (Surgeon) came. Dr Rupwate gave intracardiac Adrenaline injection twice but the patient did not respond. Hence, there was no negligence on the part of OP No. 3.**

## Analyses of Evidence :

1. **Statement of Nurse Mrs. Anni Polas :**

Nurse Ms Anni Polas has given statement to the police that when she heard Dr Page and Dr Chandavarkar talk about the **reduction of the pulse-rate of the patient and, therefore, when she saw the ECG Monitor, Dr Page asked her to immediately call the physician on duty. Thereupon she phoned the medical OPD, however, as nobody received the phone, she phoned the ICU where the duty sister informed her about the non-availability of any physician. Therefore, she asked the operator to contact at the place where the physician will be available and asked him to immediately come to the operation theatre. She informed all this to Dr.Page. Upon this he asked her to call the Chest Physician Dr Rupwate. After this, she again phoned the Medical OPD and ICU, however, Dr Rupwate was not available at both the places. Therefore, she again informed this to Dr Page upon which he asked her to call the cardiologist Dr Kumble. Thereupon she phoned the ICU, however, he was not there. She asked the telephone operator to contact the Cardiologist and asked him to come to the operation theatre immediately. He took about 10 minutes for all this. In the meantime, Dr Rupwate and Dr Harish came to the operation theatre.** Thereafter Dr Rupwate gave injection of Adrenalin in the chest of the patient. At the very time Dr Page gave shock to the chest of the patient. At that time the doctors made all the efforts to save the life of the patient, however, the patient died.

Precious ten minutes were wasted because of the non-availability of the cardiologist or the surgeon. During this period Dr Page, could have administered the Adrenalin injections and Dr Chandavarkar could have conducted tracheotomy to enable the patient to breathe.

**2. <u>Role of Dr. Page</u>**

Learned Counsel for the complainant submitted that proper pre-anesthetic check up was not done. Patient was obese weighing 81.5 kgs. This is mentioned in the nurse's notes. It is further mentioned the obesity is 1+, the height of the patient is not written. This would have indicated Body Mass Index (BMC). As the height is not mentioned we have to take the average height of women in India which is slightly above 5 ft. A lady with such a height and with 81.5 kg. is likely to have short neck and this should have been examined by Dr. Page during his pre-anaesthetic check up and if he had done so he would have known that there would be difficulty in intubation.

**Evidence and cross-examination of Dr Page :**

In his cross-examination Dr Page has stated that it is not true to say that he had not maintained a single document before, during and after anaesthesia and there are no pre-anaesthetic notes. Annexure IX page no. 69 of the complaint is the notes during and after giving first injection. The extracts of the same are given below :

**"Page No. 69 is in my handwriting it is not signed by me.** Name of the patient is written by the sister and remaining is written by me. **Column of pre-medication effect nothing is written.** In the said form on the front side shows four drugs were administered to the patient. **On front page - doses of two drugs Atropine and Adrenaline are not mentioned. Similarly timing of administering those doses is not written. Blood Pressure is recorded at 2.15 p.m. at starting, Pulse rate written is not visible. On page No. 1 of the said notes there is no record of pulse rates after 2.15 p m. It is true that on page No. 2 of the said notes there is no mention of**

**patient's pulse rates and BP after 2.15 p m till her death."**

OP 2 says that in the emergency situation, "I am not looking at watch all the time because I was busy with treating the patient. Within five minutes of incident I prepared the notes. It is true to say that I have not mentioned the time of B P and pulse rate is mentioned only once at around 02.30 p m. **I again say that the time mentioned on page No. 72 is mentioned at 02.15 p m onwards.** Onwards means about minute or so. **Inspite of giving Atropine at 02.30 p m pulse rate was 50 and came down thereafter slowly.** It is not true to say that pulse rates and B P were not record-able, therefore, I have not mentioned in the notes. **About 02.25 p m second dose of Scoline was given.**" Before giving the 2nd dose of Scoline diluted IV Atropine (0.6 mg) was given. It was given for two reasons : - (i) to diminish the secretions. (2) to Counter the effect of bradycardia due to Scoline. I have not noticed bradycardia after 1st dose of Scoline. Witness is showing page No. 69 Annexure it is written that Intra-muscular Atropine (0.6 mg) given.

**Major effect of Scoline wears off within 10 minutes. It is true that when the patient is under the influence of Scoline there is no breathing of the patient on his own as he is paralysed.** It is true that for the first 10 minutes approximately of administering Scoline, patient was not breathing. Witness volunteers that however majority effect is over within 5 minutes when patient starts breathing. **'I do not have any respiratory chart to show she started breathing on her own.'**

In his cross examination he answered the questions which are as under:

**Question : Who took the decision of calling emergency help ? You or Dr.Chandavarkar ?**

**Answer :** **I did.**

**Question :** **Who gave instructions to call for nurse ?**
**Answer :** **I did.**

**Question :** **Did she follow instructions ?**
**Answer :** **She did ring,**

**Question :** **How many times she gave call ?**
**Answer :** **As per my memory twice.**

**Question :** **If I say that 7 to 8 times nurse called to RMO, OPD, ICU, Dr Rupwate twice then you called cardiologist ?**
**Answer :** **It is not true that I had asked her to call 7 to 8 times.**

**Question :** **Do you knew that she did call 7/8 times ?**
**Answer :** **I don't know, as telephone is just outside theatre.**

**Question :** **Who was that nurse ?**
**Answer :** **Anni Polis.**

Question : You have also referred in your affidavit statement of Anni Polis ?
Answer : Yes, I referred the police statement of Anni Polis as far as my examining the said patient in recovery room of Operation theatre before taking the patient into the theatre for operation as she was a female patient, it was necessary for her to remain present.

Question : Have you gone through her police statement ?
Answer : Yes, but I can't recollect.

Question : Was any false statement made by her ?

Answer : I cannot recollect.

**Question : If she would have made false statement then you would have pointed out ?**

**Answer : Yes.**

Question : Who was the full time Surgeon available.

Answer : Dr Harish.

**Question : At what time he arrived ?**

**Answer : Dr Harish & Dr Rupwate came along with at about 2.00 PM.**

Question : Is it a fact that he was simply standing there ?

Answer : I have called for extra help, I did not call expert or Surgeon.

Question : When you say statement, means you referred statement before police ?

Answer : Yes.

Question : Do you want to say that Dr Rupwate's statement regarding Cyanosis etc., is true.

Answer : Yes.

**Question : It is correct to say that when Dr Rupwate came patient was in a critical condition ?**

**Answer : Yes.**

Question : Is it not a fact that after call, after 10 minutes emergency assistance came after first call ?

Answer : Dr Rupwate came within 3 minutes.

Question : I put it to you that Dr Rupwate came at 2.40 and not before 2.40 it is correct or not ?

Answer : It is not a correct statement.

Question : How many times you have intubated patient ?

Answer : First time I tried, second time half way, I found it is impossible.

Question : Second time you did attempt, after second dose of Scoline is given?

Answer : Yes.

Question : Why don't you notice to intubate her as on 2nd time with your 30 to 32 years experience?

Answer : No, I thought it was possible with change to longer blade.

Question : Why did not you try longer blade first time ?

Answer : First time I tried with that, which I could not succeed, second time I thought that it would be possible with better positioning with a longer blade.

**Question : I put it to you if you would have noticed abnormality of larynx and abandoned the procedure after first attempt, patient would have saved?**

**Answer : It is not true. Cardiac Arrest can occur at any time, witness volunteers, I am not sure. I am not Angel.**

Question : Did you ask Dr Page to check the patient clinically before 24th ?

Answer : The patient was asked to be admitted on the previous day and Dr Page was asked to see the patient pre-operatively.

**Question : Who can give best judgment Doctor performing the post mortem or you ?**

**Answer : Cause of death can be given by a competent person who performed post mortem.**

Learned Counsel for the complainant submitted that effect of the first Scoline would last for 10 minutes during which two intubations could have been tried. Hence, second dosage of Scoline was given only to try intubation for the third time.

He further submitted that this is a case of *Res Ipsa Loquitor*. (The facts speak for themselves). Hence the burden of proof rests on the opposite parties to prove that there was no negligence.

According to Dr. Page, Dr. Rupwate and Dr. Harish came along at about 2 p.m.. The only treatment record written by Dr. Page but not signed by him does not mention that he administered anaesthesia. The title of this note is *"Dr.Rupwate assisted along with Dr. Chandavarkar and nursing staff." The timing here starts at 2.15 p.m. which means for 15 minutes Dr. Chandavarkar, Dr. Page and nursing staff did not do anything. If this record is to be believed Dr.Rupwate also observed his administering of anaesthesia twice to the patient. Whereas the same page indicates that Adrenaline was injected after 2.30 p.m. which means Dr. Rupwate did nothing for half an hour. Dr. Page has contradicted himself many times during the cross examination e.g.*

**Question : Is it true that when Dr Rupwate came, patient was cyanosis and her pulse and blood pressure was not record able ?**

**Answer : True as per his statement.**

*Ld. Counsel for the opposite parties contended that the statement of nurse Anni Polas was given before the police, in a criminal case registered against the hospital and doctors, hence, it cannot be treated as a piece of evidence. Assuming that we keep aside her statement for a moment, Dr. Page, in cross examination admitted that he took the decision of calling for emergency assistance and he gave instructions to nurse Anni Polas and she gave ring and according to his memory she gave calls twice. To a question that nurse called 7 to 8 calls to* RMO, OPD, ICU and Dr. Rupwate he had answered it was not true that he had asked her to call 7 to 8 times. He might not have asked her to give 7 to 8 calls but nurse had to obey his instructions to secure presence of doctors urgently and for this she would have made calls so many times. To a question whether she called 7 to 8 times, he has replied that he did not know as the telephone was outside the OT.

Ld. Counsel for the parties contended that in the cross examination in a criminal case Dr. Atulya Patil who conducted post mortem had admitted that the report on post mortem was not conclusive. On the other hand, Dr. Page had admitted in his cross examination to a question as to who can give best judgment about the cause of the death, whether Dr. Page or Dr. Atulya Patil, who performed the post mortem. Dr. Page had replied that cause of death can be given by the competent doctor who performed post mortem. The doctor who performed post mortem has categorically stated in his report the cause of death, thus :- “from histopathological, chemical analysis and anaesthetic gas analysis reports

dated 5.7.1995, 20.6.1995 and 9.8.95 respectively and PM findings cause of death is

**Cardio Respiratory failure due to Hypoxia".** This report is signed by **Dr. Atulya J. Patil, Medical Officer, Civil Hospital Thane.** What Dr. Patil meant was PM report was inconclusive pending receipt of other supportive reports viz., histopathological, chemical analysis and anaesthetic gas analysis reports.

Further, if the statement recorded by nurse Anni Polas to be disregarded as it was given in connection with the criminal case then the statement made by Dr.Atulya Patil in cross examination in criminal case has to be equally disregarded.

**3. <u>Cross Examination of expert witness Dr (Mrs) Vasumati M Divekar, Professor of Anaesthesia in D Y Patil's Medical College produced by OPs.</u>**

Question : Doctor when you teach a student pre-anaesthetic check-up is given importance ?

Answer : Yes.

**Question : Doctor if I say that short neck would suggest possibility of anterior position of larynx ?**

**Answer : Yes, I can.**

**Question : Say an experienced Anaesthetist can take note of it ?**

**Answer : Experienced Anaesthetist can certainly take note of it.**

**Question : Now doctor if I say the patient in present case was obese with short neck ?**

**Answer : In this particular case it has not been mentioned.**

**4. <u>Cross examination of Dr Smt Indula Panchal, Medical Practitioner.</u>**

**Question : If patient is short necked and moderately obese do you experience**

**difficulty in intubation ?**
**Answer : Not always, very rarely.**

The expert doctors – anaesthetists who were produced on behalf of the OP 2 have agreed that pre-anaesthetic check up is very important step and short neck would suggest for possibility of anterior position of Larynx and so an experienced anaesthetist can certainly take note of it. The expert witness however, has said that in this particular case that patient was obese and short neck was not mentioned. This is a wrong statement as nurse's records clearly show that patient was obese. The nurse's record does not show the height of the patient. If this was recorded, it would have been possible to draw the inference that she had short neck.

Smt. Indula Panchal in her statement referred above has contradicted the statement of Dr. Vasumati Divekar. This shows that experts themselves are inconsistent.

**5. <u>Cross examination of the Opposite Party No. 1 Dr. Yogishwar Chander Mahajan :</u>**

Que : In your Affidavit at Pg. No. 6 you have stated about the apparatus used in the O.T. Can you elaborate ?

Ans : I have mentioned in Para 6 on Pg. 3 of my Affidavit that the list produced below that paragraph is the standard list of equipments kept in the O.T. of the Hospital at that time and my statements are based from the contents of the statements filed on behalf of the Hospital by the then Hospital Administrator. His statement was made available to me in the office of my advocate. I have no personal knowledge, as I was not present in the Hospital at that time.

Que : Dr. who is the best person to attend cardiac arrest? Which Doctor?

Ans : Whosoever is present close to the patient, but if a choice is available in my opinion, an anaesthetist is a highly qualified person to tackle a person having cardiac arrest.

Que : Dr. Ravi Rupwate, who attended this case is a Chest Specialist?

Ans : It is true.

Dr. Y.C. Mahajan evidence loses its value because his affidavit is not based on his personal observation or experience but based on the contents of the statements filed on behalf of the Hospital by the then Hospital Administrator. He has also admitted that he has no personal knowledge as he was not present in the hospital at that time. So we do not have any conclusive evidence that pulse oxymeter was kept in the concerned operation theatre.

In view of the above analysis we come to the conclusion that Dr. Page should not have waited for Dr. Rupwate to come and he should have administered the life saving Adrenaline injection himself which he did not do which was a major contributory factor to the death of the patient.

## **FINDINGS** :

The model consent form reads as follows :

**MODEL CONSENT FORM**

Dr. ..A……..

Regn. No.

Address :

O.PD. No……..Indoor No…….

I, ……. An adult, r/at…….

hereby consent to undergo operation of …….

the nature and purpose of which has been explained to me by

Dr. ---A----------

in a language I understand. I also understand the possible complications of this procedure and anaesthesia. I am also explained about failure rate of this operation.

I also consent to such further or alternative operative measures as may be found necessary during the course of the above mentioned surgery and to the administration of general, spinal or local anaesthesia by Dr. X……. for any of the purposes. I have no objection to performance of surgery by another doctor arranged by hospital/Dr.A.

Signature of Patient
Date :

Witness :

We confirm that Dr. A has explained the nature and purpose of this operation and anaesthesia to this patient.

Surgeon
(Dr.A) Signature

Anaesthetist Signature
(Dr.X)

A perusal of the consent form in this case shows that there is no mention of the name of the anaesthetist who was to administer anaesthesia. This is an important omission.

Despite the fact that there is no mention of the name of the anaesthetist, it is

claimed in the written version of OP 2 Dr Page that he has ascertained that the patient had given an informed consent to undergo anaesthesia. If he has really done so, he would have seen his name was missing in the consent form. **Risks of sudden unforeseeable and unpreventable complications of unknown origin, which fact was explained and conveyed to the patient. The same was conveyed as reflected in the consent form**. **What was required of the doctors was to sit patiently with the patient and explain to the patient the urgency or otherwise of the surgery/ procedure and the risk involved in the performance of the surgery as well as in the administration of anaesthesia. He has not explained to the patient the risk involved in administering anaesthesia. The signatures on the printed consent forms have been obtained mechanically. Therefore, we conclude that in this case no informed consent was obtained from the patient/guardian.**

**Maintenance of the hospital records :**

The nurse's progress report shows B.P. and weight 81.5 kgs., which cannot by any stretch of imagination be considered to be a normal weight. B.P. is recorded as 130/80, Obesity 1 plus. The patient therefore, was obese. The earlier records of the case indicate that the bleeding had stopped much before the date fixed for the operation and **the patient was complaining of some pain for which she desired to undergo hysterectomy according to Dr. Chandavarkar.**

We fail to understand this statement that 'she desired to under go hysterectomy'. The patient does not suggest what surgery she should undergo. The treating doctor/ surgeon after examining the patient and conducting tests decides the mode of treatment i.e. medical/surgical. **In this case date was fixed, which was mutually convenient**

**according to the treating doctor, which means it was purely an elective surgery with no urgency attached to it.**

**Out of these voluminous records the most important page relating to the stay of the patient in the operation theatre which was written by Dr. P.G. Page is reproduced below :**

Dr. Rupavate assisted along with Dr. Chandavarkar & Nursing staff.

**2.15 P.M.**

1. Induction Smooth under Cardiac Monitoring

**2.30 P.M.**

2. After I.V. Scoline given. Found to be Very anterior Larynx and hence difficulty in passing Tube. Allowed to regain back breathing I.V. Atropine given 0.6 mg and allowed to have Halothane to keep under Anaesthesia. Second dose of Scoline 100 mg given and found too have again same situation hence

**2.30 p.m. onwards**

No intubation tried. Patient was given 100% oxygen by mask under pressure (Hand ventilation). Patient suddenly developed bradycardia and No Peripheral pulse suddenly palpable

I.V. Hydrocortisone 200 mg given. Pulse 50/min

I.V. Atropine given. Intra Cardiac Adrenaline 1 : 1000

1 C.C. given. No response. Mephentin diluted given

¼ c.c. twice at Intervals. As further bradycardia developed.

Defribrillator used to give shock 360 Joules. No response Noted. Cardio – Pulmonary resuscitation continued inspite of that No Blood Pressure Palpated and No Pulse felt & seen on Cardioscope.

**Patient declared dead at 3 p.m.**

Similarly, nurses progress report from the time the patient was taken to the operation theatre is produced below :

**SHRIMATI SUNITIDEVI SINGHANIA HOSPITAL**
**& MEDICAL RESEARCH CENTRE**
P.O. JEKEGRAM THANE – 400 606, MAHARASHTRA INDIA

**NURSES PROGRESS REPORT**

| | | |
|---|---|---|
| NAME<br>JAYASHREE<br>OPD/IPD NO.<br>950471<br>WARD / BED<br>NO. FS -1. | | |
| DATE<br>TIME | | NURSES<br>SIGN |
| 1.40 P.M. | Received the Patient in O.T. at 1.40 p.m. | |
| | Catheterisation done at 2 pm Cardiac | |
| | Monitoring done. Pt is conscious B.P.-120/80 mm Hg | |
| | Pulse 88/min. After scolin there was | |
| | difficulty in passing endotracheal tube | |
| | O2 under pressure given | |
| | Inj Atropine 1 amp given. Patient gone to | |
| | Bradycardia. Inj Efcorlin 200 mg i.v.given | |
| | Inj mephentin ¼ c.c. I.V. given Inj Adrenaline | |
| | 1 amp Intracardial given. Cardiac massage | |
| | given. External cardiac shock given (160) | Signature |
| | Inj Adrenaline 1 ampoule i.v. & Inj Atropin | |
| | 1 amp I.V given. Cardiac Massage | |
| | given by Dr. Chandavarker, | |
| | Dr Ravi Rupwate & Dr. Harish | Signature |

| | | |
|---|---|---|
| | alternatively. All life saving | Signature |
| | measures failed and declared | |
| | Death at 3 p.m. Informed to | Signature |
| | Vartak Nagar police station. Reply | |
| | received & attached the file. Deposition | |
| | form filled by Dr. Usha rani | |
| | Sending the file to billing at | |
| | 5.30 pm body packed and sent | |
| | to mortuary at 6.50 p.m. | Signature |

Note :- mark

Xxxx items not Legible.

The notings are incomplete and perfunctory as can be seen from the hand written notes purported to have been written by Dr.Page the title of which reads thus : “Dr Rupwate assisted along with Dr. Chandavarkar and nursing staff”. The timing given is 2.15 p.m. If we have to believe this sheet Dr. Page was assisted by Dr. Rupwate and Dr. Chandavarkar from 2.15 p.m. onwards.

The nurses progress report pertaining to the period, the patient was in the OT does not mention that Dr. Rupwate assisted Dr. Chandavarkar from 2.15 p.m. onwards. It indicates that Dr. Rupwate came to the OT only after CPR had begun. If we believe the written version then Dr. Rupwate arrived at sometime between 2.30 and 3 p.m. before the death of the patient. He would not have arrived before 2.30 p.m., because from 2.30 p.m. onwards following steps were taken at the OT. Emergency help was sought only after the patient developed bradycardia.

2.30 Second dose of 100 mg Scoline given and found to have same situation

No intubation tried

Patient was given 100 5 Oxygenunder pressure
(Hand ventilation) pulse 50 per minute

Patient suddenly developed bradycardia hydrocortisone given.

Suddenly no peripheral pulse felt. i.v. Atropine given

Mepheatine diluted 7.5 mg. quarter cc twice at intervals.

After this the nurse Anna Polis went out of the theatre and made several calls and also announced through the public address system. After hearing the same Dr. Rupwate came, which means he must have come between 2.40 and 3p.m. by which time the patient was either dead or almost dead. Treatment records do not indicate the arrival time of Dr. Rupwate. According to the treatment records, he was in the operation theatre at 2.15 itself. The treatment records do not mention the arrival time of Dr. Harish either. The further records read as follows :

As further bradycardia intra cardiac **Adrenaline** given.

Cardio-pulmonary resuscitation (CPR ) continued

No blood pressure palpated and no pulse seen on cardio scope.

Patient declared dead at 3 p.m. “

The treatment records further state intra-cardiac Adrenaline given. The written statement on behalf of the hospital mentions that Adrenaline injection was given **thrice**, whereas in the statement of Dr. Page there is a mention of Adrenaline injection being given **twice**. There is a clear cut contradiction between these two statements.

**Looking at the hospital records we get an impression that the records are written perfunctorily especially the sheet starting with 2.15 p.m. which has no**

**date written on that anywhere. These records cannot be compared favourably with the written submissions and the affidavits filed by the doctors and on behalf of the hospital as in the latter, elaborate essays have been written about the efforts made by Dr. Page and Dr. Chandavarkar, and also the other doctors of the hospital and the supporting staff. It is clear from the written submissions and affidavits filed by the doctors and on behalf of the hospital that they are as a result of after thought. Hence, we have no other choice but to draw adverse inference against the hospital and treating doctors.**

**Opinion of Dr. Anjan Trikha :**

Dr. Anjan Trikha, Additional Professor, Department of Anaesthesiology, All India Institute of Medical Sciences , (AIIMS), New Delhi has given his expert opinion after going through the records and statements of various persons sent to him by the Medical Superintendent, AIIMS.

Let us analyze his opinion parawise.

1. *The anesthetic technique and the medications used and their dosages for administering general anesthesia to the patient are correct and as per standard practice*.

   **In this para Dr. Trikha has given a clean chit to Dr. Page.**

2. *The anesthesiologist involved in the case did carry out a pre anesthetic examination as per his statement about two hours prior to surgery. However, his statement does not mention any likelihood of difficult mask ventilation and/ or intubation that finally was the cause of cardiac arrest and death. A standard routine in all pre anesthetic evaluations is to look for and document a "Difficult Airway" and in case it is anticipated various mechanical aids and / or another anesthesiologist is usually made available.*

**Dr. Trikha has stated that as per the statement of Dr. Page, anaesthesiologist has carried out pre anesthetic examination two hours prior to surgery. This means he does not certify that Dr. Page has carried out a detailed pre anesthetic examination.**

Now let us see rest of the sentences in this paragraph.

**Dr. Trikha observes that Dr. Page does not mention any likelihood of difficult mask ventilation or intubation that finally was the cause of cardiac arrest and death. He has further observed that a standard routine in all pre anesthetic evaluations is to look for and document a "Difficult Airway" and in case it is anticipated various mechanical aids and/ or another anesthesiologist is usually made available. Neither Dr. Page had looked for a difficult airway nor he had documented it. Had he done so, he would have marshalled various mechanical aids and also would have asked for the assistance of another anaesthesiologist.**

3. *In the present case as per the statement of the anaesthesiologist he was unable to intubate after he had administered suxamethonium (Scoline) a muscle relaxant. There is a possibility that the anesthesiologist involved was not able to anticipate this problem beforehand. Unanticipated difficulty in intubation can arise in an anesthesiologist's practice. The anesthesiologist tried to intubate the patient a second time after giving standard medications, but failed again and thereafter the patient deteriorated.*

**This is an analysis purely based on the statement of Dr. Page which does not indict Dr. Page directly.**

4. *The records that have been sent do not mention any thing about the oxygen saturation – a monitoring modality that is essential for ascertaining the level of oxygen in the blood.*

**No records have been produced about oxygen saturation though tall claims have been made by Dr. Page in his written statement.**

5. *The resuscitation measures were taken after the catastrophic incident (though not in a correct order) but there is no mention of the fact that the patient was being adequately ventilated or not.*

**Dr. Trikha has opined that CPR measures were not performed in a correct order and there is no mention about adequately ventilating the patient. This proves negligence.**

Final opinion :

*The patient in question most probably died of hypoxia following an inability to mask ventilate and intubate.*

*Monitoring modalities that were used for induction and intubation of anesthesia lacked an oxygen saturation monitor that could have helped the anesthesiologist to detect and possibly avoid this hypoxia. This monitoring modality is considered to be a standard monitoring device for a general anesthetic.*

**Dr. Trikha has stated that the patient in question most probably died of hypoxia following an inability to mask ventilate and intubate. According to Butterworths Medical Dictionary Hypoxia has been defined as 'a *supply of O2 to the tissues which is inadequate to maintain normal tissue respiration'* and this statement of Dr. Trikha is fortified by the post mortem report. In the next para he has mentioned about monitoring modalities that were used for induction and intubation of anesthesia lacked an oxygen saturation monitor that could have helped the anesthesiologist to detect and possibly avoid this hypoxia. This monitoring modality is considered to be a standard monitoring device for a general anesthetic.**

**The hospital authorities have tried to defend stating that there was an oxygen saturation monitor but there was no printer. However, they have not produced any record to show that they have monitored the oxygen saturation level.**

*I am unable to comment on the fact whether the patient had features of difficult mask ventilation and intubation that could have warned the anesthesiologist regarding the catastrophic event as there is no mention of the same.*

**This issue is connected to the obesity and short neck which we have already analyzed earlier.**

*The resuscitation procedures were tried but the notes do not mention any details regarding their adequacy and in my opinion (more invasive techniques (cricothyroidectomy and tracheostomy) should have been carried out by the surgeon who was present in the operation theatre at the time of the event.*

**This clearly proves the negligence of surgeons who were present in the operation theatre namely Dr. Chandavarkar and Dr.Harish.**

**This expert opinion strengthens our analyses that there was negligence on the part of Dr. Page, Dr. Chandavarkar and also the hospital.**

**Medical Texts – Extracts:**

At this stage it is relevant to refer to the relevant medical texts produced by the opposite parties but relied upon by both the parties. In the text book on Anesthesia Fourth Edition (Volume II) Edited by Ronald D Miller in which under the subtitle **Failure of intubation during anaesthesia** it is written: “Every practitioner, no matter how skilled, will encounter patients who are unexpectedly difficult to intubate. The induction of anesthesia should be approached with this possibility in mind so that a clear plan of action (rather than panic) can be pursued.”

In the same text following analysis is made **when ventilation via mask and endotracheal intubation are impossible.** “The patient who is truly impossible to mask ventilate (two handed mask ventilation with oral and nasal airways, complete forward mandibular dislocation, and bag ventilation by an assistant) or intubate presents a brain- and **life-threatening emergency that has been estimated to occur once in 10,000 cases in which anesthetics are` used. As in so many instances in medicine, the best treatment is prevention. The clinician must always carefully evaluate the airway to determine the safest plan for intubation and extubation.** In the patient who has been thoroughly denitrogenated, there should be sufficient time to institute one of the following interventions before serious oxygen desaturation and consequent hemodynamic deterioration occur. In reality, one is often dealing with a severely hypoxic patient who has suffered or is near to cardiac arrest.”

**British Journal of Anaesthesia** edited by Graham Smith speaks about **'Anatomical factors in failed intubation'**. "It is the unexpected difficult intubation that leads to disaster. Predicting a problem at intubation should not be difficult where there is obvious pathology involving the next, maxillo-facial, pharyngeal and laryngeal structures, whether or not this is associated with specific medical conditions or congenital syndromes."

Under the heading **Assessment of anatomical factors** it has been stated that a knowledge of detailed anatomical factors is essential if difficult intubation is to be predicted. Bony structures, soft tissues and their mobility should be examined. The contribution of the soft tissues in a difficult intubation has been under-estimated. This is especially so with the mobility of the base of the tongue. No single anatomical factor determines the ease of direct laryngoscopy and therefore, with the exception of patients with obvious pathology, no single anatomical factor can be used to predict a difficult intubation. **A careful history and clinical examination should elicit the obvious problems.**

**Aetiology of Morbidity and Mortality Associated with failed intubation : "Although intubation problems will occur from time to time during anaesthesia and failure to intubate successfully may be unavoidable, it is seldom possible to defend any case where a patient dies or suffers brain damage as a direct result of unsuccessful tracheal intubation."**

There is an article on Difficult Airway and its management by Illa Ghose, Manojushree Ray, Susmita Dutta published in the Indian Journal of Anaesthesia (42), 20, 1988. The authors have stated as follows :

**Management of the difficult airway :**

"Difficulty in managing the airway is the single most important cause of anaesthesia – related morbidity and mortality. Available literature show that most airway catastrophes have occurred when possible difficulty with the airway was not recognized. In 1998, Sia and Eden estimated that 90% cases of difficult intubation should be anticipated. However, in few cases, inspite of careful assessment of airway endotracheal intubation may prove to be impossible after induction of general anaesthesia. So difficult airway are of two types, anticipated and unanticipated."

A. **Anticipated difficult airway :**

"When management of the airway is expected to be difficult, either because of the presence of a pathologic factor (s) and/ or a combination of anatomic factors, an endotracheal intubation should be done while the patient is awake. Although awake intubation is generally time consuming for the anaesthesiologist and a more unpleasant experience for the patient, there are several reasons why awake intubation should be done."

B. **Unanticipated difficult airway**:

Occasionally inspite of careful assessment of the airway difficulty cannot be anticipated pre-operatively and after induction of anaesthesia, intubation may found to be impossible. In such circumstances further management depends upon the clinical situations. First adequacy of ventilation should be assessed. If patient can be ventilated artificially then oxygenation should be maintained by gentle mask ventilation while maintaining the cricoid pressure.

At this point anaesthetist must assess that what makes the visualization of larynx difficult. Poor positioning of head or misapplied cricoid pressure may be the cause. In such circumstances after proper positioning, second attempt of intubation should be made.

Multiple, laryngoscopies should be avoided, because it may cause airway trauma that may lead to oedema, bleeding and upper airway closure.

After a few failed intubation attempts manual ventilation should be continued and patient is allowed to resume spontaneous ventilation. If the surgery is not an emergency then patient should be allowed to wake up and then try for awaken intubation. In **emergency cases, anaesthesia can be continued via mask anaesthesia or emergency tracheostomy/cricothyrotomy may be indicated for securing the airway.**

In this case it is clear that the anaesthetist did not conduct proper pre-anaesthetic

check up. He saw the patient only at 1.30 p.m. i.e. half an hour prior to the scheduled commencement of surgery and 1 ½ hours prior to her untimely death. It is essential to maintain pre-anaesthetic records but the case sheets are silent on that. The needle of suspicion directly points towards Dr.Page. It is clearly mentioned in the medical text supplied by the opposite parties that **"Although intubation problems will occur from time to time during anaesthesia and failure to intubate successfully may be unavoidable, it is seldom possible to defend any case where a patient dies or suffers brain damage as a direct result of unsuccessful tracheal intubation."** In view of this Dr. Page cannot defend his negligent actions.

## Citations :

In **Savita Garg (Smt.) Vs. Director, National Heart Institute (2004) 8 SCC 56 Apex Court** held that

> *"Once a claim petition is filed and the claimant has successfully discharged the initial burden that the hospital was negligent, and that as a result of such negligence the patient died, then in that case the burden lies on the hospital and the doctor concerned who treated that patient, to show that there was no negligence involved in the treatment. Since the burden is on the hospital, they can discharge the same by producing the doctor who treated the patient in defence to substantiate their allegation that there was no negligence. It is the hospital which engages the treating doctor, thereafter it is their responsibility. The burden is greater on the institution/hospital than that on the claimant. In any case, the hospital is in a better position to disclose what care was taken or what medicine was administered to the patient. It is the duty of the hospital to satisfy that there was no lack of care or diligence. The institution is a private body and it is responsible to provide efficient service and if in discharge of its efficient service*

*there are a couple of weak links which have caused damage to the patient, then it is the hospital which is to justify the same and it is not possible for the claimant to implead all of them as parties."*

Perfunctory treatment records of the hospital does not enable the hospital to defend its stand in this case.

***"T*he Apex court in Spring Meadows Hospital and another versus Harjol Ahluwalia through K S Ahluwalia and another { (1998) 4 S.C.C. 39} has held that :**

*"Gross medical mistake will always result in a finding of negligence. Use of wrong gas during the course of anaesthetic will frequently lead to the imposition of liability and in some situations even the principle of res ipsa loquitur can be applied".*

Ratio of this case to a great extent applies to the case under consideration.

The importance of Bolam Test has been stressed in the celebrated judgment of the Supreme Court in **Jacob Mathew vs State of Punjab and Another – (2005) 6 SCC 1**.

The treating doctors Dr. Page and Dr. Chandavarkar have claimed to be highly qualified in their written statement. They have given a long list of their educational qualifications and national and international experience but analysis of the case (supra) indicates that they have not taken ordinary precautions and they have not exhibited average skills possessed by an average surgeon or an anaesthetist. Dr. Page has not taken average precautions which an anaesthetist has to take by not conducting a

detailed pre-anaesthetic checkup. His handwritten records are silent on this aspect. Further, his negligence in administering anesthesia has resulted in cardiac arrest which is self-evident. Dr.Chandavarkar has not used ordinary skills to save his patient when she suffered hypoxia by not performing tracheotomy. Hence, it is clear that Dr. Page and Dr. Chandavarkar have not passed the 'Bolam Test'. The hospital though claimed to have State of Art equipment, it did not have printer attached to the pulse oxymeter. Even the existence of pulse oxymeter in the OT, when the surgery was to be conducted is in doubt, because there is no record of readings by the nurse or by the doctor that is why Dr.Anjan Trikha had observed the absence of pulse oxymeter.

The Apex **Court in Jacob Mathew's case** (supra) has stated as follows :

*"Res ipsa loquitur is a rule of evidence which in reality belongs to the Law of Tort. Inference as to negligence may be drawn from proved circumstances by applying the rule if the cause of the accident is unknown and no reasonable explanation as to the cause is coming forth from the defendant."*

In a medical negligence case the doctors and the concerned hospital have a responsibility to correctly explain their conduct and their records should prove that there was no negligence on their part, which they have failed to do.

In view of the above analysis we hold that medical negligence by the opposite parties is proved in this case. The complainants have claimed the total compensation of Rs. 72.6 lakhs under following grounds :

"Rs. 35 lakhs for the loss, agony suffering that they are undergoing due to the

negligent acts of the opposite parties; a total of Rs. 37,50, 000 for the financial loss suffered by them as a consequence of the untimely death of Jayshree Lohakpure caused negligently by the opposite parties and Rs. 10,000/- for the expenses paid to the hospital."

As we have no records before us to prove the financial loss suffered by the complainants as a consequence of untimely death of Smt. Lohakpure, we are unable to award any amount towards this. Rs. 10,000 is claimed towards expenses paid to the hospital. We have seen some receipts issued by the hospital totaling up to 7,495/- accordingly, we award the same to the complainants. As against 35 lakhs towards for the loss, agony and suffering, we hereby award Rs. 10 lakhs. Out of this amount of Rs. 10,07,495/-, Dr. Page is directed to pay Rs. 6 lakhs, Dr. Chandavarkar is directed to pay Rs. 2 lakhs and the hospital authorities are directed to pay Rs. 2,07,495/- within four weeks from the date of the receipt of this order. Delay in payment will attract interest @ 10% per annum. Each of the above parties shall also pay Rs. 20,000/- Rs. 10,000/- and Rs. 10,000/- respectively as costs to the complainants.

**……J**
**[ K S Gupta ]**
**Presiding Member**

**……**
**[ P D Shenoy ]**
**Member**

Rajani/rsk