NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION
NEW DELHI

ORIGINAL PETITION NO. 289 OF 1997

1. 1. Shri Joginder Singh,
S/o Honorary Captain Alwel Singh

2. Master Jasprit Singh,
S/o Shri Joginder Singh

3. Master Balwinder Singh,
S/o Shri Joginder Singh,
Both petitioner No. 2 and 3
Through their father and natural
Guardian
Shri Joginder Singh

All residents of
House No. D-764,
Chawla Colony,
Ballabgarh,
Haryana … Complainants Versus

1. Dr. Rajeev Kumar Majumdar,
S/o Shri Anil Charan,
R/o House No. 684,
Sector 17,
Faridabad (Haryana)

2. Dr. Harish Kumar Khurana,
S/o Shri Kewal Krishan,
R/o House No. 1356,
Sector 15,
Faridabad (Haryana)

3. Shri Ashok Kumar,
O.T. Technician,
S/o Shri Kanahiya Lal,
R/o House No. 509,
Rahul Colony,
Behind B.K. Hospital,
Faridabad (Haryana)

4. Smt. Leelamma Vargis,
W/o Shri Bhoushil Vargis,
R/o 1147, Sector-29,

Faridabad (Haryana)

5. Ms. Sashamma Vargis,
W/o Mr. John Vargis,
R/o House No. 54,
5-C, Faridabad (Haryana)

Second Address of all the Respondent Nos. 1 to 5
M/s. Sun Flag Hospital &
Research Centre,
Sector 16-A,
Faridabad (Haryana)

6. M/s. Sun Flag Hospital &
Research Centre,
Sector 16-A,
Faridabad (Haryana)
Through its Incharge,
Dr. Arvind Pratap

7. New India Assurance Co. Ltd.,
BK Chowk, NIT,
Faridabad, Haryana,
Service through its Branch Manager … Respondents

BEORE:

HON'BLE MR. JUSTICE R C JAIN, PRESIDING MEMBER
HON'BLE DR. P D SHENOY, MEMBER

For the Complainants : Mr. Vijaindra Nigam, Advocate
For the Opposite party
Nos.1 & 3 to 6 : Mr. A.S. Chadha, Advocate,

For the Opposite Party No.2: Ms. Sunita Harish, Advocate

For the Opposite party No.7: Mr. A.K. Raina, Advocate

PRONOUNCED ON 13th August 2009

ORDER

PER DR. P.D. SHENOY

This is a case of alleged medical negligence against M/s. Sun Flag Hospital & Research Centre, Faridabad, the treating doctors and the staff of this hospital (opposite parties). The important issues to be decided in this case, *inter alia,* are as follows:-

1. **1. Whether the opposite parties are negligent in performing surgery on the patient on 16.12.1996 without obtaining the valid consent of the patient in writing, though the deceased patient was an adult and was in a condition to give consent or otherwise for the second surgery to be performed on her?**
2. **2. Whether the second surgery should have been taken up when it was clearly written in the case records by the treating doctor that the patient has poor tolerance to anaesthesia?**
3. **3. Whether the opposite parties should have taken up the surgery of the second kidney within eight days of the surgery of first kidney though it was an elective surgery and not an emergency one?**
4. **4. Whether the opposite parties should have kept the automatic ventilator ready in the operation theatre at the time of the starting of the second surgery when it was well known that the patient has poor tolerance to Anaesthesia?**
5. **5. Whether the patient should have been examined and treated by Neurologist/Neuro surgeon who was available in the hospital when the patient went into Coma and remained in that stage for a few days and if they did not have full confidence in their own Neurologist, whether the opposite parties should have utilized the services of an expert Neurologist from another hospital?**
6. **6. Whether the opposite parties should have kept a Cardiologist as a stand**

by at the time of starting the surgery in view of the above stated conditions of the patient?

7. **7. Whether a team of Cardiologists, available in the hospital reached in time to revive the patient who had suffered cardio respiratory arrest soon after administering of anaesthesia by the Anaesthesiologist?**

8. **8. Whether the report of the enquiry conducted by the Additional Deputy Commissioner and Magistrate can be taken into consideration for deciding the case of medical negligence?**

9. **9. Whether the treating surgeon/ Anaesthesiologist can pass on the blame on each other when they are part of the same team of specialists/ incharge of treating the patient?**

10. **10. Whether it was humanly possible for the Anaesthesiologist to have continuously operated the Boyle's Apparatus for ten hours as claimed by him to ensure proper breathing by the patient without delegating this task to another Anaesthesiologist or a technician?**

11. **11. Whether the principle of Res-Ipsa Loquitur can be applied in this case?**

12. **12. If medical negligence is established, what is the relief if any, the complainants are entitled to?**

A detailed analysis of the case will provide answers to these issues.

Case of the complainant in brief:

The complainant no.1 Sh. Joginder Singh is the husband of the patient Smt. Jasbir Kaur (now deceased) and complainants no.2 & 3 – Jasprit Singh and Balwinder Singh are the sons

of the deceased. Smt. Jasbir Kaur was got checked in the OPD of the respondent no.6 hospital, viz., M/s Sun Flag Hospital & Research Centre, Faridabad (in short, 'the Hospital') and it was opined on 8.10.96 by respondent no.1 - Dr. Rajiv Kumar Majumdar (in short, Dr. Majumdar), the surgeon that she had a stone in her right kidney. On 3.12.96, she was checked again and it was found that her right kidney stone has enlarged and resulted in the kidney getting damaged and further the left kidney also had a stone.

Therefore, the surgeon Dr. Majumdar advised Smt. Jasbir Kaur to get herself admitted for the purposes of taking treatment and also for the surgery of her kidney. He assured her and the complainant that she would get the best facilities and services in the hospital and since he was the surgeon in charge of the surgery, the operation would be done under his control, there will be no problem. After admission, she was advised to go through several tests and found fit for the surgery, which was performed on 09.12.96.

After the procedure, Dr. Majumdar gave a report to the effect that the patient was found to have poor tolerance of anesthesia and after that patient was transferred to the ICU where she was recovering and the doctor found the progress satisfactory. Dr. Majumdar continuously pressed and advised her from 13th to 15th December 1996 to undergo the second surgery of the right kidney though the complainant and the relatives requested the doctor that if there was no urgency, the second surgery may be conducted after her recovery and healing from the first operation which was not liked by Dr. Majumdar and he warned of dire consequences.

On 15.12.96 around 11.00 a.m. Dr. Majumdar told the complainant that he should arrange three units of blood for the second operation, which was arranged from the Red Cross Society, New Delhi. On 16.12.96, the patient was taken to the operation theatre in the morning

hours. When the complainant and the relatives were waiting outside the operation theater, they heard some commotion/noise and on enquiry, they were informed that the injection/medicine pertaining to anesthesia given to the patient by respondent no.2 Dr. Harish Kumar Khurana (in short, Dr. Khurana) had caused problems and respondents no. 1 to 5 were trying to control the reaction.

At about 11.00 a.m Mrs. Surender Burman, serving nurse in the ESI Hospital informed that the patient is serious and Dr. Majumdar had called Dr. Jindal who gave electric shock / massage etc. to the patient and through the heart of the patient started functioning her brain was not responding and she went into coma. **Around 1.00 p.m., the patient was brought outside the operation theatre with the manual ventilator/Boyle's machine in coma and only at about 7.00 p.m., the hospital authorities arranged an automatic ventilator from Delhi.**

At the request of the complainant, Dr. Avdesh Bansal from Apollo Hospital was called who recommended the CT scan of the patient to assess the damage done to the brain which facility was available in Escorts Hospital and Research Centre, Faridabad. Requests of the complainant to take the patient to Escorts Hospital was declined.

The complainant alleged that the second surgery was performed by Dr. Majumdar on the patient having known fully well that she was not fit for the second surgery. Secondly, soon after the administration of anesthesia by Dr. Khurana, the condition of the patient worsened and she suffered cardiac attack. The respondents no. 3 to 5 - the technician and nurses did not participate in the damage control exercise. Dr. Manjumdar did not immediately requisition the services of Dr. Jindal who was working as a physician in the hospital. He came later on after changing his dress after around 20-25 minutes.

Preliminary resuscitation measures were delayed after the patient suffered cardiac attack. Critical equipments were lacking in the hospital like the automatic ventilator. The patient was taken into the operation theatre on 16.12.96 in the hale and hearty condition and the doctor found her fit for conducting the second operation but due to her poor tolerance of anesthesia, she went into coma and ultimately death.

Therefore, a criminal FIR was registered with the Supdt. of Police, Faridabad and a Magisterial Inquiry was ordered by the District Magistrate. The Inquiry Officer/ Magistrate found that the respondent no.1 to 6 were not only negligent but also careless in handling the case and condition of the patient deteriorated during the second surgery. The Inquiry Officer/Magistrate also fund that the hospital was not possessing necessary equipments and trained staff to handle the situation like this. A civil surgeon was also associated with the Inquiry officer. Complainants alleged that negligence and carelessness resulted in the death of Smt. Jasbir Kaur. Though the deceased expired on 16.12.96 itself, to cover up their misdeeds, they did not declare the patient as dead and kept on saying to the complainant that the patient has gone into 'coma' and they are making their best efforts to revive her.

Hence the complainants sought the compensation under following heads:

(i)	Medical expenses	Rs. 50,000/-
(ii)	Funeral/last rites expenses	Rs.10,000/-
(iii)	Special diet, conveyance etc.	Rs.15,000/-
(iv)	Loss of income/estates	Rs.5,00,000/-

(v) Loss of love & affection of complainant no.1 Rs.5,00,000/-

(vi) Loss of love & affection of complainant no.2 & 3@ Rs.10,00,000/- each Rs.20,00,000/-

(vii) Mental agony and physical pain Rs.10,00,000/-

(viii) Misc. expenses Rs.25,000/-

Rs.41,00,000/-

It was also prayed to pay the amount of Rs.41 lakhs with 18% interest from the date of filing of the complaint till the date of payment at quarterly rests and also to award costs and expenses throughout.

<u>Case of Respondent no.1 – Dr. Rajeev Kumar Majumdar:</u>

After necessary tests, it was revealed that the right kidney was having stone and was grossly damaged having had developed grade IV hydronephrosis. The radiological report also revealed that left kidney had also developed a stone with Grade II hydronephrosis. Under these circumstances it is the rule to first rectify the defect in the lesser affected kidney it was decided to perform surgical operation to remove the stone from the left kidney and correct any other problem. Accordingly, the patient was operated on 9.12.96 after obtaining written informed consent and the operation was a complete success.

Approval of the physicians namely Dr. P.K. Babbar, M.D. and Anaesthetist, Dr. H.K. Khurana, was taken by Dr. Majumdar before deciding upon to operate upon on the right kidney of the patient. However, before the surgery could commence on 16.12.96, the

patient developed problems after the administration of the anaesthesia at approximately 10.00 a.m. and Dr. H.K. Khurana, respondent no.2 who was anesthetist requested Dr. Majumdar to assist him to revive the patient. Considering the condition of the patient Dr. Majumdar and the nursing staff, respondents no. 3, 4 and 5 gave cardiac massage to the patient.

Dr. Mazumdar is a professionally qualified surgeon specialist having done his Master of Surgery from Medical College, Amritsar and he was judged as a best post-graduate. Further he has experience at Medical College, Amritsar, Safdarjung Hospital, RML Hospital, and St. Stephens Hospital, New Delhi.

The complainant No. 1 has allegedly made a claim for loss of love and affection on the part of Jasbir Kaur and a hefty sum of Rs. 20.00 lakhs has been claimed whereas he has remarried after some time after the death of Smt. Jasbir Kaur and started a new happy married life with another woman.

The first informed consent obtained on 9.12.96 bears testimony to the fact that the patient and her husband were well aware of this strategy and had consented for the same after having fully satisfied themselves regarding all the relevant information pertaining to the disease of Smt. Jasbir Kaur and its proposed course of treatment. At no point of time, Dr. Majumdar pressed the patient or the complainant for the second operation

The factual position is that after the first surgery, the patient's condition improved considerably, the feasibility of the second operation was considered in consultation with Dr. P.K. Babbar, M.D. and Dr. H.K. Khurana, Anaesthetist. **It is not disputed that Dr. Majumdar had**

observed while performing the first operation regarding the poor tolerance of anaesthesia by the patient but such an observation did not mean that while performing the second operation the anaesthesia could not be administered at all to the patient. By observing poor tolerance to the anaesthesia it only means that the Anaesthetist had to combine anaesthesia in his judgement in view of the said observation. Poor tolerance to anaesthesia in medical terminology is not very significant.

Dr. Majumdar has described happenings of the day in the following words :

Smt. Jasbir Kaur was brought in the operation theatre at about 9.45 a.m. The equipment in the operation theatre was perfectly in order and the patient could very well be operated upon with the said equipment. It is submitted that pre-anaesthesia check up was done in the Ward by Dr. H.K. Khurana. **The informed consent of the complainant was obtained for the second operation including the high-risk consent.** The patient was received in the operation theatre by respondent no.3 in good condition. **Before the surgery could commence, Dr. Khurana, the respondent no.2, administered injection of Pantathol sodium and Scoline which are normally administered to a patient before anaesthesia is started. After giving the said two injections a tube called Endotracheal tube 7.5 mm was inserted in the trachea by Dr. H.K. Khurana in order to give nitrousoxide mixed with oxygen and the two gages were given by Dr. H.K. Khurana. Soon thereafter, the condition of the patient started deteriorating**. The blood pressure of the patient started falling and pulse also became feeble. Immediately the nitrousoxide was switched off and 100% oxygen was started. The respondent no.4 was directed

by respondent no.2 Dr. H.K. Khurana that respondents no.4 and 5 to prepare the injections of Adrenalin and keep other emergency drugs ready like Inj. Efcorline, Inj. Sodabicarb, Inj. Decadron, Inj. Dopamine and Inj. Atropine in correct dosage. The respondent no.1, Dr. R.K. Majumdar was present who injected intracardiac injection of adrenalin to the patient, Jasbir Kaur. Dr. Majumdar and the respondents no.4 and 5 gave cardiac massage and administered other drugs as is reflected in the records of the hospital. Dr. Khurana operated Boyles machine to give necessary oxygen to the patient. Electric D.C. shock was also administered by Dr. R.K. Majumdar at Dr. Khurana's request. Thereafter, Dr. Vinay Jindal, Physician Cardiologist was called in, who also gave electric shock and cardiac massage. Thereafter, Dr. P.K. Babbar, M.D. and Dr. Bhowmik, M.D. also came and with the combined effort of all the medical team the patient was revived. It is not correct that the patient had gone in coma at that time because apparently the patient was under the effect of anaesthesia.

Dr. Majumdar submitted that he is a surgeon and not a specialist physician cardiologist. He, however, immediately sought the opinion of Dr. Khurana and physician cardiologist Dr. P.K. Babbar. After examining of patient's condition by Dr. Khurana and Dr. P.K. Babbar, it was found that the heart sounds of Smt. Jasbir Kaur were feeble and muffled. The ECG was also examined by them and they opined that it was highly risky to shift the patient at that stage for CT scan and, therefore, the attendants were explained in details about it.

Para no.11 of the complaint, the complainant is falsely alleging that the death of the deceased "occurred in the second surgery". The so-called second surgery on 16.12.96 had not yet commenced because the patient reacted to anaesthesia being administered by Dr. H.K. Khurana, which can happen with any patient.

A Magisterial Inquiry was ordered and it is not disputed that Shri Ankur Gupta,

Executive Magistrate, conducted the inquiry, but his report is not based on correct facts.

Case of Dr. Khurana, opposite party no. 2

Dr. Khurana vehemently denied that he was at all jointly and severally responsible for the act and conduct of omissions and commission. **At no point of time, Dr. Majumdar informed Dr. Khurana that the patient was found to be poor in anesthesia tolerance** and there was no complication of any nature at the time of administration of anesthesia, during the first surgery and in the post surgery period. In fact the entire anesthetic procedure was uneventful on 9.12.96. X-ray tests of the patient revealed that Smt. Jasbir Kaur was suffering from bilateral kidney stones with hydro nephrosis. She was admitted under the care of Dr. Majumdar. In so far as bleeding part is concerned, any operation of the kidney has to produce bleeding and it is a natural phenomenon in cases involving surgery.

Smt. Jasbir Kaur was taken to operation theatre in the morning of 16.12.1996 at around 9.45 a.m. and pre-medication was given. Throughout, the procedure, Smt. Jasbir Kaur was being given IPPV with 100% oxygen through Boyle's Machine which was manually operated by Dr. Khurana from about 10.00 a.m. in the morning to 8 p.m. This was done by Dr. Khurana because even after revival, the patient continued to remain unconscious and could not breath on her own. So IPPV and necessary medication was continued by him. The cardiac arrest during administration of anesthesia and in the post anesthesia period are medically recognized phenomena and, therefore, the requisite safety measures are always kept as stand by at the time of giving anesthesia. It was, therefore for this reason that Boyle's machine was kept handy.

It is also worth high lighting here that a cardiologist namely Dr. Vinay K. Jindal had also been summoned immediately. As far as the question of giving D.C. Shock

(Electric shock) is concerned, in the medical science it is considered safe that such a shock be administered by a cardiologist. Again, this is an established fact recognized by medical fraternity that a patient suffering from cardiac arrest goes into coma and there was therefore nothing unusual in Smt. Jasbir Kuar going into coma. It is admitted that Dr. Avdesh Bansal had been summoned on the request of the relatives of Smt. Jasbir Kaur on 19.12.96. He after examining Smt. Jasbir Kaur at 10.30 a.m. had explained to her attendants the details regarding prognosis and had also advised C.T. scan. On the same day at 11.30 a.m. ECG was done which showed ischaemic changes. Heart sounds were feeble and muffled. Before a decision on shifting her to some other centre for CT scan, a call was sent to doctor P.K. Babbar, the Cardiologist/physician. ECG was also shown to him. He after examining the patient and her ECG was of the opinion that it was highly risky to shift the patient at that stage for CT scan and, therefore, the attendants were explained in detail about it. It was denied that the respondent no.3 to 5 did not participate in damage control exercise. In fact they did participate in resuscitative measures and had given Smt. Jasbir Kaur the best possible medical and nursing help/care. The patient was successfully revived by these measures coupled with the electric shock and other medication.

The Magisterial Inquiry into the present case was more in the nature of an inquest. The statements on the witnesses were not tested by way of cross-examination. The Inquiry report does not indict Dr. Khurana on any point other than to mention that the respondent could have handed over the Boyle's machine to some other person and should have done cardiac massage himself.

Case of respondents no.3 to 5:

That the respondent no.3, Mr. Ashok Kumar, at the relevant time was technician in the

operation theatre of M/s Sunflag Hospital and Medical Research, Sector 16-A, Faridabad. The respondent no.4, Smt. Leelamma Vargis and Respondent No. 5, Ms. Sashamma Vargis were appointed as operation theatre nurses. The job of the operation theatre assistant is to receive the patient in the operation theatre, position him for the operation and ensure that the lighting system and other equipment within the operation theatre are in working condition. Smt. Leelamma Vargis was on the relevant date working as operation theatre nurse (circulating nurse). Ms. Sashamma Vargis was to assist the surgeon for purposes of surgery as scrubbed nurse. Since no surgery took place on 16.12.1996, her role does not arise at all and hence her alleged complicity is false and denied. The equipment in the operation theatre was perfectly in order and there was nothing wrong in it. No such allegation has been made in the complaint with regard to the non-working of any of the equipment present in the operation theatre. Thus, Mr. Ashok Kumar has been unnecessarily dragged in the present complaint.

The complaint is not based on correct facts. The allegations against the respondents no.3 to 5 to the effect that in the Magisterial inquiry the respondents were indicted are incorrect.

It is wrong to say that the respondent no.3 to 5 did not participate in the damage control exercise as alleged. It is submitted that the aforesaid injections were given, cardiac massage was given by the respondent no.3 to 5 as well as by Dr. R.K. Majumdar. The electric shocks were also administered by Dr. R.K. Majumdar to revive the patient and in all these exercises the patient was revived. It is incorrect that the services of Dr. Jindal were not requisitioned. It is submitted that not only Dr. Jindal came hurriedly all other doctors namely, Dr. P.K. Babbar, M.D., Dr. Bhowmik, M.D. also came and all of them joined to bring the patient out of critical condition.

Case of respondent no.6:

The complainant organised an agitation of union leaders after the death of Smt. Jasbir Kaur and also publicised the issue of death of Jasbir Kaur in the local newspapers. The local administration seeing the position registered a cause u/s 304-A of IPC against Dr. R.K. Majumdar and others and ordered for a magisterial inquiry. The said inquiry was one sided and the hospital records were neither properly perused nor the version of the respondents was appreciated. Therefore, the report of the inquiry officer was not based on evidence.

The New India Assurance Co. Ltd. is a necessary party to the complaint as the Hospital has taken an insurance policy, which was valid upto 15.12.97. Hence, if any order for compensation passed in favour of the complainant then the liability to pay the amount should be fixed on the New India Assurance Co. Ltd.

The surgery started at 9.45 a.m. on 16.12.96 and the equipments in the operation theatre were perfectly in order.

Evidence

Affidavits evidence has been filed on behalf of the complainant. Affidavits have been filed by opposite parties no.1 to 6.

In this connection it is relevant to look into some of the questions posed by the complainant to Respondent no. 2, Dr. Khurana and replies given by him to these interrogatories:

Q. Did you check the records of the patient after 1st Operation on 9.12.2006?

Ans: Patient had no side effects/complications during operation. On leaving the operation

theatre patient was in the custody of surgeon. I was not called for any complication related to anesthesia. I had written my anesthesia notes in the anesthesia register. Therefore, there was no need to see the hospital record after first operation.

Q. Did you read the comment of the surgeon after 1st operation in the treatment sheet of the deceased "poorly tolerant to anesthesia"?

Ans: I read the comments of the surgeon on 14.12.96 during pre-anesthetic check up for second operation. The words "poorly tolerant to anesthesia" had no meaning, as the first operation was uneventful and successful. There was no anesthesia related complication of any kind at all.

Q. By what means, you announced the emergency and by what mode of communication you alerted the hospital and requisitioned the help of cardiologist?

Ans: Full operation theatre team was already inside the O.T. Cardiologist was summoned by one of the members of the O.T. team. By similar mode hospital authorities were informed. I can not say who did what since all present in O.T. got busy with the primary object of saving the patient.

Q. After how long did you sound second alarm?

Ans: There was no need for second alarm as full O.T. team was already inside and had got busy with resuscitative measures.

Q. What mode of communication did you have in O.T. to sound alarm?

Ans: Apart from medical and paramedical staff, there was tele/com service/pager system.

Reply to the interrogatories indicate that Dr. Khurana was fully aware of the notings made by Dr. Mazumdar that the patient had poor tolerance to anaesthesia and despite that he disregarded this observation. Atleast he could have organised a discussion with any other Anaesthesiologist and other specialists, surgeon and cardiologist before embarking upon administration of anaesthesia for the second surgery. Further he could have waited for the

patient to recover and recoup fully after the first surgery before taking a decision on the second surgery, as it was an elective surgery. Though Dr. Khurana said that there was a paging system yet the magisterial enquiry has come to the conclusion that there was no paging system.

Submission of the learned counsel for the complainant:

Patient's consent was taken for the first surgery whereas for the second surgery only her husband's consent was taken and hence it is not a valid consent.

As there was no emergency then the second surgery could have been conducted after her discharge from the Hospital and after her recovery from the first operation so that the patient could be ready for the second surgery.

The learned counsel for the complainant submitted that a line was interpolated in 'Patient's Sheet' dated 14.12.96 that 'Patient insisting for surgery of the other side'.

Learned counsel further submitted that in the 'Patient's Sheet' dated 14.12.96, there is an interpolation of the following sentence:-

"Patient and her husband thoroughly briefed regarding the diseased condition, surgical risk and other risks involved."

Learned counsel further submitted that on the day of surgery on 16.12.96, the procedure started at 9.45 a.m. and the patient was shifted at 1.45 p.m. There is no mention of the detailed steps taken in these four hours. The whole scenario has changed resulting in coma of the patient. There is mention of visit of physicians Dr. V.K. Jindal, Dr. P.K. Babbar and Dr. Bhowmik. But at what time they came and what treatment they had given to the patient and how long they were there is not mentioned and if they had come in time why the patient could not survive is not explained.

Dr. Khurana stated that he handled the Boyle's Apparatus for 8-10 hours. Is it humanly possible? Learned counsel for the complainant argued. In the patient's sheet dated 9.12.96 of OP notes, surgeon Dr. Majumdar, Anesthetist Dr. Khurana and anesthesia G/A, it is mentioned that "patient poorly tolerant to anesthetic". This note has been signed by Dr. Majumdar. Further on the record of operation, it is mentioned that GA started at 9.50 a.m. and operation started at 10.15 a.m.

Looking into the serious condition of the patient, which were the medicines and equipment kept ready before the start of the second surgery, has not been explained by the doctors in charge of the Hospital authorities to enable the breach Tracheotomy. There was no public address system available in the Hospital for making emergency aid and therefore, surgeon himself had to come out to call them.

Submissions of Mr. A.S. Chadha, learned counsel for Respondent no.1 and Respondent no.3 to 6

Mr. A.S. Chadha, learned counsel painstakingly took us through the list of important dates and events. He submitted that on 8.10.96, Jasbir Kaur came for check up in the OPD. Admittedly, right kidney was having stone and was damaged. It is also admitted that left kidney had a stone. According to the complainant herself on 3.12.96, Dr. Majumdar advised her for admission for treatment and assured of best services would be under his care. There is a clear averment in para 4 of the complaint that after the tests it was found that she was fit for surgery. On 9.12.96, Jasbir Kaur was operated upon on the left kidney and the stone was removed by a team of doctors consisting Dr. Majumdar, the Surgeon and Dr. Khurana, the Anesthetist. It

is also alleged in para 4 of the complaint that the patient was poor tolerant to anesthesia. On 16.12.96, according to the averments made in para 8 of the complaint, the relatives of Jasbir Kaur heard that an injection pertaining to anesthesia was given to the patient that had reacted. Injection was given by respondent no.2, Dr. Khurana whereas respondent no.1 to 5 tried to control the reaction. A team of doctors including Dr. Bansal, Dr. Babbar and Dr. Bhowmik were called who did the damage control exercise. In fact no surgery was performed on that day. Admittedly, she was brought out from the operation theatre without operation and Boyle's machine was attached to her, which was manually operated. By 7.00 p.m., automatic ventilator was also arranged from Delhi and was put on the patient.

The complainant's further allegation was that Dr. Avdesh Basal of Apollo Hospital was brought who recommended a CT scan but was not allowed by Dr. Majumdar. It is the allegation in para 10 of the complaint that second surgery was performed contrary to the wishes of the attendants of the patient. This is factually incorrect and this assertion is contrary to the averment contained in paras no. 8 and 9 of the complaint. The consent for the second operation was taken from the petitioner. It is factually incorrect to state that nurses and technician did not cooperate and that the services of Dr. Jindal were not requisitioned in time. **On 23.12.96, the patient died.**

The cause of death was cardiac arrest. There is an allegation in the complaint that there were lack of facilities in the hospital without mentioning which facility was lacking. On 24.12.96, FIR was lodged bearing no.1282 under Section 304-A and admittedly charge sheet was filed and a lot of resentment, demonstrations, press coverage followed. On 21.1.97, magisterial inquiry was ordered. On 15.9.97, Mr. Ankur Gupta, the then ADC, Faridabad gave his report and indicted doctors and staff.

It is averred in para 13 of the report that the staff was not equipped to handle such

a situation. In para 16 of the complaint, an averment has been made that the Surgeon, Dr. Majumdar ought to have first performed operation of the right kidney instead of opting for left kidney. The case of the complainant is that the patient was not alive after 16.12.96 and despite that injections were given. Though the complainant spent Rs.50,000/-, the claim made is for Rs.41 lakhs.

The correction of the left kidney was considered necessary because the surgeon in his decision based on the accepted medical textbooks thought that in case of bilateral calculi the less affected kidney should be corrected first. The right kidney was having hydero nepherosis of Grade 4. The death of the patient took place on 23.12.1996 due to cardiac arrest. The allegation that injections were given on the dead body of Jasbir Kaur, speaks volumes about the false story propounded by the complainant. Dead body cannot receive any injection.

The team of surgeons was the same as was on 9.12.1996. The equipment and infrastructure and facilities were the same.

Magisterial inquiry under Section 176, Cr. P.C. was not legally sustainable. The criminal case has already ended in acquittal of all the persons on 27.11.2006 by the Court of Addl. Chief Judicial Magistrate, Faridabad. No case of culpable negligence is made out. Even if while making decision, there is bonafide error even then no culpable negligence could be attributed.

Learned counsel Mr. Chadha further submitted that no post mortem was conducted hence there is no report to indicate the actual cause of death. The inquest cannot be used as evidence. It can only be used to contradict the evidence given by others. There is no expert witness to support the contentions of the complainant. There is no brain death. It has to be certified by a team of surgeons. Though Rs. 41 lakhs has been claimed and as the complainant

had remarried after sometimes after the death, he cannot claim a huge sum of Rs.5 lakhs for loss of love and affection. Further Rs. 5 lakhs has been claimed for loss of income and estates but the complainant's, wife was not working. So this claim is grossly exaggerated.

Mr. Chadha further submitted that the complainant has wrongly relied upon the enquiry report under section 176 of the Cr. P.C. given by Additional District Magistrate. The enquiry report under section 176 of Cr. P.C. can only be given when a person dies in police custody or when a person commits suicide. The report by itself does not affect the rights of the parties nor it is admissible in evidence in any proceedings. The proceedings for holding inquest are intended to primarily investigate the matter and the report in the trial is not admissible. No other medical evidence has been produced to indict any of the respondents for any medical negligence.

To a query raised by us, Mr. Chadha stated that there was a neurologist in the hospital at the relevant point of time.

Submissions of Ms. Sunita Harish,learned counsel for Respondent No. 2

Smt. Sunita Harish submitted that Dr. Harish Kumar Khurana, Respondent No. 2 is a qualified, experienced and conscientious doctor. **After doing his M.B.B.S. in the year, 1967**, he joined Haryana Civil Medical Service on 4.3.68 and he took voluntary retirement from Govt. service w.e.f. 4.8.1988. During the year, 1977 onwards, he has worked in anaesthesia speciality only **and has given anaesthesia to about 25000 patients.**

Dr. P.K. Babbar, M.D. in medicine examined the general condition and clinical parameters of Smt. Jasbir Kaur and declared her fit for surgery. After that Dr. Khurana himself performed the pre-anesthetic check up on 14.12.1996. Informed consent and high risk consent were taken from the patient and complainant no. 1. After the patient

was shifted on operation table on 16.12.96, pre-medication was given. He administered 2.5% Pentothal Sodium 10 ml. followed by 2cc Scoline injection. Immediately Intermittent Positive Pressure Ventilation (IPPV) with 100% oxygen was given. After that he inserted endotracheal cuffed tube in her trachea for ventilation of patient and to use relaxant, gas, oxygen with Controlled Respiration Technique. He used the same technique that was used during her earlier successful operation on 9.12.1996 based on his sound judgment and experience. Suddenly her pulse became feeble and cardio-respiratory arrest was noticed. Immediately, nitrous oxide gas was put off and IPPV with 100% oxygen with Boyle's Machine was started by Respondent no. 2. Instantaneously, other cardio-pulmonary resuscitative measures were started, including cardiac massage done by doctors present including Dr. Ajay Gupta who came from the causality. Respondent No. 3 to 5 were instructed side-by-side to load all emergency injections and give them as and when asked. Doctors present were also giving the injection/medications.

Simultaneously, Dr. V.K. Jindal was also summoned who gave S.C. shocks. Dr. P.K. Babbar & Dr. Sachin Bhowmik had also joined. It was the team effort which saw the revival of Smt. Jasbir Kaur. Heart beats, pulse and blood pressure were recordable and ECG showed normal tracings. Throughout the procedure, Smt. Jasbir Kaur was being given IPPV with 100% oxygen through Boyle's machine which was manually operated by Respondent No. 2 from about 10 a.m. in the morning to 8 p.m. in the evening. This was done by him because even after revival, the patient continued to remain unconscious and could not breath on her own. So IPPV and necessary medication was continued by him. The cardiac arrest during administration of anesthesia and in the post anesthesia period are medically recognized phenomena and, therefore, for this reason Boyle's Machine was kept handy.

Smt. Jasbir Kaur was brought out of operation theatre and shifted to I.C.U. at about 1.45

p.m. with IPPV being continued manually with the help of Boyle's Machine by him. In the case of person suffering cardiac arrest who does not breath by himself/herself, artificial respiration is done with the help of Boyle's Machine operated manually. It is only after assessing that the patient would require artificial respiration for a longer duration that the patient is put on automatic ventilator. **Automatic ventilator or respirator is, therefore, not a necessary equipment to be kept as stand by at the time of administering anesthesia in such type of operations. In the particular case, Smt. Jasbir Kaur was put on automatic ventilator at about 8.00 p.m. after it was ascertained on thorough examination that she would require respiration for comparatively longer period.** Till that time i.e. 8.00 p.m. Respondent No. 2 continued manual IPPV with 100% oxygen. He remained by the patient in those times of extreme distress and performed his part of the job in a diligent manner showing no deficiency or negligence in service or skill.

It is submitted here that through an automatic respirator usually 60% oxygen coupled with 40% air is given to the patient and on his advise that instead of 60% oxygen, 100% oxygen be given and 40% air should be discontinued, it was done so.

After Dr. Mazumdar had certified Smt. Jasbir Kaur fit for second operation, the other usual and necessary routine was started. When Smt. Jasbir Kaur suffered cardiac arrest all the Respondents participated in damage control exercise.

In the facts and circumstances of the case no medical negligence is made out and the case of the complainants is liable to be dismissed with costs.

Submissions of Mr. A.K. Raina, learned counsel for Respondent No. 7, New India Assurance Co.

Mr. A.K. Raina submitted that he will adopt the arguments advanced by the learned counsels for the respondents.

Analysis of some important cases cited by Mr. Chadha, learned counsel

The Hon'ble Supreme Court in the case of Martin F. D'Souza Vs. Mohd. Ishfaq (Civil Appeal No. 3541 of 2002) – JT (2009) (2) SC 486, observed as under:-

> "We, therefore, direct that whenever a complaint is received against a doctor or hospital by the Consumer Fora (whether District, State or National) or by the Criminal Court then before issuing notice to the doctor or hospital against whom the complaint was made, the Consumer Forum or Criminal Court should first refer the matter to a competent doctor or committee of doctors, specialized in the field relating to which the medical negligence is attributed, and only after that doctor or committee reports that there is a prima facie case of medical negligence should notice be then issued to the concerned doctor/hospital".

In the case under consideration, the complaint was filed as long as back in the year 1997 and the proceedings have been held since then. After that, OPs have filed the written versions and the OP No.1 had filed an application for impleading the New India Assurance Co. and the Insurance Co. had already been impleaded. Interrogatories have been exchanged and since 25.5 2007, hearings have been taking place. When the hearing was almost concluded, the recent (2009) judgment of the Hon'ble Apex Court in Martin F. D'Souza case (supra) has been brought to our notice. The ratio of this judgment is applicable only to the fresh cases where the hearing has not begun and the notices have not been issued to the doctors and other opposite parties. It is not applicable to the case under consideration because the hearing of this case is almost completed.

Learned Counsel for the Respondents, Shri Chadha had quoted judgment of this Commission in S.R. Shivaprakash & Ors. – II (2006) CPJ 123 (NC). The facts of this case are

entirely different from the case under consideration. In this case bypass surgery was performed on the patient. Two days after the surgery, the patient died due to sudden extubation of ET tube, resulting in cardiac arrest. As ET tube was displaced by sudden violent coughing which resulted in cardiac arrest. It was observed that the main factor responsible for patient's death was poor pre-operative inherent condition of patient. As the facts are distinguishable, the ratio of this case is not applicable to the case under consideration.

Another case quoted by Mr. Chadha is the case of Krishna Murari Sinha vs. Dr. MD Basheer Alam- IV (2006) CPJ 332 (NC), wherein there was knee surgery. It was alleged that in such cases of operation, plastering was unnecessarily done and patella was not required to be removed because it could be joined. As the facts are totally distinguishable, the ratio of the case quoted supra is not relevant to the case on hand.

Further in the case of Ramdeo Prasad Singh & Ors. Vs. Dr. Ramesh Chandra Sinha – I (2007) CPJ 285 (NC), quoted by Mr. Chadha, this Commission held as under:-

> "This is a case wherein a child was suffering from syndactyl i.e., fingers of both the hands and toes of both the feet were fused and a surgeon through a four-stage operation got separated the fingers of the hands and fingers of the left foot but could not separate the two of the fingers of the right foot due to absence of phalanx. The issue to be decided in this case is, whether in such case a surgeon could be held negligent in the performance of his duties. The simple answer to the question is No".

Again the facts of this case are totally different from the case under consideration and hence the ratio of this Judgment is not applicable to the case under consideration.

FINDINGS:

Issue No. 1. Whether the opposite parties are negligent in performing surgery on the patient on 16.12.1996 without obtaining the valid consent of the patient in writing, though the deceased patient was an adult and was in a condition to give consent or otherwise for the second surgery to be performed on her?

Ans: The consent for the second operation was not signed by the patient and it was signed by her husband, which is not valid.

In the consent form of Sun Flag Hospital and Research Centre dated 9.12.96, it is clear that prior to the first surgery it was signed by the patient Jasbir Kaur whereas the consent form prior to the second surgery of 16.12.96 was signed by her husband – Joginder Singh at 8.00 am. This is not a valid consent.

In Samira Kohli vs. Dr. Prabha Manchanda & Anr. In Civil Appeal No. 1949 of 2004 – 2008 AIR 1385, the Hon'ble Apex Court has held as follows:-

"We may now summarize principles relating to consent as follows:-

i. (i) A doctor has to seek and secure the consent of the patient before commencing a 'treatment' (the term 'treatment' includes surgery also). The consent so obtained should be real and valid, which means that: the patient should have the capacity and competence to consent; his consent should be voluntary; and his consent should be on the basis of adequate information concerning the nature of the treatment procedure, so that he knows what he is consenting to.

ii. (ii) The 'adequate information' to be furnished by the doctor (or a member of his team) who treats the patient, should enable the patient to make a balanced judgment as to whether he should submit himself to the particular treatment or not. This means that the Doctor should disclose

(a) nature and procedure of the treatment and its purpose, benefits and effect; (b) alternatives if any, available; (c) an outline of the substantial risks; and (d) adverse consequences of refusing treatment. But there is no need to explain remote or theoretical risks involved, which may frighten or confuse a patient and result in refusal of consent for the necessary treatment. Similarly, there is no need to explain the remote or theoretical risks of refusal to take treatment, which may persuade a patient to undergo a fanciful or unnecessary treatment. A balance should be achieved between the need for disclosing necessary and adequate information and at the same time avoid the possibility of the patient being deterred from agreeing to a necessary treatment or offering to undergo an unnecessary treatment.

iii. (iii) Consent given only for a diagnostic procedure, cannot be considered as consent for therapeutic treatment. Consent given for a specific treatment procedure will not be valid for conducting some other treatment procedure. The fact that the unauthorized additional surgery is beneficial to the patient, or that it would save considerable time and expense to the patient, or would relieve the patient from pain and suffering in future, are not grounds of defence in an action in tort for negligence or assault and battery. The only exception to this rule is where the additional procedure though unauthorized, is necessary in order to save the life or preserve the health of the patient and it would be unreasonable to delay such unauthorized procedure until patient regains consciousness and takes a decision.

iv. (iv) There can be a common consent for diagnostic and operative procedures where they are contemplated. There can also be a common consent for a particular surgical procedure that may become necessary during the course of surgery.

v. (v) The nature and extent of information to be furnished by the doctor to the patient to secure the consent need not be of the stringent and high degree mentioned in Canterbury but should be of the extent

> which is accepted as normal and proper by a body of medical men skilled and experienced in the particular field. It will depend upon the physical and mental condition of the patient, the nature of treatment, and the risk and consequences attached to the treatment".

The Hon'ble Apex Court in the Judgment quoted (supra) has further held that as there was no consent by the appellant for performing hysterectomy and salpingo-oopherectomy, performance of such surgery was an unauthorized invasion and interference with appellant's body, which amounted to a tortuous act of assault and battery and therefore a deficiency in service.

(In the above cited case, the 'appellant' was the 'patient')

In this case, it is crystal clear that the patient was conscious and in a fit stage to give consent or otherwise. The treating doctors have not taken her consent. On the other hand, they only took the consent of the patient's husband, which cannot be by any stretch of imagination construed as a valid and informed consent.

Hence this itself is a deficiency in service on the part of the treating doctors and the hospital concerned.

Issues No. 2 & 3: **Whether the second surgery should have been taken up when it was clearly written in the case records by the treating doctor that the patient has poor tolerance to anaesthesia? Whether the opposite parties should have taken up the surgery of the second kidney within eight days of the surgery of first kidney though it was an elective surgery and not an emergency one?**

Ans: We have carefully seen the 'Patient's Sheet' dated 14.12.96 of the Hospital and it is very

clear that following lines were inserted later on in smaller letters and one or two words are touching the subsequent line which is written in a bigger letters.

'Patient insisting for surgery of the other side'.

"Patient and her husband thoroughly briefed regarding the diseased condition, surgical risk and other risks involved."

This is not a healthy practice. This has been done to evade responsibility for the consequences of the decisions to conduct second surgery.

It is clearly written in the case records by the treating doctor, Dr. Mazumdar that the patient had poor tolerance to anaesthesia. Even then Dr. Mazumdar decided to perform surgery on the patient's second kidney when the patient was in the hospital itself and had yet not been recommended to be discharged from the hospital. This means the patient had not fully recovered and not regained her normal strength to withstand a surgery of this type, which requires administration of general anaesthesia. **We are surprised to note that the treating doctor after recording that the patient had poor tolerance to anaesthesia has tried to defend his action by stating that poor tolerance to anaesthesia means nothing.**

We are also surprised to note the submissions made on behalf of the Anaesthesiologist who has claimed that at no point of time Dr. Mazumdar informed Dr. Khurana that the patient was found to be in poor tolerance to anaesthesia. This indicates that either (a) he is trying to shift the blame on the treating surgeon; and or (b) that if he was informed about the patient's poor tolerance to anaesthesia he would not have embarked upon the task of administering anaesthesia for the second surgery. The medical and surgical note of the first surgery and events and treatment leading to second surgery are part of the medical record in which there is a noting by Dr. Mazumdar that patient was found to be poor in anesthesia tolerance.

However, we cannot be oblivious of the fact that Dr. Khurana was the Anaesthesiologist during the first surgery also and he was fully aware of the conditions of the patient. In reply to the interrogatories, he has clearly admitted that he has gone through the notings of Dr. Mazumdar wherein he has said the patient has poor tolerance to anaesthesia. We are stunned to note that he has stated in the reply to interrogatories that in medical parlance poor tolerance to anaesthesia means 'nothing'.

It is common knowledge that a person can survive with one kidney, just as a person can survive with one lung. There are cases where a patient suffers from failure of both the kidneys and nephrectomy is performed to replace one of the damaged kidneys by a kidney of a donor after proper test and verification. Therefore, there was no hurry to perform the second surgery.

In this context we would like to quote the celebrated Bolam test, which has been quoted by Hon'ble Apex Court in Jacob Mathew vs. State of Punjab & Anr. (2005) 6 SCC 1 (cited by the counsel for complainant and OP2) in the following words:-

> "The water of Bolam test has ever since flown and passed under several bridges, having been cited and dealt with in several judicial pronouncements, one after the other and has continued to be well received by every shore it has touched as neat, clean and well-condensed one. After a review of various authorities Bingham L.J. in his speech in Eckersley v. Binnie, [1988] 18 Con. L.R. 1, 79 summarised the Bolam test in the following words :-
>
> "From these general statements it follows that a professional man should command the corpus of knowledge which forms part of the professional equipment of the ordinary member of his profession. He should not lag behind other ordinary assiduous and

intelligent members of his profession in knowledge of new advances, discoveries and developments in his field. He should have such awareness as an ordinarily competent practitioner would have of the deficiencies in his knowledge and the limitations on his skill. He should be alert to the hazards and risks in any professional task he undertakes to the extent that other ordinarily competent members of the profession would be alert. He must bring to any professional task he undertakes no less expertise, skill and care than other ordinarily competent members of his profession would bring, but need bring no more. The standard is that of the reasonable average. The law does not require of a professional man that he be a paragon combining the qualities of polymath and prophet."

The degree of skill and care required by a medical practitioner is so stated in Halsbury's Laws of England:-

"The practitioner must bring to his task a reasonable degree of skill and knowledge, and must exercise a reasonable degree of care. Neither the very highest nor a very low degree of care and competence, judged in the light of the particular circumstances of each case, is what the law requires, and a person is not liable in negligence because someone else of greater skill and knowledge would have prescribed different treatment or operated in a different way; nor is he guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art, even though a body of adverse opinion also existed among medical men.

Deviation from normal practice is not necessarily evidence of negligence. To establish liability on that basis it must be shown (1) that there is a usual and normal practice; (2) that the defendant has not adopted it; and (3) that the course in fact adopted is one no professional man of ordinary skill would have taken had he been acting with ordinary

care."

The abovesaid three tests have also been stated as determinative of negligence in professional practice by Charlesworth & Percy in their celebrated work on Negligence".

Judged from the touchstone of the Bolam test, the second surgery should not have been taken up in such a hurry. Further it is very clear that it was an elective surgery and not an emergency one, as there was no imminent threat to the life of the patient. An elective surgery could always have been postponed till the patient would have recovered fully and has been rehabilitated. At an appropriate future date, after holding a meeting of a team of specialists to discuss the case in a professional manner and arriving at a consensus, a carefully planned second surgery with the proper informed and valid consent could have commenced and after keeping necessary team of doctors and required equipments ready.

It is worthwhile to look into the case of Mumbai Grahak Panchayat vs. Dr. (Mrs.) Rashmi B. Fadnavis & Ors. 1996 (I) CPR 137(NC), wherein this Commission held as under:-

> "However, we find it difficult to go with State Commission's observation that the Anesthetist cannot be held liable for the payment of compensation even if it is proved that she acted negligently in her duty, since her services were hired by O.P. NO. 1 for consideration and since there is no privity of contract between the complainant and O.P.No.3".

In the case under consideration the surgeon is an MS and the anesthesiologist has claimed to have administered anesthesia to 25,000 patients are not ordinary inexperienced persons. So it is abundantly clear that they have failed the celebrated Bolam Test and hence were negligent in the performance of their duties.

Issue No. 4. Whether the opposite parties should have kept the automatic ventilator ready in the operation theatre at the time of the starting of the second surgery when it was well known that the patient has poor tolerance to Anaesthesia?

Ans: Sunflag Hospital & Research Centre claims to be a Multi Speciality Hospital and Research Centre. If it is so, they should have an automatic ventilator ready in the operation theatre which was not so. It is surprising that they did not have a single automatic ventilator in the whole hospital and secondly, when it was well known that the patient has poor tolerance to anaesthesia atleast before conducting of the second surgery an automatic ventilator should have been purchased or hired and kept ready. This too was not done. An automatic ventilator was purchased after the catastrophe had taken place and brought into service only at 8 p.m. though anaesthesia was administered at 9.45 a.m. and soon after that the patient suffered cardiac arrest.

The Anaesthesiologist has made a tall claim to have administered anaesthesia to 25,000 patients. If so, he should have insisted upon the hospital authorities (a) to buy an automatic ventilator, as it is essential equipment; (b) he should have advised recruitment of trained technician/nurses to operate Boyle's Apparatus. There is no proof of having done so.

In the case of Bhajan Lal Gupta & Anr. vs. Mool Chand Kharati Ram Hospital & Ors. – 2000 (I) CPR 70 (NC), the National Commission held that the one of the tests of medical negligence is that some thing which is required under medical practice to be done was not done or what was done was contra indicated. **At the same time, it is also a settled principle that a**

specialist is required to know the latest techniques for management of the patient and if he is ignorant about it, then he could be considered to be negligent in following his profession.

Issue No. 5. Whether the patient should have been examined and treated by Neurologist/ Neuro surgeon who was available in the hospital when the patient went into Coma and remained in that stage for a few days and if they did not have full confidence in their own Neurologist, whether the opposite parties should have utilized the services of an expert Neurologist from another hospital?

Ans: During the course of arguments, it was brought to our notice that the hospital had a Neuro Surgeon in the list of specialists. It is astonishing to note that this Neuro Surgeon was not called to examine and treat the patient when the patient went into coma as there is no mention of the Neurologist/Neuro Surgeon having examined the patient after she went into coma. Assuming for a moment, they had no faith in their own Neurologist or their Neurologist was on leave, they could have utilised the services of an expert Neurologist from other hospital. This too was not done.

Non-association of neuro-surgeon/neurologist tentamounts to medical negligence. In Nizam Institute of Medical Sciences vs. Prasanth S. Dhananka & Ors., II (2009) CPJ 61 (SC), the Hon'ble Apex Court has held that the attending doctors were seriously remiss in not associating a neurosurgeon at the pre-operative as well as at the stage of operation. In the case under consideration, they were negligent in not associating a neurologist when the patient went into coma.

Issue No. 6. Whether the opposite parties should have kept a Cardiologist as a stand by at the time of starting the surgery in view of the above stated conditions of the patient?

Ans: As the patient had poor tolerance to anaesthesia and as the patient was subjected to the second surgery by general anaesthesia even before she had totally recovered and regained her strength after her first surgery, the hospital authorities and the treating doctors should have asked one of their Cardiologists from their team of specialists to be present as a stand by before the start of this critical surgery which according to the treating surgeon, Dr. Mazumdar was a high risk surgery.

Issue No. 7. Whether a team of Cardiologists, available in the hospital reached in time to revive the patient who had suffered cardio respiratory arrest soon after administering of anaesthesia by the Anaesthesiologist?

Ans:

Analysis of the treatment sheet:

"**Date**	**Progress**		**Medicine**
16.12.96	I/V line with 18 no canula established. Premedication Inj. Atropine 1 amp + Inj. Forturn 15 mg I/V given at 9.45 am. Induced the patient with 2.5% thiopentone sodium 10 ml followed by 2cc scoline. IPPV done with 100% O2 intubator with 7.5 mm Coffed Tube. Coff inflated Suddenly Pulse became feeble and cardiorespiratory arrest was notice. N2O switched off and IPPV with 100% O2 started and cardiac massage started Inj. Adreline Inj. Cardiac given Inj. Eflorlin 2 AMP given, in the meantime physicians Dr. V.K. Jindal was summoned. Later Dr. P.K. Babbar and Dr. Bhowmik were also summoned. Patient was reviewed to sinus Rhythem as displayed by cardiac monitor. Pulse palpable, feeble Dopamine drip started and BP recordable after Dopamine drip 100/70. Pupils were dilated, non reacting		Inj. Efcorlin I/V total (800 mg) in OT Inj. Decadron I/V 60 mg Inj. Sodabicarbnonate 40cc I/V Inj. Atropine 2 amp I/V

	patient unconscious. Pt. Shifted to CCU at 1.45 pm and put on life support system in Bipay system of machine at 8 pm. Till then Pt. Was given CR manually		
By Anaesthesia Machine with 100% O2 3 pm	BP 100/70, G.C. same Pulse rate 132/mm Temp. 98F O2 = Oxygen N2O = Nitrous Oxide CR + Cardio Pulmonary Resuscitation"		

From 9.45 am to 1.45 pm (four hours) for these crucial four hours who did what is not mentioned. When the patient suffered cardiac arrest and at what point of time the cardiologist/ team of cardiologists came? What was the time gap? Who made Cardio Pulmonary Resuscitation (CPR) efforts and for how long? At what point of time the patient went into coma. No time chart is made available by the hospital. Why a neurosurgeon or Neurologist was not summoned? Why automatic ventilator was not kept as a stand by. It is mentioned that only Dr. Khurana handled the Boyle's machine for 8-10 hours. Is it humanly possible?

The hospital neither had public announcement system nor paging system, therefore, the treating surgeon, Dr. Mazumdar himself had to come out of the operation theatre at the critical time when the patient suffered cardio respiratory arrest to summon a Cardiologist. Though a team of Cardiologists had arrived at the scene, it is clear that they did not arrive in time.

Issue No. 8. Whether the report of the enquiry conducted by the Additional Deputy Commissioner can be taken into consideration for deciding the case of medical negligence?

Ans: Additional Dy. Commissioner who had conducted the inquiry submitted a report U/s 176 Cr.P.C. relating to the death case of Smt. Jasbir Kuar as per the order of District Magistrate, Faridabad. Three questions were considered in this inquiry which read as under:-

1. **1. Why was the 2nd operation performed so soon after the 1st operation?**
2. **2. Why did the patient die and who was responsible for her death?**
3. **3. Is the Hospital equipped enough to operate?**

The first point, which was considered in the inquiry report was why was the 2nd operation performed so soon after the 1st operation? The Inquiry Officer held that second operation was held rather too soon. The following questions remain unanswered: -

i. **(i) When it was a planned operation, what was a hurry to operate so soon at a stage when the patient was still recovering from the first operation when there was no emergency.**

ii. (ii) If both the operations were planned in advance, the patient should have been told in advance that the 2nd operation will be performed in normal circumstances after so many days.

2. **Why did the patient die and who was responsible for her death?**

As far as the case of death of patient is concerned, it has been proved beyond doubt that the patient died because cardiac arrest took place as soon as anesthesia was given for the 2nd operation. The patient could not be revived in time i.e. around 4-5 minutes. The patient was revived after about 30-45 minutes. When the cardiac arrest extends beyond 5 minutes, the brain suffers irreversible damage, which happened in this case and the patient, therefore, went into a coma and it was a matter of time as to when she would die. Whenever, cardiac arrest takes place, the following things are done to revive the patient:-

- Artificial respiration should continue.
- The heart should be given a massage.
- Injections should be given in the heart.
- Even electric shocks should be given.

In this case, when the cardiac arrest took place in the operation theatre, the Anesthetic Dr. H.K. Khurana, 2 O.T. Nurses (Mrs. Leelamma Varghese & Mrs. Saramma Varghese), 1 OT cum CSSD Technician (Mr. Kumar) were present. Dr. R.K. Majumdar was also there and preparing for operation. As soon as the Tube was inserted in the Trachea, the patient went into Cardiac-arrest. Dr. H.K. Khurana kept operating of Boyles Machine, which has to be operated manually using both hands to give artificial respiration to the patient. As it is clear from the statements none amongst the nurses and technicians did take any other measures to revive the heart. **In fact, the technician has gone out to call a physician. Dr. R.K. Majumdar also came out from the operation theatre and by chance Dr. Vijay Jindal who is a physician happened to be around and was called by Dr. R.K. Majumdar. As per statement of Dr. Jindal and Nurse, Mrs. Aleymma George, Dr. Jindal asked that if it is an emergency, I will come in as such or otherwise, I will change my clothes and come inside the operation theatre. He was told to change the clothes and come, which took around 20-30 minutes. When he was changing his clothes Dr. Majumdar kept on standing out the operation theatre waiting for Dr. Jindal.** All this raises following questions:-

A. A) Dr. R.K. Majumdar knew that, it is an emergency then why did he not get Dr. Jindal inside immediately rather than allowing him to change his clothes.

B. B) Since, all doctors are trained for such emergencies and specially so highly qualified

doctor like Dr. Majumdar, why did he keep waiting outside the operation theatre, rather than going inside to help Dr. Khurana in reviving the heart. This is all the more pertinent since Dr. H.K. Khurana could not leave the Boyle's Machine as otherwise artificial respiration would have stopped. No other step to revive the heart were taken by the nurses and whatever was to be done had to be done within a span of 5 minutes. Dr. Majumdar and Dr. Khurana have admitted that they know how to operate Defibrillator (which is used to give shocks to revive the heart).

C. **C) Another pertinent point to note is that even Dr. Khurana in such an emergency could have handed over the Boyle's Machine to a nurse and should have either done heart massage or give injections or shocks to revive the patient, but he did not do so. According to Dr. Jindal when he entered the operation theatre, Dr. Khurana was on the Boyles Machine and no other measures had been taken to revive the patient. In fact, when he reached it was already too late (since Dr. Jindal reached 20-30 minutes after cardiac arrest), but whatever could be done, was done by him only. He gave injections in the heart and electric shocks after which though the heart started but the brain has already been damaged.**

All the above shows that in these crucial minutes, Dr. R.K. Majumdar simply did not take any action and Dr. H.K. Khurana probably become so confused that he did not utilize the man power inside the operation theatre to take action to revive the patient. The blame also goes to the O.T. nurses and technician, because they are not trained to handle such emergencies and all the statements lead to the conclusion that they did not themselves take any action to revive the patient.

4. Is the Hospital equipped enough to operate?

In my view, the Hospital should be better equipped since at present, it suffers from various deficiencies. Till they rectify them, it is advisable that they should not operate. This conclusion is based because of following reasons:-

a. **a)** To give artificial respiration to a patient, either Boyles Machine is used, where air is pumped manually or Ventilator/Respirator is used, where pumping is done automatically. In the hospital they have just two boyles machines and no Ventilator/Respirator. In this case, also the respirator was purchased and got at 7.00 p.m. in the evening **i.e. after a gap of around 8-9 hours. Now one can imagine that in such a big hospital, when they have two operation tables, Gynecology department etc. at any given point of time, they can cater to just two patients and in case of any emergency which involves more than two patients or where they have to keep the patient on automatic respirator, they have no facility.**

b. **b) In the entire hospital, there are just two Defibrillators, whereas in a normal hospital, one Defibrillator is required in emergency, 2 in operation theatre, a few in I.C.U and at other places.**

c. **c) The hospital does not even have a complete Pathology lab, for example in this case, the patient relatives were sent to Escort Hospital to get the Blood-Gas sample test done.**

d. **d) The hospital has a medical shop, which is run by the hospital. Even there the stocks of medicine are not complete since the relatives of the patient was asked to run around and get the medicines from outside.**

e. **e) As far as operation theatre is concerned, they have just four trained OT**

Nurses for the entire 24 hours period, working in shifts.

f. f) **They have no paging system to page the doctors in case of emergency.**

Another fact, which is pertinent to note is that after the incident took place and till the patient died, the relatives were not given proper briefing and correct information, which should have been done.

In this connection, a criminal case was filed in the court of B. Diwakar, Additional Chief Judicial Magistrate, Faridabad on 27.9.97 which was decided on 27.11.2006, wherein it was observed as under:-

> **"In the present case even for the sake of argument if it is taken that there was some negligence on the part of the medical team in that event also their act was not of such a character which can be said to be "gross" negligence. Hence they cannot be held liable for any criminal prosecution."**
>
> **This observation makes it clear that there was some civil medical negligence.**

An enquiry was ordered by the District Magistrate was conducted by his deputy, who are impartial statutory authorities. Though we cannot base our decision solely on the report of the enquiry, we have gone through the report in great detail and have reproduced the same as we find that the enquiry officer has gone into certain important details and has made some important valid observations. Therefore, this report of the enquiry has a great persuasive value.

Issue No. 9. Whether the treating surgeon/ Anaesthesiologist can pass on the blame on each other when they are part of the same team of specialists/ incharge of treating the patient?

Ans: Dr. Khuranna has stated in his written version as follows:

At no point of time, Dr. Majumdar informed Dr. Khurana that the patient was found to be poor in anesthesia tolerance.

Smt. Jasbir Kaur was subjected to a pre-aesthetic check up by Dr. P.K. Babbar, on 13.12.96. Dr. Khurana has made a specific note of it in the case file of Smt. Jasbir Kaur but that particular sheet as also certain other sheets have not been filed alongwith the documents filed with the complaint. Dr. Khurana is unable to enclose those sheets because the respondent no.6 at the behest of respondent no.1 has denied him access to the said record.

Dr. Khurana has made serious allegations against Dr. Mazumdar and also against the hospital. As he had gone through the records of the case as a part of pre-anaesthesia check up, he had found out that the patient has poor tolerance to anaesthesia. He has admitted this in his replies to the interrogatories.

Issue No. 10. Whether it was humanly possible for the Anaesthesiologist to have continuously operated the Boyle's Apparatus for ten hours as claimed by him to ensure proper breathing by the patient without delegating this task to another Anaesthesiologist or a competent technician?

Ans: Anaesthesiologist claims that he has continuously operated the Boyle's Apparatus from 9.45 a.m. to 7.00 p.m. by using both hands to pump oxygen. Is it humanly possible to do so without even answering call of nature or even drinking a glass of water? This claim poses so many questions: (i) The Anaesthesiologist did not have confidence in the Technicians or Nurses as they were not trained to handle the Boyle's Apparatus; (ii) The Anaesthesiologist was himself

shocked to see the results of his anaesthesia so he decided to operate it himself; (iii) He wanted to save himself from the blame of not participating in cardio-pulmonary resuscitation(CPR); (iv) If the first question is correct, then it means the Technicians/Nurses were neither trained nor competent to operate the Boyle's Apparatus. If so, he could have asked for the services of another anaesthesiologist.

Issue No. 11. Whether the principle of Res-Ipsa Loquitur can be applied in this case?

Ans: <u>Principle of Res Ipsa Loquitur</u>

Simply stated this legal maxim '*Res Ipsa Loquitur'* means that facts speak for themselves.

The effect of *Res Ipsa Loquitur* is to reverse the burden of proof so that once the claimant establishes *Res Ipsa Loquitur,* it is upto the defendant to show that he was not negligent.

In Dr. B. Reghupati vs. B. Vasantha, I (2008) CPJ 1 (NC), this Commission held as under:

" **Anaesthesia kills patient on the Operating Table**

Ms. Vasantha's husband Mr. Balasubramanyan, who worked as a Village Administrative Officer, developed pain in his ear. Dr. B. Raghupathi, who examined him, diagnosed that the pain was due to a malignant growth in the throat and asked him to come for further tests. Dr. Reghupati took him to the operation table for biopsy and he died on the operation table.

The deceased was not a heart patient and an ECG taken before the biopsy was normal. After giving the anaesthesia, Laryngoscopy was conducted. As it failed, a direct Laryngoscopy was done. The deceased developed Bronchospasm; as the vocal cords were not visible, Intubation was conducted. The patient developed cardiac arrest and attempts to revive the patient failed.

In the case of Spring Meadows Hospital & Anr. vs. Harjol Ahluwalia through K.S. Ahluwalia & Anr. – (1998) 4 SCC 39, it was held as under:-

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

The consent of the patient was not taken for this serious surgery requiring general anaesthesia. Though the patient was known to have poor tolerance to anaesthesia, second surgery was planned inspite of the fact that the patient had not fully recovered from the first surgery and there was no emergency compelling the treating surgeon to embark upon the second surgery. Further total lack of co-ordination between the hospital staff and the specialised doctors in treatment of the patient was visible. It is important to note that complications arose and the patient went in coma within four walls of operation theatre where patient's relatives had no access whatsoever and the onus is on the doctors and the paramedical staff in the operation theatre to explain the events that happened there. **In the said context the surgeon, anaesthetist and cardiologist have not been able to explain the events and the ultimate outcome i.e. the death of the patient to the satisfaction of the relatives of the patient. Hence this is a clear case of *res ipsa loquitur*.**

Issue No. 12. If medical negligence is established, what is the relief, if any, the complainants are entitled to?

Ans: As medical negligence is clearly established in the case under consideration. Now we need

to see what is the relief the complainants are entitled to? The complainants have claimed Rs. 41 lakhs with interest @ 18% p.a., as compensation.

We are drawing inspiration from the Judgment of the Hon'ble Apex Court in Civil Appeal No. 4119 of 1999, Nizam Institute of Medical Sciences vs. Prasanth S. Dhananka & Ors. – II (2009) CPJ 61 (SC) decided on 14.5.2009. The Hon'ble Apex Court held as under:-

> "We must emphasize that the Court has to strike a balance between the inflated and unreasonable demands of a victim and the equally untenable claim of the opposite party saying that nothing is payable. Sympathy for the victim does not, and should not, come in the way of making a correct assessment, but if a case is made out, the Court must not be chary of awarding adequate compensation. The "adequate compensation" that we speak of, must to some extent, be a rule of the thumb measure, and as a balance has to be struck, it would be difficult to satisfy all the parties concerned. It must also be borne in mind that life has its pitfalls and is not smooth sailing all along the way (as a claimant would have us believe) as the hiccups that invariably come about cannot be visualized. Life it is said is akin to a ride on a roller coaster where a meteoric rise is often followed by an equally spectacular fall, and the distance between the two (as in this very case) is a minute or a yard".

Items: (i) Medical Expenses (ii) Funeral/last rites expenses & (iii) Special diet, conveyance etc.

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The claim of medical expenses to the tune of Rs. 50,000/-, Funeral/last rites expenses of Rs. 10,000/-, special diet, conveyance, cost of expenses incurred to the tune of Rs. 15,000/- are reasonable claims. Hence they are allowed as such.

Item No. (iv): Loss of income/estates:

No proof has been adduced before us to show that the deceased was employed or was running a business but the deceased was a homemaker and the responsibility of a homemaker is enormous. Though, it is difficult to assess exact income of the homemaker, who is managing household, it cannot be less than Rs. 3,000/- per month. Therefore, as the deceased died at the age of 35 years and considering the life span of 60 years, the loss of income comes to Rs. 25x12x3000=9,00,000/-. As complainants have claimed Rs. 5 lakhs, we deem, it appropriate to restrict the same to Rs. 5 lakhs only.

Item No. (v): Loss of love & affection of complainant No.1

Complainant no.1, husband of the deceased has lost his wife and therefore, he is eligible to be compensated for loss of love and affection but the claim of Rs. 5,00,000/- is very much on the higher side especially because he has married for the second time sometime later after the death of the first wife. **Therefore, it would meet the ends of justice, if Rs. 1,00,000/- is awarded against this.**

Item No. (vi) Loss of love and affection of complainant nos. 2 & 3

Complainant Nos. 2 and 3 are the children of the deceased. The age of the children at the time of death was 13 years and 7 years. They required motherly care, love and affection atleast upto the age they attained adulthood and to some extent even after that. **"God wanted to be in every home, so he created mothers". This famous saying clearly establishes the unique importance of mother in the family scenario. Mother is irreplaceable. Though, Complainant nos. 2 and 3 have claimed Rs. 10 lakhs each, we deem, it appropriate to award Rs. 5 lakhs each.**

Item No. (vii) Mental agony and physical pain: Rs. 10,00,000:

As we have awarded substantial compensation to all the three complainants as above, we do not propose to award any further sum under this head separately.

tem No. (viii) Miscellaneous expenses: Rs. 25,000/-

In a case of this type, there are several expenses, which cannot be listed to have been incurred. As this amount is reasonable, it requires to be awarded. In total the compensation comes to Rs. 17,00,000/-.

The complainants have demanded 18% interest, which in our view is exhorbitant. Accordingly, we hereby direct that this amount of Rs. 17,00,000/- shall be paid with interest @ 9% p.a. from the date of filing the complaint till the date of payment.

The amount awarded to the children of the deceased should be deposited in the name of the children with the father as a guardian in fixed deposits and to be utilised after they become adults for their higher education etc.

We hold that medical negligence is clearly established, therefore, all the respondents are liable jointly and severally to pay this amount. As Opposite parties 3,4 and 5 are low paid sub-staff, the hospital authorities would be responsible to pay on their behalf. This amount shall be initially paid by the opposite parties 1,2 and 6 and to the extent the OPs are covered by insurance; they may claim reimbursement from the insurance co. The insurance co. shall reimburse to the extent of insurance cover provided by them.

The opposite parties shall pay Rs. 50,000/- as cost to the complainants.

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…….J
(R C JAIN)
PRESIDING MEMBER

……
(P D SHENOY)
MEMBER

VS