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NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION

Case No: None

P.VENKATA LAKSHMI — APPELLANT

Vs

Y.SAVITHA DEVI — RESPONDENT

Date of Decision: April 25, 2001

Citation: 2001 3 CPJ 402

Hon'ble Judges: P.Ramakrishnam Raju , Mamata Lakshmanna J.

Final Decision: Complaint dismissed

Judgement

1. THE facts as revealed in the complaint are these as briefly narrated. 1. THE complainant gave birth to a normal child in her first delivery in March, 1988. After a gap of four years she conceived again but unfortunately she had a missed abortion in February, 1992. She conceived in August, 1992 a third time. She consulted Dr. I. Nirmala Reddy, Gynaecologist and Obstetrician, her family doctor and on her advice she had been taking harmons injections from 25.9.1992 to avoid miscarriage. She had rescanned which showed normal single viable foetal node with age of 8-9 weeks. Again on 24.11.1992 she had another ultrasound scan as well as blood, urine etc., tested and everything found normal. On the advice of the family doctor she had one more ultrasound scan fourth time which revealed that the weight of the foetus was good. As her family doctor was not having nursing home she referred the complainant to the first opposite party who is having a nursing home and accordingly she was regularly consulting the first opposite party since 5.4.1993.

2. WHILESO from 15.5.1993 onwards she was feeling inconvenience i.e., 7 days before the expected date of delivery i.e., 22.5.1993. As 16.5.1993 happened to be Sunday and the first opposite party nursing home will be closed for consultation she

consulted Dr. I. Nirmala Reddy who told her that cervix was opened and dilatation started and she may develop labour pains any time and deliver the baby. Even for her first child she did not get labour pains and it was a case of induction and normal delivery. She waited the whole day and on 17.5.1993 she approached the first opposite party and explained to her about the history of the first delivery and requested her whether she would arrange for induction. But she refused to check-up and asked her to wait till the due date. Accordingly she waited up to 22.5.1993 and told her that she was having greenish discharge for the last 3 days and there were no labour pains. Thereupon the first opposite party had conducted ''Per Vaginum'' Test at 12.45 p.m. and told her that the baby was passing motion inside the womb and advised her for immediate admission. She prescribed ''None-stress Test'' (NST). In spite of treatment the vaginal discharge continued. On 23.5.1993 the first opposite party came for rounds and after enquiring about the problem she instructed her assistants to arrange for induction on 24.5.1993 at 6.00 a.m. On 24.5.1993 she was given injections for labour pains and the first opposite party removed a good quantity of motion passed by the baby into a tray and showed it to her husband and she suggested caesarean section. One sister in the hospital arranged the belt very casually and started the Contraction Stress Test (CST). But as the report was not coming properly it was repeated. The first opposite party after perusing the CST report advised her assistants to give Oxygen to her as foetal heart beating was going down. The complainant was getting second stage labour pains and could not deliver the child as the size of the baby was big. Then the first opposite party asked one of her sisters to press the complainant''s abdomen and push the baby out. When the sister did accordingly the doctor pulled the baby out by using forceps which made her almost unconscious. The baby was delivered but did not cry. The baby had birth asphyxia due to swallowing fluids and motion and due to the delay and crude method of delivery adopted by the doctor and her assistants. They suctioned the fluids and motion swallowed by the baby and gave Oxygen (intro-02) and warmed up the baby. The baby started crying slowly after 10 minutes. When the doctor knew that the baby was passing motion in the womb she could have reasonably anticipated the problem and should have called the paediatrician to be present at the time of delivery. But it was not done. It was at 10.00 a.m. on 24.5.1993 i.e., after 45 minutes the paediatrician came and examined the baby and told her to start feeding from 1.30 p.m. The first opposite party came to her room around 10.00 p.m. during her rounds and told her that the baby was alright. But throughout that night the baby did not sleep and she was crying and over sweating. The second opposite party also visited on 25.5.1993 at 10.00 a.m. and stated that the condition of the baby was good. But the first opposite party who visited later said that there was some breathing problem with the baby which will subside as the overall condition of the baby was good. Within two hours thereafter the baby started crying and suddenly developed convulsions. The complainant informed the duty doctor immediately. The duty doctor could not contract the second opposite party till 2.00 p.m. but told them that the second opposite party

asked him to take the baby to Basant Sahney Hospital over telephone. Her husband came within 15 minutes and he along with her mother took the baby to Basant Sahney Hospital. Whereupon the doctors at the hospital told them that they were already informed about the shifting of the baby on 24.5.1993 itself and accordingly admitted the baby in "Neo-natal Intensive Care Unit" as an emergency case. The consultant doctor said that the condition of the baby was very bad and nothing could be said for the next 48 hours. The complainant went there on 27.5.1993. The first opposite party did not bother to examine even the sutures nor suggested any further treatment but sent message that the (sic.) was there on 27.3.1993 and 28.3.1993 feeding the baby whenever instructed. Dr. Indrasekhara Rao, Neonatalogist told her that the baby was fast recovering. But on 28.5.1993 at 4.00 p.m. when the baby was given to her for feeding after taking 2 or 3 drops of milk the baby started having ''cyanosis'' (baby colour turned to blue). Immediately Oxygen was given to the baby. The baby was kept in Neo-natal Intensive Care Unit continuously from 25.5.1993 to 8.6.1993. The complications like (1) Bilateral per ventricular haemorrhage (Brain), (2) Cerebral Edema (Brain), (3) Blood infection (Staphylococcus Aureas grown in culture), (4) Pneumonitis and (5) Jaundice, developed due to negligence of the doctors at Swapna Nursing Home, the third opposite party. Ultimately the baby was discharged on 11.6.1993 from Basant Sahney Hospital after treatment.

The first opposite party should have taken a decision for induction when she noticed that the baby was passing motion in the womb. She has also failed to test the heart beat of the baby till 24.5.1993 by which time heart beat went down. She also failed to opt for caesarean section on 24.5.1993 even after doing P.V. Test at 7.15 a.m. Instead of conducting caesarean she instructed the sisters to press her abdomen for pushing the baby out, adopted a crude method. The first opposite party failed to call the paediatrician to be present at the time of delivery and failed to advise her to shift the baby to the Neo-natal Intensive Care unit. Even the second opposite party who knew the condition of the baby that it was serious failed to take proper action in time. Failure to furnish all relevant details of the case to Basant Sahney Hospital also complicated the condition of the baby. In view of the weight of the baby i.e., 3.8 kg. which is much above the average of Indian babies ceasarean should have been opted. The second opposite party informed her on 25.5.1993 at about 10.30 a.m. that the baby was perfect in all respects. But she developed convulsions within two hours thereafter which goes to show the negligence on the part of the opposite parties.

The complications narrated above are the classical evidence of lack of Oxygen due to delayed delivery and crude method of conducting delivery which affected the brain of the baby as the discharge card dated 27.5.1993 issued by the third opposite party clearly reveals that the baby was born with ''asphyxia'' an indication of inadequate Oxygen supply to the baby.

3. THE complainant spent nearly Rs. 15,000/- towards the expenditure including fees, medicines, bed charges etc. Had the first opposite party conducted the operation or conducted normal delivery at a proper time all the above complications could have been avoided. At this stage the damage caused to the brain of the baby cannot be precisely measured. It cannot also be visaulized about the future complications that may arise due to the inborn infections and diseases on the baby caused due to the negligence and delay in attending to the delivery or on the baby. THE complainant, therefore, claims a sum of Rs. 5,00,000/- towards compensation.

In the counter filed by the first opposite party the allegation that she refused to check-up the genuineness of the complainant''s complaint when she approached her on 17.5.1993 stating that there was no question of induction of labour and asked her to wait till the due date is false. The inconvenience complained of by the complainant is usually present close to the expected date of delivery. During this prelabour period which precedes by few weeks onset of true labour there would be increased uterine activity and is associated with cervical effacement and slight to moderate cervical dilatation. Onset of true labour is indicated by the development of uterine contraction of increasing intensity and frequency. On 17.5.1993 the complainant had not developed true labour. The inconvenience felt by the complainant could not be said to be true labour unless uterine contractions of increasing intensity and frequency develop. Induction of labour is not a matter to be taken lightly unless there are clear indications for such induction. 50% of the patients would like to be induced before expected date as they are tired of carrying the weight and face inconvenience. The complainant had vaginal infection which had to be treated before delivery, she was explained and accordingly advised against induction.

4. THE complainant visited the opposite party No. 3 nursing home on 22.5.1993 on the expected date of delivery with a complaint of greenish discharge and it was diagnosed that she was suffering from ''Monilial Vulvo-Vaginities'' a common infection affecting 25% of pregnant woman close to the expected date and caused by a fungus, candida albicans. THE greenish discharge is not Meconium (motion passed by the baby). Membranes were intact at 12.45 p.m. In the presence of intact membranes even if the child in the uterus were to pass Meconium the same would not have been visualized outside. THE membranes cover the entire foetus and close

the cervical canal.

It is further stated that NST Test was done to evaluate the health of the foetus. Acceleration of the foetal heart with foetal movement very often indicates the foetus will survive in-utero for one week or atleast 3 days. If normal the test needs to be repeated after 3 days to one week. Delivery is recommended only if decelerations are present or the test remains non-reactive for prolonged time. In view of the presence of vaginal infection it was decided to treat the infection. Vaginal tablets were prescribed. Candid Vaginal Pessary contains Nystatin which is recommended for treating Monilial Vulvovaginitis. It takes about 48 hours for the infections to subside. As infection was present and as the complainant was only one day beyond the expected date of delivery and the foetus was still a term foetus and not post-dated or post-mature as such the complainant and the foetus were being monitored regularly on 23.5.1993. On 24.5.1993 regular monitoring of the complainant and the foetal heart was done. The complainant was in active phase of labour. Artificial rupture of membranes done at that time revealed meconium staining of amniotic fluid which by itself is not an indication of foetal distress or foetal jeopardy. It only suggests further investigations. C.S.T. was prescribed which indicates the response of the foetal heart to uterine contraction. Both the complainant and her husband informed that she noticed meconium stained amniotic fluid which requires further testing of foetal heart rate. The monitoring of the foetal heart revealed normal. Later on, after delivery this was explained by the presence of cord around the neck of the baby. In such cases when the uterus contracts strongly as in the second stage of labour the cord tightens and can cause foetal asphyxia. In between contractions it loosens and the baby compensates. This only leads to mild asphyxia and is not an indication for termination of labour or for immediate delivery. Hence ''Epidosyn'' injections were administered to ensure smooth muscle relaxation and cervical dilatation leading to rapid progress of labour without compromising the foetus. Amniotic fluid was with meconium and the same was brought to the notice of the complainant and her husband and the situation was explained to them.

The allegation that one of the sisters arranged belt very casually etc., and started CST are incorrect as the CST revealed that the foetal heart underwent post contract decelerations, Oxygen was given to the complainant to improve the oxygenation of the foetus. At that stage at 8.30 a.m. P.V. Test was done which revealed that the complainant was fully dilated and she was in the second stage of labour and vaginal delivery was imminent. Hence she was shifted to the labour room. The allegation that the first opposite party has come to attend on her after finishing her consultations is not correct as no out-patient is seen by her before 11.00 a.m. except in case of emergency.

5. IT is further stated that during the second stage of labour there is some amount of foetal asphyxia due to compression of head by the contracting uterus. This is a normal phenomenon. In the instant case discent of the foetus is likely to tighten a loop of cord around the neck and further augment the asphyxia. Prolonged, uninterrupted expulsive efforts by the mother can be dangerous to the foetus in these circumstances. Therefore, the sister places a hand on the patient''s abdomen and encourages the patient to make expulsive efforts only in the presence of uterine contractions and to relax in between to prevent jeopardy of the foetus. This was, what was done to the complainant and no effort was made to push out the baby by force and no forceps was applied. She delivered normally through vaginal route. If the delivery was crude as presumed by the complainant there would have been tell-tale signs on the baby in the form of bruising, abrasions, cephalhematoma, facila palsy and also in the complainant in the form of perineal tears, hematomas, retention of urine and postpartum sepsis with foul smelling discharge. None of them was noticed. After delivery it was noticed that there was a loop of cord around the neck of the baby which was responsible for the reactive CST and mild birth asphyxia of the baby. In keeping with the norms of resuscitation suctioning was done to prevent aspiration of meconium, baby was kept warm, Oxygen inhalation was given and Soda Bicarbonate and Decadron were administered. Baby was given antibiotics and Vitamin ''K''. IT showed remarkable improvement and the 5 minutes apgar was 10 indicating a normal non-asphyxiated baby. The aspiration of some amount of amniotic fluid before birth is normal physiological process. When meconium stained amniotic fluid is aspirated it can lead to infection and asphyxia. Proper treatment for this is efficient suctioning at the time of delivery and not delivery by caesarean section.

6. FOR every obstetrician during their post graduate course principles of neonatal resuscitation are taught. Even in most advanced institutions of our country paediatrician cannot be liable to cover every case of birth asphyxia. Attending obstetrician who is trained to do so would be able to provide initial resuscitation. The paediatrician who attended the baby within 45 minutes of birth found no problem with the baby. The allegation that the baby started crying slowly after 10 minutes is only a figment of imagination of the complainant. The further allegation that he advised not to give bath to the baby is equally false. The weight of the baby at 3.8 kg. at birth is by no means over-weight. The allegation that the baby was

over-grown, over-matured is absolutely false. The babies delivered in time after 37 completed weeks of gestation through 42 completed weeks of gestation are considered to be term infants. The infant born after completion of 42 weeks is defined as post-matured. In the instant case the baby was born after two days from the completion of 37th week. Therefore, the question of first opposite party telling the complainant that the counting of her last menstrual period (LMP) was wrong does not arise.

It is submitted that excessive crying of the baby and wakefulness in the night are common neonatal problems and may be due to continuation of the intra uterine sleep-wake rhythm of the baby. Various other reasons like hunger, fulness of bladder and discomfort due to temperature changes may also add to the problem. It is submitted that right from the time of admission the doctors are attending on the complainant diligently conducting necessary tests and taking timely decisions as well as promptly implementing them. She was never left unattended by the opposite parties. The baby was promptly seen by the duty doctor and found to have twitchings and not convulsions. It is only on 25.5.1993 the baby developed twitchings as such the baby was shifted to Basant Sahney Hospital because of better facilities. The allegation that Basant Sahney Hospital was informed that the baby would be shifted on 24.5.1993 is incorrect and does not arise. When the complainant expressed her desire to get herself discharged the opposite parties readily permitted her. Normally such patients would be kept in the hospital routinely up to 4th day of delivery to attend upon any problems that may creep in. As first opposite party has examined the complainant on the morning of 27.5.1993 and when the latter expressed her desire to join the baby in Basant Sahney Hospital it was readily accepted and at that time there was no need to examine the sutures once again the same day.

The allegation in para 19 of the complainant''s affidavit are not true and correct. The details furnished while shifting the baby to Basant Sahney Hospital vide Document No. 21 are sufficient and if any further clarification is necessary the Basant Sahney Hospital would have asked for it and the first opposite party would have furnished any such information called for. It is submitted that pneumonitis is an anticipated complication of meconium aspiration. For this all possible precautions were taken in the form of adequate suctioning and administration of antibiotics. Liberal use of caesarean section for meconium stained amniotic fluid does not reduce the incidence of meconium aspiration. The management of meconium aspiration consists of careful suctioning of the mouth and nostrils by the obstetrician before the shoulders are delivered which was done in this case. In spite of best management of meconium aspiration sometimes it is not fool proof. The following aspects are tested and accepted :

"(a) Meconium stained amniotic fluid is not an evidence of foetal jeopardy. (b) Absence of foetal heart irregularities along with meconium in amniotic fluid does

not warrant immediate delivery. (c) The only complication to be prevented in such conditions is MAS. (d) Use of caesarean section routinely for meconium stained fluid fails to prevent MAS. (e) Even the most efficient suctioning at the time of delivery fails to prevent MAS in 5% of the neonates."

As already stated cord around the neck may cause complication. It manifests in late labour when the head of the baby descends from the womb to the vagina. As a result of this the umbilical cord which connects the placenta to the baby and supplies blood and Oxygen to the foetus is stretched and the loop tightens around the neck and can lead to asphyxia. In the instant case this occurred only at the terminal stages of labour. Caesarean section as repeatedly alleged by the complainant is not an answer or effective alternative as it is a major operative procedure with 4 times increased morbidity than a vaginal delivery with increase in the incidence of infection, deep venous thrombosis, urinary tract problems and the risk of scar rupture in future pregnancies on the top of it added risk of anaesthesia.

7. IT is submitted that caesarean will not prevent meconium aspiration and even the most efficient suctioning cannot prevent aspiration in 5% of these babies. Unfortunately this child fell into that 5% category in whom meconium aspiration couldn''t be prevented despite all preventive and therapeutic measures. The opposite parties 1 to 3 have taken indemnity policies during the relevant period from either National Insurance Company or New India Assurance Company and they have filed implead petitions to include them. IT is finally submitted that the complainant is not entitled to any compensation muchless Rs. 5 lakhs for which no breakup is forthcoming. Therefore, the complaint may be dismissed.

In the counter filed by the fourth opposite party it is stated by the Administrative Officer that the Divisional Office-I, Bank Street, Hyderabad issued a Doctor Indemnity Policy to the first opposite party bearing No. 550100/46/8700041/92 valid from 1.6.1992 to 31.5.1993 with indemnity limit up to Rs. 5 lakhs during the policy period. However it is stated that there is no deficiency in service on the part of the first opposite party.

8. IN the counter filed by the fifth opposite party it is stated by the Administrative Office that their Branch Office at Habsiguda issued a medical establishments-errors

and omissions policy to the third opposite party Swapna Nursing Home bearing No. 4661030600067 valid from 8.9.1992 to 7.9.1993 and the indemnity limit during the policy period is Rs. 10 lakhs and the indemnity limit per person not exceeding 25% of the above limit i.e., Rs. 2.5 lakhs. Nothing is stated about the second opposite party.

The complainant examined herself as P.W. 1 and filed Exs. A-1 to A-50. The opposite parties 1 to 3 filed Ex. B-1 besides examining opposite parties 1 and 2 as R.Ws. 1 and 2 respectively.

The points for consideration are :

(1) Whether the opposite parties 1 to 3 are negligent in conducting delivery and rendering post-natal services to the complainant and the child respectively, if so ? (2) To what relief ?

9. THE facts which are relevant for appreciating the complainant''s case are briefly stated hereunder : THE complainant gave birth to a normal child in March, 1988. After a gap of almost four years she conceived in November, 1991. She had a missed abortion in February, 1992. She conceived again in August, 1992. She was under the advice of Dr. Nirmala Reddy and had been taking harmons injections to avoid miscarriage. U.S. Scan was done periodically to observe the growth of foetus which was quite normal. On 28.3.1993 she was referred to the first opposite party and ever since she was consulting her regularly. While so on the night of 15.5.1993 she was feeling inconvenience which was 7 days before the expected date of delivery. On 16.5.1993 being Sunday as the third opposite party nursing home would be closed on Sundays for consultations she approached Dr. Nirmala Reddy who expressed that the complainant may develop labour pains as cervix was opened and dilatation started. THE complainant approached the first opposite party on 17.5.1993 and requested her whether the will examine her and arrange for induction. But she refused to examine and told her to wait till due date. Accordingly the complainant waited till 22.5.1993 and approached the first opposite party again with a complaint that she was having greenish discharge for the last 3 days and that there were no labour pains as seen from the complaint.

10. IT is the case of the complainant that the first opposite party had done P.V. Test at 12.45 p.m. and told her that the baby was passing motion inside the womb which is an abnormality and advised for immediate admission. Non-stress Test (NST) was conducted to check the heart beat of the baby. On that evening the duty doctor gave her some vaginal tablets but the coloured discharge continued. The first opposite party was informed of the same on the morning of 23.5.1993 who stated that she would observe for one more day before taking a decision for induction. On 24.5.1993 induction was arranged, injections were given for labour pains by administering saline. On 24.5.1993 the first opposite party came at about 7.15 a.m. P.V. Test was done and she removed good quantity of motion passed by the baby into a tray. She also suggested caesarean to take out baby. The complainant and her husband gave consent. One of the sisters arranged belt very casually and started the Contraction Stress Test. The assistant doctor who came after 15 minutes was not satisfied with it and again started doing test for proper report. The first opposite party after looking into the C.S.T. report advised the assistants to give Oxygen to the complainant as baby''s heart beat was going down. She was taken to main labour room and the first opposite party came there around 9.05 a.m. From this what can be culled out is that though the complainant approached the first opposite party on 22.5.1993 with greenish discharge and requested whether induction can be arranged on the ground that even for her first child the complainant did not get natural labour pains and it was a case of normal delivery on induction the first opposite party did not accede to her request but only prescribed some vaginal tablets to control the discharge. However on 22.5.1993 itself the first opposite party after examining the complainant expressed that the baby was passing motion inside the womb. Though she admitted the complainant into nursing home did not arrange for induction and delivery. She asked her to wait for one more day i.e., on 23.5.1993 for observation. Finally she decided to induct labour and accordingly gave injections for labour pains on 24.5.1993. At about 7.15 a.m. P.V. Test was done and she removed good quantity of motion passed by the baby in a tray. The complainant had apprehension about the baby''s condition inside for the past two or three days. When C.S.T. was done the baby''s heart beat was going down. As such the first opposite party decided to conduct delivery.

It is also the case of the complainant that the first opposite party has noticed that the baby was passing motion inside the womb at 12.45 p.m. on 22.5.1993 itself and as such according to her there is no justification to wait for induction till 24.5.1993. Under these circumstances the first question is whether the delay to induct labour from 22.5.1993 to 24.5.1993 is negligence on the part of the first opposite party ?

This part of the complaint has been further explained by the complainant that after delivery the baby had birth asphyxia due to swallowing amniotic fluid mixed with meconium (motion passed by the baby) and as such the first opposite party should have anticipated this and inducted labour and conducted delivery without loosing time.

11. IN the counter filed by the opposite parties it is stated that the complainant was examined on 17.5.1993 and found that she had not developed true labour as such induction of labour is not warranted. Isolated cervical findings are not an indication of onset of labour unless they are associated with uterine contractions of true labour. So the request of the complainant to induct labour on 17.5.1993 could not be acceded. The complainant had vaginal infection which had to be treated before delivery. It is further stated that the complainant visited the nursing home on 22.5.1993 with a complaint of greenish discharge. On examination it was found that she was suffering from ''Monilial Vulvo-Vaginities'' a common infection affecting 25% of pregnant woman close to the expected date of delivery. This discharge cannot be meconium. The membranes were intact. IN the presence of intact membranes even if the child in the uterus were to pass meconium the same would not be visible from outside. Therefore, the allegation that the first opposite party gave an impression that the baby was passing motion inside the womb is not true. So the question is whether the greenish discharge noticed by the complainant couple of days earlier and by the first opposite party on 22.5.1993 is meconium ?

There is no gain-saying that it is a very serious matter if it is meconium as the foetus is likely to swallow meconium in amniotic fluid and suffer serious health hazard.

12. MR. S. Subrahmanyam Reddy, the learned Counsel for the opposite parties 1 to 3 submits that as long as the membranes are intact the question of meconium coming out does not arise. If meconium is mixed in amniotic fluid the amniotic fluid cannot come out as long as membranes are intact. In this case admittedly artificial rupture of membranes (ARM) was done at 7.15 a.m. on 24.5.1993. Therefore, there is no question of meconium or the motion passed by the baby coming out being noticed. He submits that amnion is a tough layer which provides main strength of the membranes and as such meconium or amniotic fluid could not pierce the said layer. He refers to the text book "Williams Obstetrics" 20th Edition, page 116, Chapter II, "Physiology of Pregnancy" which reads as follows :

"The Amnion : The amnion at term is a tough and tenacious but pliable membrane. It is the inner-most foetal membrane of the ''bag of waters'' being contiguous with amniotic fluid. This particular avascular structure occupies a role of incredible importance in human pregnancy. In many obstetrical populations, preterm premature rupture of the foetal membranes (PT-PROM) is the single most common

antecedent of preterm delivery (Chap. 11). The amnion is the tissue that provides almost all of the tensile strength of the foetal membranes. Therefore, the development of the component(s) of the amnion that protects against rupture or tearing is vitally important to successful pregnancy outcome especially the well being of the foetus. xxx xxx xxx Amnion Tensile Strength. More than 125 years ago, Matthew Duncan (1868) examined the nature of the forces involved in foetal membrane rupture. During tests of tensile strength, he found that the decidua and then the chorion laeve gave way long before the amnion rupture. This prompted his contention, subsequently confirmed by many investigators, that the amnion provides the main strength of the membranes."

Not only amnion but other layers like smooth chorion, decidua parietalis, myometrium etc., separate amniotic fluid from membranes as such it is not possible to see meconium when the membranes are intact. As rightly contended by the learned Counsel for the opposite parties 1 to 3 that once the membranes were ruptured the entire amniotic fluid will gush out and the whole sac is emptied in no time. In other words the entire amniotic fluid comes out and no part of the fluid stays back after rupture of membranes. Hence we are of the opinion that the greenish discharge noticed on 22.5.1993 cannot be meconium. The first opposite party on examination diagnosed as ''Monilial Vulvo-Vaginities'' a common infection affecting pregnant woman by a fungus, candida albicans and not meconium.

The complainant admits that the duty doctor gave some vaginal tablets on 22.5.1993 itself but according to her there was no improvement even on the next day, therefore, the first opposite party decided to arrange for induction on 24.5.1993 at 6.00 a.m. Of course these facts are not denied by the first opposite party. So the next question for consideration would be whether the greenish discharge is caused by fungus as diagnosed by the first opposite party.

The learned Counsel for the opposite parties 1 to 3 placed reliance on medical literature ''Williams Obstetrics'' eighteenth edition - ''Management of Normal Pregnancy'' page 273 which reads as follows :

"Candida albicans : Candida (Monilia) can be cultured from the vagina in about 25 percent of women approaching term. Asymptomatic vaginal candidiasis probably requires no treatment. However, it may sometimes cause an extremely profuse irritating discharge. Miconazole Nitrate, 2 percent, in a vaginal cream, has been claimed to be highly effective for the treatment of candidiasis during pregnancy (McNellis and co-workers, 1977). Candidiasis is likely to recur, thereby requiring repeated treatment during pregnancy, but usually it subsides at the end of gestation. Serious foetal infections with Candida occur but are rare when compared to the high prevalence of Candida in the maternal vagina. Penetration of the foetal membranes, even without gross rupture and invasion of the umbilical cord, can lead to an intense inflammatory response in the foetus, with a high mortality rate. The presence of a foreign body such as an intrauterine device in the maternal

reproductive tract appears to enhance the risk of foetal infection (Whyte and associates, 1982)."

So on the basis of this authority in the absence of any evidence on the side of the complainant we can safely conclude that the discharge complained of is candida albicans as diagnosed by the first opposite party. It is also seen that 25% of the pregnant woman approaching term may develop this problem which probably does not require any treatment as it usually subsides at the end of gestation. Therefore, we cannot attribute any negligence on the first opposite party in this regard.

13. MR. Devender Rao, the learned Counsel for the complainant vehemently urged that in view of the history of the patient namely the complainant who had delivered the first child 13 days before the due date on induction without labour pains had a missed abortion second time and in addition to this there is also uterine inertia on the part of the complainant and as such the first opposite party should have accepted the request of the complainant for induction of labour even on 17.5.1993 or at any rate on 22.5.1993.

14. ON the other hand the learned Counsel for the opposite parties 1 to 3 submits that induction of labour cannot be taken lightly unless and until well-identified indications are present. He relies on "Practical Obstetric Problems" text book by Ian Donald. At pages 505 to 508 obstetric indications for induction as well as medical indications for induction are mentioned which include eclampsia which is absence of onset of spontaneous labour within forty eight hours, pre-eclamptic toxemia where both foetal and maternal interests are at stake, previous history of large babies in earlier delivery, post-maturity, prolongation of pregnancy, unduly breach presentation particularly with extended legs, intra-uterine death, hypertension, diabetes, bleeding etc. The opposite parties 1 to 3 contend that none of these factors is present. After weighing the pros and cons induction was advised against. In the absence of proof of any of the factors identified we cannot hold that there is negligence on the part of the first opposite party on this count.

It is next submitted by Mr. Devender Rao, the learned Counsel for the complainant that the weight of the baby at the time of delivery was recorded at 3.8 kg. which is above the average indian babies and as such the first opposite party should have

conducted caesarean section. The learned Counsel for the opposite parties 1 to 3 submits that caesarean is a major operative procedure with four times increased mobidity than a vaginal delivery. There would be increase in the incidence of infection deep venous thrombosis, urinary tract problems and risk of scar rupture in future pregnancies besides risk of anaesthesia.

In "Progress in Obstetrics and Gynaecology" volume nine by John Studd - complications of caesarean section and problems are narrated at page 163 onwards. The author also does not encourage caesarean section. Further the weight of 3.8 kg. of the baby does not give any indication that it is over-weight baby and in fact 3.8 kg. at birth is by no means over-weight for a baby coming from the socio-economic status of the complainant. As the woman coming from such a variable status they deliver babies up to 4 kgs. in weight. In text book of obstetrics by D.C. Dutta under Chapter 38 ''Special Topics in Obstetrics'', page 643, it is stated that the neonate is at high risk if the baby is more than 4 kg. weight. Going by this standard 3.8 kg. cannot be said to be the high risk baby. Further as contended by the learned Counsel for the opposite parties 1 to 3 it is not possible to visualize the weight of the baby by the obstetrician and gynaecologist before its birth. At best the approximate weight with a variance of .2 kg. or .25 kg. may be estimated. It may not be out of place to mention that the complainant is a multy parae and not primi gravidae and Ex. A-9 shows that the complainant''s first delivery was a normal delivery. From the Ultrasound reports Exs. A-2 to A-4 it is seen that no abnormality is indicated. In fact in Ex. A-4 it is specifically mentioned that no major anomaly detected. These reports answer the contention of the learned Counsel for the complainant that there is cephalo pelvic disproportion by which there is prolonged head compression as the pelvis is narrower than the foetal head obstructing smooth passage. He further submits in support of his contention that caesarean section should have been opted having regard to the fact that the baby is a post-mature baby, there was uterine inertia (will not develop labour pains) as well as increase in the weight of the mother during the pregnancy. The anti-natal cord does not show any weight abnormalities of the mother. Even uterine inertia was not noted in the anti-natal cords by Dr. Nirmala Reddy before the complainant was referred to the first opposite party. The delivery took place admittedly two days after the expected date of delivery. Therefore, this argument also cannot be countenanced. Apart from this, part of the argument was not pleaded in the complaint and as such there was no opportunity for the opposite parties 1 to 3 to meet the same.

15. THE learned Counsel for the opposite parties 1 to 3 submits that after the artificial rupture of membrane on 24.5.1993 meconium is noticed in amniotic fluid.

THErefore, aspiration of some amount of amniotic fluid before birth is a normal psychological process and when it is meconium stained some amount of meconium also might be aspirated which could lead to infection and asphyxia. THErefore, sufficient suctioning at the time of delivery was done to reduce its adverse effects and caesarean section is not the remedy. THE learned Counsel for the opposite parties 1 to 3 placed reliance on "Williams Obstetrics" eighteenth edition, Chapter 33 - Diseases, infections, and injuries of the foetus and newborn infant. It shows that aspirations of some amniotic fluids before birth is most likely a physiological event. THE amniotic fluid containing thick meconium, which, in some cases, leads to subsequent respiratory distress and hypoxia with many complications. This incidence was not predicted by variable, saltatory, or late foetal heart decelerations during labour. In Chapter 42 it is further clarified that roughly 20 per cent of pregnancies, this fluid is contaminated by the passage of foetal meconium. To prevent further aspiration the mouth and nares are carefully suctioned, all meconium stained fluid that remains above the vocal cords is aspirated. It is also aspirated from trachea. THE stomach should be emptied to avoid the possibility of further meconium aspiration. Suction at delivery of the head by either bulb or DeLee trap is also prevalent. It is stated in the counter as well as in the evidence of the first opposite party that such of these steps were taken and that there is no deficiency on this score. It is also further contended that caesarean is not an answer to such situations. In fact consent was also taken from the complainant to go in for caesarean section if any abnormality is detected. Monitoring of the foetal heart revealed it as normal except for immediate post contraction decelerations which were picking up to normal.

The learned Counsel for the opposite parties 1 to 3 relies on "Mudaliar and Menon''s Clinical Obstetrics", ninth edition, Chapter 46 - Asphyxia Neonatorum which reads as follows : "We believe that simple meconium staining of the liquor in a vertex presentation is only a sign for more careful watch on the fetal heart rate. By itself, it is not a sure sign demanding immediate delivery, but we have no objection to completing the delivery if it can be done easily per vaginum." Therefore, in view of this authority we are of the opinion that the presence of meconium stained amniotic fluid ipso facto is not decessive warranting caesarean section. In ''Williams Obstetrics'' Chapter 42, Diseases and Injuries of the Foetus and Newborn, it is stated as follows :

"This incidence was not predicted by foetal heart decelerations during labour. Importantly, they reported that liberal caesarean section (60 percent) for labours complicated by meconium and foetal heart rate abnormalities did not alter the frequency of meconium found beneath the cords. Moreover, the single death was not prevented by aggressive peripartum airway management."

However the learned Counsel for the complainant submits that in addition to the presence of meconium there are other signs like irregular or slow foetal heart

sound and, therefore, the first opposite party should have taken this as a warning for foetal distress. The first opposite party explains the situation that CST revealed that the foetal heart underwent post contraction discelerations, Oxygen was given to the complainant to improve oxygenation of the foetus. P.V. Test was done which revealed that it was fully dilated and that the complainant was in the second stage of labour and vaginal delivery was imminent. No forceps was applied and no force was used. The complainant delivered normally through vaginal route without any instrumentation. Following delivery of the baby it was noticed that there was a loop of cord around the neck which was responsible for the reactive CST and mild birth asphyxia of the baby. Apgar scores at the birth was 6, at one minute 7 and at five minutes 10. Oxygen inhalation was given and baby was put on antibiotics and Vitamin-K was administered. The baby showed remarkable improvement and the five minutes apgar was 10 indicating complete recovery from mild asphyxia. There is no other evidence on behalf of the complainant indicating that there was any negligence on the part of the opposite parties 1 to 3 in conducting delivery or paying sufficient attention or treating the baby.

16. THE learned Counsel for the complainant submits that no paediatrician is called to attend the delivery to provide initial resuscitation to the new born baby as complications were noticed. In fact till the artificial rupture of membrane was done on 24.5.1993 at 7.15 a.m. everything was found normal including the CST. THE first opposite party has stated in her evidence that even in the most advanced institutions of our country a paediatrician could not be available to cover every case of birth asphyxia and every obstetrician during their post graduate courses are taught neonatal resuscitation procedures and as such there is no deficiency in this regard. However the learned Counsel for the complainant submits that after the presenting part is seen the opposite party No. 1 should have noticed with the dilatation of cervix is there which shows that it is second stage of labour and thereafter allowing a couple of hours for completing the delivery is negligence moreso when meconium stained amniotic fluid was recovered. It is further stated that the first opposite party asked one of the sisters to press the abdomen of the complainant to push the baby out and the doctor pulled the baby by using forceps which is a crude method of delivery. THE first opposite party of course in her affidavit states that when she noticed that descent of the foetus is likely to tighten up loop of cord around the neck of the foetus and worsen asphyxia and as such prolonged expulsive efforts by the mother can be dangerous to the foetus and in such circumstances the sister placed a hand on the patient''s abdomen to encourage the patient to make expulsive efforts only in the presence of uterine

contraction and to relax in between and no forceps were applied. THE learned Counsel for the first opposite party submits that during the second stage of labour there is some amount of foetal asphyxia due to compression of head by the contracting uterus. This is normal phenomenon. In the present case discent of foetus is likely to tighten a loop of cord around the neck and further augment the asphyxia and as prolonged uninterrupted expulsive efforts by mother can harm the foetus and in those circumstances a sister placed a hand on the patient''s abdomen and encourages the patient to make expulsive efforts only when there are uterine contractions and to relax in between and this procedure is adopted only to facilitate normal delivery.

The learned Counsel for the opposite parties 1 to 3 placed reliance on ''Willims Obstetrics'' 18th edition - Conduct of Normal Labour and Delivery, page 314, which reads as follows :

"Instructions should be to take a deep breath as soon as the next uterine contraction begins and with her breath held, to exert downward pressure exactly as though she were straining at stool. She should not be encouraged to "push" beyond the time of completion of each uterine contraction. Instead, she and her foetus should be allowed to recover from the combined effects of the uterine contraction, breath holding, and considerable physical effort. Usually, bearing down efforts are rewarded by increasing bulging of the perineum-that is, by further descent of the foetal head. The mother should be informed of such progress, for the encouragement at this stage is very important. During this period of active bearing down, the foetal heart rate ausculated immediately after the contraction is likely to be slow but should recover to normal range before the next explusive effort."

The learned Counsel for the first opposite party placed reliance on the same author Chapter 16 "Conduct of Normal Labour and Delivery", wherein it is mentioned as follows :

"Descent of the foetus is more likely to tighten a loop or loops of umbilical cord around the foetus, especially the neck, sufficiently to obstruct umbilical blood flow. Prolonged, uninterrupted expulsive efforts by the mother can be dangerous to the foetus in this circumstance."

Therefore, the procedure adopted by the first opposite party cannot be said to be exceptional.

As already seen it is the version of the complainant that forceps were used by the first opposite party at the time of delivery. The first opposite party denies this version. It is stated in her evidence that if delivery was crude or forceps were used, there would have been some signs on the baby in the form of bruising, abrasions, cephalhematoma, facila palsy, retention of urine and postpartum sepsis with foul smelling discharge etc. As none of them was present, this contention of the complainant cannot be accepted. In support of this contention the learned Counsel

for the opposite parties relies on "Mudaliar and Menon''s Clinical Obstetrics", ninth edition, Section VIII : Obstetric Operations Chapter 52 ''The Forceps''. Number of pressures as is inevitable in the application of forces may result in some damage to the foetus and leave some injuries or marks to the head or other parts of the body. In this case either the case-sheet or any other record except Ex. A-50 which is dated 9.5.1997 four years after delivery that too as history given by the mother shows that forceps was applied. In the absence of any other reliable evidence of the contemporaneous period the contention that forceps was used also is not substantiated.

17. THE learned Counsel for the complainant submits that the baby was over sweating and irritable besides the baby had convulsions and seizures which continues till the baby was shifted to Basant Sahney Hospital. THE presence of meconium is a clear indication that the baby had birth asphyxia and, therefore, the baby should have been immediately sent to Neo-natal Care Unit without delay. THE learned Counsel for the first opposite party submits that simply because meconium stained amniotic fluid is recovered it is not by itself an indication of foetal distress unless it is accompanied with foetal heart rate. He relies on the text book ''Practical Guide to High Risk Pregnancy and Delivery'' by Fernando Arias, Chapter 20 ''Birth Asphyxia'' sub-heading Meconium in the amniotic fluid, which reads as follows :

"Meconium in the amniotic fluid : In the past, the presence of meconium in the amniotic fluid was considered to be a sign of foetal hypoxia. However, most of the recent literature tends to disregard the importance of intrapartum meconium as a sign of foetal hypoxia. Meconium is an unspecific finding that may be associated with many other foetal problems different from foetal asphyxia. xxx xxx xxx THE predictive value of meconium as an indicator of foetal asphyxia is better when it occurs in high risk patients and when it is dark green or black, thick, and tenacious. Lightly stained, yellow or greenish meconium has a poor correlation with foetal hypoxia."

THErefore, we are of the opinion that merely because meconium is noticed in the amniotic fluid it cannot be said that there is cerebral palsy or intrapartum birth asphyxia.

18. THE learned Counsel for the first opposite party submits that baby was promptly seen on 25.5.1993 by the duty doctor and found to have twitchings and accordingly the baby was shifted to Basant Sahney Hospital as there was a loop cord around the neck of the baby which was responsible for the mild birth asphyxia. THE apgar score at birth was 6, at one minute 7 and at five minutes 10. THE condition of the baby was improved as resuscitation procedure of suctioning as adopted yielded result. Oxygen inhalation was given and Soda Bicarbonate and Decadron were administered.

The child was found to have neo-natal jaundice as seen by Basant Sahney Hospital. When Bilurubin level increases it effects brain. This stage is called ''Kernictarus and scepticemia'' as diagnosed at Nimhans, Bangalore.

The learned Counsel for the first opposite party further relies on Williams Obstetrics, 20th Edition, Chapter 42, ''Diseases and Injuries of the Foetus and Newborn'', which reads as follows :

"The American College of Obstetricians and Gynaecologists (1996) has summarized the use and misuse of the apgar score to assess asphyxia and to predict future neurological deficit. It was concluded that low scores at 1 and 5 minutes are excellent indicators for identification of those infants who need resuscitation. It further was concluded that low apgar scores alone are not evidence for sufficient hypoxia to result in neurological damage. In a child found to have cerebral palsy, low 1 or 5 minute apgar scores provide insufficient evidence that the damage was due to hypoxia."

Therefore, basing on this view of the author the learned Counsel for the first opposite party contends that intra ventricular hemorrhage which was observed by Basant Sahney Hospital three days after the birth perhaps was felt that it was at birth, while it is not so.

19. IN Obstetrics and Gynaecology by John Bonnar - Birth INjury and the Obstetrician, S.L.J. Johnson D.M.B. Hall writes as follows :

"IN many cases the cause of CP is to be found in the pregnancy rather than in the birth. Factors in the pregnancy, such as low placental weight, are more strongly predictive of CP than those occurring at birth. Many of the infants with CP also have other major organ malformations, a finding that suggests a prenatal rather than perinatal cause. Furthermore, some of these infants show evidence of birth asphyxia, which might lead to the erroneous conclusion that this was the cause of the CP. We probably do not know what causes most cases of CP'' (Nelson and

Ellenberg 1986)."

Therefore, we are of the view that the possibility of the cerebral palsy is prenatal rather than perinatal.

It is submitted by the learned Counsel for the first opposite party that excessive crying of the baby or wakefulness in the night are common neonatal problems and may be due to continuation of the intra-uterine sleep wake rhythm of the baby. It is also stated that the first opposite party visited the complainant on the evening of 24.5.1993 and found that both the complainant and the baby were doing well. The learned Counsel for the first opposite party further submits that the cerebral palsy or foetal jeopardy may occur due to some unknown reasons. He relies on Bailliere''s "Clinical Obstetrics and Gynaecology" Volume 2/Number 1 March 1988 - Antenatal and Perinatal Causes of Handicap - sub-heading Developmental Impairments, which reads as follows :

"...Often there is no history of any problem in pregnancy even the presence of grossly pathological anomalies such as porencephalic cysts, which must have been present long before labour commenced, although they have also been reported after episodes of severe maternal asphyxia. It seems likely that temporary aberrations in placental blood supply of unknown cause might lead to disturbances in brain architecture or the architecture of its blood supply, and such events are more common where there has been chronic foetal hypoxia (Wigglesworth,1984)." In Bailliere''s "Clinical Obstetrics and Gynaecology" Volume 2/Number 1 March, 1988, Chapter-13 ''Birth trauma and brain damage'', it is further clarified as follows : "...The causes of cerebral palsy are multifactorial and birth trauma is probably only a modulating influence to worsen an already unfavourable condition." In "Practical Guide to High Risk Pregnancy and Delivery" Chapter 20 ''Birth Asphyxia'' the author Fernando Arias states "Also there is compelling evidence indicating that the foetus with conditions affecting the central nervous system may develop hemo dynamic alterations during labour as a result of the brain diseases. In other words Asphyxia is the result rather than cause of the brain damage".

Therefore, it can be concluded that causes for cerebral palsy are still obscure and that identification of a particular cause is not possible and because of birth asphyxia cerebral palsy is caused is no longer correct.

20. IT is next contended by the learned Counsel for the complainant that due to the delay of 48 hours to conduct delivery from 22.5.1993 to 24.5.1993 the child was delivered asphyxiated due to lack of Oxygen and that the colour of the baby turned

blue cyanosis by 28.5.1993 due to the negligence of the first opposite party. As already seen till the A.R.M. was done on 24.5.1993 it could not be noticed that amniotic fluid was stained with meconium. Therefore, no negligence can be attributed to the first opposite party on this count.

The learned Counsel for the complainant continuing his arguments that apgar score noted 6 at the birth and 7 after one minute cannot be correct as Sodium Bicarbonate was given intravenous. According to him if the apgar score is ''0'' only Sodium Bicarbonate would be administered and hence the contention of the opposite parties 1 to 3 that apgar score was 6 at the birth cannot be correct. Ex. B-1 case-sheet shows that apgar score was 6 at birth and 7 after one minute and 10 after 5 minutes. These scores are confirmed by Ex. A-10, the discharge summary. There also apgar score was mentioned at 6 at birth. Therefore, there cannot be any lurking doubt about the recording of the said scores. The contention of the learned Counsel for the complainant that just because Sodium Bicarbonate was administered the apgar score must be less than 4 cannot be eschewed as there is no basis for such a contention.

It is further contended by the learned Counsel for the complainant that use of Oxytocin (Cintocinon) is contra indicated in the presence of meconium in amniotic fluid. There is no plea regarding this contention. Be that as it may.

21. NO doubt in ''Pharmacology and Pharmacotherapeutics'' by R.S. Sitoskar and S.B. Bhandarkar at page 487, it is stated that "Injudicious use of Oxytocin during labour may result in premature birth foetal death, too rapid a delivery or uterine rupture. It cannot be taken for granted that an experienced pediatrician and gynaecologist having conducted good number of deliveries would not know the proper administration of Oxytocin in the absence of a plea that meconium stained amniotic fluid was thick. So also resuscitation procedures were not properly done is another contention for which there is no basis in the complaint. On the contrary it is admitted that resuscitation procedures were done, as such we cannot accept that there was any failure of following the correct procedure in the absence of any material placed before us. So also Sodium Bicarbonate was not properly used also cannot be accepted for the same reasons.

22. IT is next contended by the learned Counsel for the complainant that due to the negligence on the part of the opposite parties 1 to 3 complications developed in the baby leading to cerebral palsy of the child due to ante partem asphyxia and Basant Sahney Hospital treated the baby for cerebral edema, brain, blood infection, Bilateral Per ventricular, (brain) pneumonities and jaundice. The discharge certificate of Basant Sahney Hospital Ex. A-27 dated 11.6.1993 shows ''Scepticemia''. The diagnosis was shown as HIE and MAS. As there was birth asphyxia it might have resulted in cerebral palsy. But as already seen above in Obstetrics and Gynaecology by John Bonnar that "we probably do not know what causes most cases of CP'' (Nelson and Ellengerb 1986)" and that the possibility of cerebral palsy is prenatal rather than perinatal as such the defect in brain architecture of child could result in birth asphyxia cannot be ruled out.

The next contention raised by the learned Counsel for the complainant is that there is incompatibility of blood group of both the mother and the child and as Bilurubin deposit exceeds the baby develop ''Kernicterus''. Kernicterus is jaundice which occurs if Bilurubin deposits in Periventricular region. So also features incompatibility of the blood group of mother and baby it may result in Kernicterus. It is seen from Ex. A-19 that the serum bilurubin percentage was in excess of normal limits and as such it can be seen that liver of the baby was affected. But merely because the baby has jaundice at the time of birth or in the first week of its birth it cannot be straight away concluded that on account of the deficiency in conducting the delivery the baby suffered from jaundice. The contention of the learned Counsel for the complainant that morbidity of the baby was only on account of the negligence of the opposite parties while the first opposite party contends that in view of umbilical cord pressing the neck of the baby at the time of delivery there was mild asphyxia. This version of the opposite parties that there was loop around the neck at the time of delivery was disclosed in the case-sheet. The learned Counsel for the complainant submits that Ex. A-13 referal letter does not show that the presence of umbilical cord around the neck of the baby was noticed during delivery and this itself is a deficiency in service. As already stated the first opposite party in her evidence has stated that the necessary information was given while referring the child to Basant Sahney Hospital and if further information is necessary they would consult the opposite parties 1 to 3 for further clarifications, if any and as such this cannot be viewed as deficiency. As both the hospitals are in the city and as the opposite parties have referred the case to Basant Sahney Hospital it is always open to the latter hospital to contact the opposite parties 1 to 3 for further information or clarification whenever they so desire. Therefore, this contention also in our view cannot indicate any deficiency on the part of the opposite parties 1 to 3 in the absence of any evidence indicating to the contra. Even otherwise in our view this cannot be a deficiency which has resulted in the cerebral palsy of the child. Therefore, this contention also cannot help the complainant. As already seen in the absence of any evidence to the contrary we have no hesitation to accept the version of the opposite

parties 1 to 3. In view of the discussion above we cannot conclude that there is any deficiency on the part of the opposite parties 1 to 3 in conducting delivery or attending post-natal care.

The next question is whether there is any negligence on the part of the second opposite party.

23. ON 24.5.1993 within 45 minutes after the baby was born the second opposite party examined the condition of the baby and expressed satisfaction. ON 25.5.1993 at 10.00 a.m. he examined the baby and found her normal. However after half an hour the first opposite party found that there is breathing problem for the baby. By about 12.30 twitchings were noticed on 25.5.1993 and as advised by the second opposite party the baby was shifted to Basant Sahney Hospital because better facilities for treating such babies are available at the latter hospital. His failure to notice the problem at 10.00 a.m. was seriously criticised. But it cannot be said that the baby who was normal at 10.00 a.m. could not develop problem later. Even in Basant Sahney Hospital according to the complainant she was told on 27.5.1993 by Dr. Indrasekhar Rao, Neonaatologist, the baby was recovering fast. But on 28.5.1993 at 4.00 p.m. when the baby was given for feeding to the mother, the baby after two or three drops of the milk started having cyanosis. Hence the future condition of a child in the first weeks cannot be predicted. Therefore, we do not find any substance in this contention of the complainant.

To prove negligence on the part of a medical practitioner high degree of probability is required. No doubt he is expected of not only reasonable skill in performing his duty but also exhibit diligence and care. But it is wrong to assume negligence on the part of the doctor merely because something went wrong with the patient. It is most unfortunate that the baby has birth asphyxia and one would have a strong feeling to compensate it. But asphyxia by itself in the absence of proof of negligence on the part of opposite party No. 1 may not make out a case for damages. There must be direct connection between injury suffered and the treatment given. Some times there is scope for adopting different methods of treatment, both are known and acceptable and if the doctor has followed one course of action no case of negligence can be made out. Sometimes decisions have to be taken instantaneously and it is difficult to visualize situations and what type of action the situation demands the doctor alone is the best Judge to judge, and accordingly decide the course of action. Even genuine or bonafide mistakes committed while exhibiting due care and diligence may have to be kept out of the purview of negligence. After all negligence is failure to perform the duty cast on him and so long as he performs the said duty

with care and caution no negligence can be attributed to him and no doctor of ordinary skill would be guilty of the said conduct resulting in negligence if reasonable care is taken. In this case for all the foregoing discussion and the reasons stated supra we are unable to hold that there is negligence on the part of the opposite parties 1 to 3. In the result the complaint is dismissed. But in the circumstances without costs. Complaint dismissed.