(1999) 02 BOM CK 0082

Bombay High Court

Case No: Complaint No. 219 of 1995

Mr. Sakil Mohammed Vakil Khan		APPELLANT
	Vs	
Dr. Miss Perin Irani and others		RESPONDENT

Date of Decision: Feb. 1, 1999

Acts Referred:

- Consumer Protection Act, 1986 - Section 2(1)

Citation: (1999) 4 BomCR 65

Hon'ble Judges: Smt. Rajyalakshmi Rao, Member; G.R. Bedge, J; A.A. Halbe, President

Bench: Full Bench

Advocate: Sanjeev Ahooja @ Dr. Kamath, for the Appellant; Mokashi, Naidu and Jehangir, for the Respondent

Judgement

@JUDGMENTTAG-ORDER

Smt. Rajyalakshmi Rao, Member

1. The complainant Mr. Sakil Mohammed Vakil Khan filed this complaint on behalf of his wife Mrs. Salma Khan for negligence against Dr. Perin Irani-anaesthetist, O.P. No. 1- Dr. C.K. Dave-Anesthetist O.P. No. 2 and Parsi Lying-in Hospital O.P. No. 3 as she has became a vegetable/brain dead in their custody.

On 4th December, 1994 at 11.00 p.m., Mrs. Salma Shakil Khan, the patient, in labour was admitted into the opposite party No. 3''s hospital with a complaint of possibility of absence of foetal movements. Opposite party No. 1 examined the patient and found her general condition good with readings of pulse as 84/Min., B.P. 130/90, uterus full term with vertex floating and foetal heart sounds were heard with Doppler as 140/Min. The patient was given I.V. fluids with necessary medication and her progress was watched by opposite party No. 1 every hour.

2. On 5-12-94, at 6.00 a.m., O.P. No. 1 informed Dr. Bhagat, the regular Anaesthetist to be available in case anaesthesia was required. Dr. Bhagat was busy with prior

commitment to attend at Breach Candy Hospital and so excused his absence. At 8.00 a.m., the patient''s membranes ruptured spontaneously and there was meconium stained liquor which indicated foetal distress which decided the case fit for the caesarian operation which is unavoidable at the present stage. Opposite party No. 1 sent a message to another anaesthetist Dr. Gada to come to Hospital and also arranged for a Podiatrist to be present. Opposite party No. 1 also called for Dr. Dinoo Dalai, an honorary doctor at the hospital along with Dr. Mrs. Langdana her coresident, who is another honorary doctor to be around and help as the patient was obese.

3. Dr. Gada, the anaesthetist arrived at 9.00 a.m. but could only wait till 10.00 a.m. as the consent form was to be signed by male members and they were not present at the time. At 10.00 a.m. the father-in-law of the patient gave the consent for caesarian operation and then it took time to find another anaesthetist. Another anaesthetist, Dr. C.K. Dave, the O.P. No. 2 arrived at 11.15 a.m. and on examination decided to administer spinal anaesthesia. Delivery of the baby was quick, baby cried well and placenta was expelled. While suturing the lower segment, O.P. No. 1-Dr. Irani noticed blood to turn dark and informed O.P. No. 2 - Dr. Dave immediately about it. O.P. No. 2 assured O.P. No. 1 that the patient''s condition was good and told her not to worry and that necessary measures were being taken by him. O.P. No. 1 continued with the abdominal closure with the assurance of O.P. No. 2. Meanwhile, O.P. No. 2 was found struggling to feel the pulse and O.P. No. 1 requested Dr. Langdana to assist O.P. No. 2 for intubations the patient. After intubation, pulse was satisfactory and O.P. No. 2 ventilated the patient and told O.P. No. 1 to continue suturing that the patient was alright. When O.P. No. 1 completed the operation, O.P. No. 2 was still ventilating the patient and said that the patient was coming out and he removed the intubation tube. When the intubation tube was removed, breathing became very difficult and the patient was comatose and eyes rolled up. At this stage, O.P. No. 2 kept insisting that "the patient is fine and that there is nothing to worry."

4. O.P. No. 1 and Dr. Langdana felt it should be better to shift the patient to I.C.U. Care in a good hospital and informed the relatives of the seriousness of the condition of the patient. Thereafter, O.P. No. 1 started telephoning the nearby hospitals and requested Dr. Bhagat at Breach Candy Hospital where he undertook to keep a bed in I.C.U. ready. Meanwhile, Dr. Langdana made arrangements to call for ambulance, and O.P. No. 2 shifted the patient to the ambulance with the help of the hospital staff and patient''s relatives. It is an accepted position by all that there was no oxygen arrangement with the hospital except I.V. drip managed by the sister and O.P. No. 2 drove in his car behind the ambulance van.

5. The patient was shifted to I.C.U. in Breach Candy Hospital where she was examined by various doctors and reported that proper care and attention was not provided and the mandatory requirement-oxygen was not given, resulting in a

permanent damage to the brain. Medical papers refer that the patient went into prolonged hypertension during the said surgery which resulted in the brain damage. The patient is now bed-ridden and the baby boy is deprived of the care and attention necessary for an infant. The patient has also three more children and all of them are deprived of mother''s love for life time. The family is put to a permanent suffering for curing for a person who may never recover, thereby causing continuing permanent mental agony, tension and most importantly, the inability to bear the unending financial burden throughout her life.

6. The material facts given so far are the undisputed version given by all parties concerned with this case. Now we look into various aspects of contentions raised by all the concerned parties individually to defend their case. The complainant is very clear in his arguments that he be compensated for maintaining his wife with medical help such as hiring a professional nurse to keep all-round watch on the patient and the expenses for the prolonged hospitalisation losses borne by him so far. He has given detailed summary of these where he claimed for cost of hospitalisation, medical expenses, etc. Rs. 8,00,000/- and Rs. 2,00,000/- for damages and Rs. 10,000/- for mental torture and business losses suffered by him. He further narrated that high inflation costs and further delays in the case and the high rise in cost of medicines would be a great burden on him to bear with. The patient was only 30 years old with four children and the loss of love from his wife to him and his children is not even accounted for.

7. The following points are raised by the complainant as for deficiency of service regarding the three opposite parties.

a) It is his contention that opposite party No. 1 waited till 11.00 a.m. for the patient''s father in-law to come and give written consent for performing caesarian operation on the patient is not valid excuse in law. It is a known fact the patient''s consent is adequate, final and binding. There was no need to wait for the consent of the father-in-law from 6.00 to 10.00 a.m. and to let off Dr, Gada the anaesthetist go at 10.00 a.m. for lack of consent of the male members. When it was decided by O.P. No. 1 and her assisting doctors that L.S.C.S. was indispensable, they should not wait when the anaesthetist was available. This is the allegation against O.P. 1 which the complainant raised for the delay in performing caesarian operation, which could have created unnecessary complications at that crucial time.

8. The complainant raised many objections towards O.P. 2''s conduct and claimed that he is mostly responsible for the present state of affairs of the patient. It is relevant to mention at this point, the Commission had sought all the parties to provide it with expert opinions of two eminent doctors Dr. Rustom P. Soonawala and Dr. Bhojraj, practising in respective fields i.e. a anaesthetist and an Anaesthetist. Their expert opinions were taken on record and the names of these expert doctors came from the parties concerned as an unanimous selection. Strangely, later O.P. 3 had objections to Dr. Bhojraj''s opinion and requested to allow cross-examination of

the said doctor. Further O.P. 3 filed an affidavit stating that when the representative Mr. Jehangir Gai O.P. 3 went to the residence of Dr. Bhojraj, to collect the expert opinion report, the Doctor told him the case was being messed up because of infighting of the doctors concerned in this case blaming each other instead of putting up a united defence. According to Mr. Gai, Dr. Bhojraj was suggesting a meeting of all opposite parties to sit together and discuss as to how to put up a consolidated front to defend the complaint. This affidavit was filed before the expert opinion report was received and filed. Mr. Gai objected to taking Dr. Bhojraj''s expert opinion being taken on record stating that it is a biased opinion and an unfair conduct on behalf of Dr. Bhojraj to go beyond his duty as far as this case is concerned. To cut this short, Dr. Bhojraj was called in for cross-examination to defend the expert opinion given by him and the report of that was also taken into record.

9. O.P. 3-Hospital also stated the anaesthetic notes sent in by O.P. 2 are three different ones even though they pertain to the same patient in respect of the same operation. It is their say that O.P. 2 has manipulated the said record by either destroying or tampering the original record to cover up his negligence in the said case. Keeping these strong objections in mind, we heard all the parties to understand the case from medical angle and went through the text book references, etc. during the arguments.

10. This deviation to discuss O.P. 3''s objection on affidavit to the expert''s opinion of Dr. Bhojraj and O.P. 2''s conduct towards anaesthetic notes is necessary to mention in light of the developments that took place during the pendency of the case. Going back to the complainant''s grievances, he objected to O.P. 2''s defence that the patient was given holy water before the operation and that resulted in anaesthetic complications. The complainant submitted that holy water was not given to the patient by anybody and it is an after thought escape route O.P. has taken. The patient was kept nil-by mouth as per records and in reality it was a known fact that O.P. 2 had not taken history of the patient himself to check on this as he rushed in at 11.00 a.m. and patient was already in the operation theatre.

11. It is the complainant''s say that in O.P. 1''s written statement, the rejoinder and indoor papers clearly indicate that O.P. 2 did not monitor the patient as she was sinking and the blood was turning dark till it was brought to his notice by O.P. 1 and her supporting team of doctor''s like Dr. Langdana. Not only did O.P. 2 take it lightly and delayed the necessary recuperating process but later after aspirating the patient, he again extubate the patient and later claimed that she was biting the tube. Biting the tube and serious consequences that arose out of such action by the patient is the reason given by O.P. 2 for extubating the patient, complainant claimed this as an argument of afterthought by O.P. 2 as nowhere in the hospital records or O.P. 1''s affidavit this action of biting the tube was noted. Since the patient became brain dead due to lack of oxygen, complainant blamed O.P. 2 for such negligence

and for not giving reasonable care and for not using known medical skill to revive the patient completely .

12. Another deficiency in service against O.P. 2 is that he did not provide oxygen to the patient enroute to Breach Candy Hospital at a time emergency when it was decided upon to shift to I.C.U. Patient was in a state of unconsciousness and O.P. 2 did not provide oxygen and such conduct cannot be excused. He did not accompany the patient in the ambulance and instead he travelled by his own car. The complainant pleaded that O.P. 2 had abandoned the patient without oxygen and necessary medical care in the ambulance and obviously vital damage took place during transport. This amounts to clear negligence on the part of O.P. 2.

13. He further contends that the conduct of O.P. 2 is to be questioned in this case as three separate anaesthetist''s notes were on record and the hospital O.P. 3 also confirmed that O.P. 2 tried to change his notes. The letter of O.P. 2 to O.P. 1 asking her to insert his papers into indoor case papers throw a shadow of doubt in this case.

14. The complainant claims damages also from O.P. 3 as they are covered under the principle of vicarious liability and the letter of appointment produced by O.P. 1 indicates that 50% of fees is taken by the hospital O.P. 3. Lastly, the complainant persuaded the Commission to reject and ignore the evidence given by Dr. Bhojraj on the basis of the affidavit filed by Mr. Jehangir Gai where the Doctor was portrayed to be biased and prejudiced to help O.P. 2 and sought help of O.P. 3 to have a meeting to fight unitidly against the complainant.

15. Now, we come to the pleadings of O.P. 1. Dr. Miss. Perm Irani, the anaesthetist who is practising in the Parsi Lying -In Hospital O.P. 3 and also residing in the same venue as O.P. 3. She stated that she is the resident doctor employed by the O.P. 3 hospital for last 28 years on a salary of Rs. 450 per month. She claimed that no payment of fees was received by her from the complainant in this case and that she acted as an employee of the hospital O.P. 3. She further clarified as per her terms of appointment, although she is allowed to do private practice, she is entitled to receive only 50% of the fees. Keeping this in view, she claimed that she has no direct nexus with the consumer as per the Consumer Protection Act. She is not liable to pay.

16. O.P. 1 brought to our notice that the complainant''s four sisters and the patients deliveries were taken care by herself, thus establishing their confidence in her professional abilities as an Obstetrician. In the present case, the patient requested for termination of pregnancy and due to relatives pressure, she carried on the pregnancy but she seemed careless and irregular in attendance. She was obese with the weight of 96 kg. slightly anaemic and mild B.P. 130/90 and the weight of the baby was 9 kg. according to the Sonography. Details of the patient being brought in at 11.00 p.m. on 4-12-94 and further actions of O.P. 1, O.P. 2, and O.P. 3 seemed to

coincide with each other as far as the need to do operation in Lower Segment Caesarian Sector.

17. The delay of two hours in doing the Caesarian operation was due to getting the written consent which was to be obtained from the father-in-law and he came in at 11.00 a.m. O.P. 1 could not force the patient to give written consent as the women did not want to give the consent without father-in-law. The regular anaesthetist Dr. Gada waited from 9.00 a.m. to 10.00 a.m. and left for another committed appointment. Dr. Langdana, the co-resident Doctor and Dr. Dinoo Dalai and both agreed that L.S.C.S was indispensable after examining the patient. O.P. 1 somehow managed to get Dr. Dave O.P. 2 to come. It was noted that delivery of the baby was quick, baby cried well and placenta was expelled. According to O.P. 1, there was no extra bleeding and the patient''s condition was stable which means O.P. 1 did her job correctly. While she was suturing the Lower Segment blood was found to be dark which alarmed her of something going wrong.

18. O.P. 1 informed Dr. Dave- O.P. 2, that the blood was turning dark but O.P. 2 assured her that the patient''s condition was good and she should not worry. While she continued to do the abdominal closure, she found O.P. 2 struggling to feel the pulse of the patient. Dr. Langdana who was assisting her went on to help O.P. 2 in pushing I.V. Mephentine and Decoding in I.V. fluids and the pulse improved. He incubated the patient with Dr. Langdana''s help. O.P. 2 told O.P. 1 not to worry and asked her to continue. According to O.P. No. 1, it is O.P. 2 who was in charge of the condition of the patient as far as the general maintenance during the operation. O.P. 1 further claimed that she had done a good job in delivering the baby and sufficient care and expected professional skill was displayed during the said operation.

19. O.P. 1 further reiterated that she did not subscribe to the decision to extubate the patient and it was solely the decision of O.P. 2. She further contended that it was her decision to warn O.P. 2 of the seriousness of the condition of the patient. It was she who realised the emergency and forced everyone to rush the patient to a better I.C.U. equipped hospital where she did look a bed in. She actually travelled in the ambulance and also noted that O.P. 2 got down the ambulance saying that he will follow in his own vehicle. Though she noticed that the patient was not on oxygen, it was too late for her to go back to the hospital and it was in better judgment she rushed the patient to Breach Candy Hospital.

20. The learned Counsel further contended that it was under O.P. 2''s supervision, the patient was shifted from operation table to Ambulance and it is O.P. 2 who removed the endotracheal tube from the patient. On top of it O.P. 2 did not travel with a complaint where his personal presence and care were necessary. O.P. 1 also stated that she had not abdicated the patient and she visited the patient in Breach Candy Hospital and thereafter, in the Prince Aly Khan Hospital to enquire about the patient''s health.

21. The three expert opinions also prove her decision to perform caesarian operation was right. She also made it clear that O.P. 3 had 14 oxygen cylinders in the hospital to provide for any emergency. In her version, O.P. 1 is not liable to pay any costs or damages to the complainant because she has done her best to the patient concerned and there was no deficiency in service or negligence. Her other colleagues agreed with her as for professional skill during the timely caesarian operation to save the mother and the baby.

22. O.P.1 concluded her case. She was vigilant in warning the anaesthetist no sooner a change in the colour of blood was noticed on two occasions and despite of the assurance of anaesthetist, she took the decision to shift the patient to an I.C.U. facility. She denied any payment of money to her in the present case and claimed to have done her duty as employee of O.P. 3. She also added that the patient with problems of obesity and possible hypertension in future could not continue her routine life upto 75 years. It was also O.P. 1''s case that the medical bills submitted are in question and do not pertain to the present patient and denied, liability to compensate the complainant.

23. The Counsel for O.P. 2 Dr. C.K. Dave the anaesthetist has put forward long, elaborate arguments with supporting medical and legal case submissions. These along with the evidence led by Dr. Bhojraj support his expert opinion supporting O.P. 2 is a record. While agreeing with the admitted facts of the case given earlier on the dates and timing of the said operation, the Counsel disagrees with the contentions raised by O.P. 1, O.P. 3 and the complainant. O.P. 2. pleaded that the condition of the patient is purely due to a medical mishap and not due to medical negligence. He added O.P. 2 is a distinguished, 70 years old anaesthetist practising since the last 40 years who is generally requisitioned in supra major or critical surgeries. O.P. 2 stated that O.P. 1 telephonically informed him of the patient being unable to deliver inspite of prolonged overnight labour and that she had observed foetal distress requiring delivery of the baby through caesarian section. He reached the O.P. 3 hospital at 11.15 a.m. and the patient was in the theatre for L.S.C.S. whom he checked and noted pre-operative findings. After the child was delivered, he narrated that the patient had severe hiccups and bringing out some stomach fluid. Suspecting regurgitation and aspiration in the air passage, he administered injections and passed a cuffed endotracheal tube of adult size with larynx with the help of the laryngoscope.

24. It is his say that at the end of the operation, even though all parameters were normal, the patient was confused and irritable. Patient was fully conscious and was no longer tolerating the endotracheal tube and was trying to pull the tube out. He explained that it was safer to remove the tube so that catastrophe like patient biting on the tube and choking herself should be avoided. In view of the acid regurgitation, he felt that she should be transferred to Breach Candy Hospital which has good I.C.U. facility. He decided to extubate her because he believed that she would choke

herself biting the tube in the ambulance in-transit. He admits following the ambulance in his car with all the necessary resuscitation equipments.

25. O.P. 2 further stated that he distinctly recalls that to his query as to whether the patient had consumed something orally just prior to being brought to the theatre, one of the relatives of the patient informed him that she was given little holy water. It is his case that due to consumption of holy water which mixes and stimulates the gastric secretion and under anaesthesia, the stomach contents regurgitate into the air passage causing "Mendolson''s Syndrome" or "Acid Aspiration Syndrome". He further clarified that the pathogenesis of acidic stomach contents in lung alveoli causes Hypoxia and due to destruction of surfactant causes being collapse due to hypotension.

26. He denied averment made by O.P. 1 that the patient suffered brain damage during operation was due to lack of oxygen or that she was unconscious at the time of the operation. He reiterated his argument that the patient''s condition was stabilised and only then she was shifted to Breach Candy Hospital. It is O.P. 2''s say that the oxygen was not administered to the patient while she was transported to the Breach Candy I.C.U. because she was breathing spontaneously upon intubation at the O.P. 3 hospital. He further adds that the patient reached safely and without any complications to the Breach Candy Hospital.

27. O.P. 2 denied on affidavit the allegations of the complainant, O.P. 1 and O.P. 3 against himself as per the three anaesthetists'' reports placed in O.P. 3''s hospital. O.P. 2 clarified that these reports were given at different times that is the first one is a "Theatre voucher form" of O.P. 1 which is not filled by himself. The second one is a "Diet-History-Treatment Sheet" of O.P. 3 and bears the detailed notes of O.P. 2. The third document wherein the O.P. 2 has filed in details of some of the medications requisitioned by him and on the reverse are concise observations noted by O.P. 2. The Anaesthetist''s record was forwarded by O.P. 2 through a covering letter of O.P. 1 which clearly indicates the correctness and good intention on his part because a formal covering letter of O.P. 2 was not necessary. Vital parameters of the patient are never constant and are fluctuative and it is the say of O. P. 2 that at different times and circumstances they were taken, these readings vary. Mentioning the above explanations O.P. 2 ruled out O.P. 3''s above allegations as false and baseless.

28. O.P. 2 further expressed surprise why the expert opinion of Dr. Bhojraj reads to be questioned and challenged in the question whereas he was unanimously selected by all the parties and Commission. He contends that the report is not convenient for complainant and O.P. 3 and that is why they have made allegations against O.P. 2 which is not proper. They could have sought expert opinion of another doctor, an opportunity they did not avail.

29. The learned Counsel for O.P. 2 cited eleven judgments in support of his case which are briefly stated here. In the case of Sachin Agarwal v. Dr. Ashok Agarwal,

1993(1) C.P.J. 113, Consumer Disputes Redressal Commission, Haryana, it was held the complaint is not maintainable.

a) Where there is no proper medical evidence adduced either on behalf of complainant or of a medical expert to support his allegations and

b) Where during arguments, the complainant could not cite Medical authorities in support of his allegations.

National Commission in Union of India v. Justice Ram Naresh Thakur, in 508 of 1992 reported in C.P.R. VIII, 1997(II) has dismissed the complaint noting "The complainants or any of them should have appeared in the witness box or should have filed an affidavit in support of the allegations contained in the complaint".

In Mrs. Suvarna Baljekar v. Rohit Bhatt, in F.A. 534 of 1993 N.C. noted "The complainant did not lead any evidence to show that he has suffered from the alleged ailment narrated by him in the complaint after taking medicines prescribed by the opposite party" and dismissed the complaint.

In Dr. N. T. Subramanyan and another v. Dr. B. Krishna Rao and another, in Appeal No. 570 of 1993, the complaint was dismissed on the same grounds that the complainants did not examine any of them to prove allegations.

In the case of Brij Mohan Kher v. Dr. N. Banka in 1994(3) C.P.R. 197, N.C. has taken a very strict view of the fact that the complainant had not denied the allegations of the O.P. in the complainant''s rejoinder. They also held "In our opinion, the present case is a typical instance of such indulgence in speculative litigation and adventurism by the complainant, a tendency which must be put down with a heavy hand. This case was dismissed awarding Rs. 10,000/- by way of costs to each O.P. 1 and O.P. 2 to be paid by the complainant to ensure Consumer Protection Act is not misused.

National Commission in K. Jayraman v. The Poona Hospital & Research Centre and others, in Petition No. 52 of 1992, reported in 1994 (1) C.P.R. 23 : 1992 (3) C.P.J. 70 dismissed the complaint asking the complainant to pay Rs. 10,000/- as costs to the respondent saying the complaint is frivolous and is a misuse of the C.P.A. and further noted that it was an inflated claim.

In J.N. Shrivastava Vs. Rambiharilal and Others, , "Some discretion must be left to the judgment of the doctor on the spot. He has to bear the whole picture in mind, use his common sense, his experience and judgment as far as it fitted the particular case " is noted which was highlighted by the learned Counsel supporting O.P. 2. The present case contending that one doctor should not be criticized merely because the other doctors disagree.

In Bolam v. Friern Hospital Committee, All England Law Reports 1957 (2) All E.R. 118, quotation was used from a Scottish case Hunter v. Hanley, goes as ''In the realm of diagnosis and treatment there is ample scope of genuine difference of opinion and

one man clearly is not negligent merely because his conclusion differs from that of other professional men, nor because he has displayed less skill or knowledge than others would have shown.

The learned Counsel for O.P. 2 contended that the complaint is not based on any medical expert''s opinion or medical text in support of his contentions and that this case should be treated as a medical mishap.

30. On behalf of Parsi Lying-in Hospital, O.P. 3, its Chairman Dr. Burjor Dastur filed an affidavit and challenged that the complaint is not maintainable since it has been filed by Mr. Haji M. Vakil Khan on behalf of Shakil Mohammed Vakil Khan without disclosing the capacity in which he has signed the complaint. He also contended that the compensation claimed was Rs. 20 lakhs with interest and that the total aggregate goes beyond the pecuniary jurisdiction of the State Commission. He further raised objection to the complaint being just bare allegations without the support of oral evidence or with the affidavit supporting the complaint. In view of the grounds given above, O.P. 3 submitted the complaint should be dismissed and cited the judgments of the National Commission to support this plea.

31. Mr. Gai argued on behalf of O.P. 3 that O.P. 1 is allowed to do private practice in the premises of their hospital and the receipts are issued on her own letter head and thus the patient is her private patient. Since the hospital Receipt No. 923 dated 17th January, 1995 shows that only room and labour ward charges were included and nothing else was charged, such as doctor''s fees, anesthetists fees for medicines and for injections, etc. This receipt once again reconfirms his contention that the patient was a private patient of O.P. 1 and direct payments were made to O.P. 1 and O.P. 2 for their services. Since she had been hospital patient, the receipt would have the doctors fees charged through the hospital receipt. O.P. 3 emphatically stated that the hospital cannot be held vicariously liable for the acts of omission or commission of the doctors and submitted that the hospital may be discharged from the proceedings as not maintainable against O.P. 3. Keeping in mind that there might be litigation on account of negligence of the anaesthetist, O.P. 1 did not charge any fees directly.

32. O.P. 3 further submitted that all the allegations were against the O.P. 1 and O.P. 2 and the hospital has no control over the manner or method of diagnosis, medical treatment given, operation performed by these professionals. At the material time, the hospital had a stock of requisite oxygen cylinders and proper infrastructure and the equipment was well maintained and there is no negligence or deficiency in the services of the hospital.

33. O.P. 3 elaborately discussed and perused the three different anaesthetist records which were on record which pertain to the same operation and he alleged that the anaesthetist had prepared these different set of notes to cover up his negligence. He went on affidavit and submitted that the real anaesthetic record has

been destroyed or tampered with or manipulated obviously an attempt to cover up his negligence by O.P. 2.

34. It is stated that the documents on record show that the colour of the blood changed and turned dark and such a change happens due to inadequacy of oxygen to the blood and this had to be brought to the notice of the anaesthetist O.P. 2 by the anaesthetist O.P. 1. It is further argued that O.P. 2 at that stage of seriousness also took it very casually and insisted that the patient was all right and there was no cause to worry. This version is supported by the statement of Dr. Z.K. Langdana, Dr. Dinoo Dalai and Dr. Irani-O.P. 1, which indicates the negligence is two-fold. Firstly, the anaesthetist failed to monitor the patient and secondly, he brushed aside the observation of serious condition of the patient made by O.P. 1. It is obvious that O.P. 2 took it lightly and failed to take corrective action even after O.P. 1 pointed out the impending seriousness in the condition of the patient.

35. Mr. Jehangir Oai filed an affidavit on behalf of O.P. 3 objecting to the expert opinion of Dr. Bhojraj stating that he went to collect the report from his residence on the basis of covering letter given by State Commission on 5th March 1998 found him biased in his approach. He submitted Dr. Bhojraj further stated that the proper approach should be for all the concerned defendants to unite, sit together and discuss the matter to put up a consolidated front to defend the complaint. He stated that his objection to take Dr. Bhojraj''s expert opinion to be taken on record because of his bias was filed before he knew the contents of his report and thus no ulterior motive can be attributed to him in this regard.

36. On a careful consideration of the evidence adduced in the case, we are firmly of the opinion that the patient in this complaint has suffered brain damage during the Caesarian operation due to negligence. It is an admitted fact that when the patient was transferred to I.C.U. in Breach Candy Hospital, from the reports given, it is noted that she was not given proper care in providing oxygen facility which brought this present condition of permanent damage to the patient Mrs. Khan. It is evident from the records the Caesarian operation had no complication in the surgical procedure and O.P. 1 Dr. Irani with the help of Dr. Langdana delivered the baby and handed over to the paediatrician for resuscitation. The baby cried and the placenta was expelled. Till this stage the operation was uneventful. This is corroborated by Dr. Langdana and Dr. Mulji K. Gada an honorary obstetrician of O.P. 3 who assisted O.P. 1 who further went on record to say there were no operative complications.

Dr. Rustom P. Soonawala, an eminent obstetrician gave his expert opinion at the request of the Commission where he noted "In my opinion, the surgery was not complicated or prolonged. The blood loss was within accepted limits. Regards the obstetrical managements, there was no negligence".

37. After keeping in mind the above expert opinion and perusal of hospital records and considering the say of all the concerned doctors and the hospital, we are

inclined to believe that the said complication did not arise out of negligence of Dr. Irani O.P. 1.

38. O.P. 3, the Parsi Lying In Hospital, cannot be held responsible since they have provided well equipped operation theatre for the said operation. At the material time, the hospital had a stock of requisite oxygen cylinders and proper infrastructure and non-utilization of these facilities and negligence arising out of such action, becomes purely a burden on the doctor to bear for not availing it. Though the question of vicarious liability was discussed, the hospital being an extremely poor Charitable Trust which cannot pay their resident doctors well, they have been allowing doctors to do private practice paying a meagre amount of Rs. 450/- a month which O.P. 1 was recounting. We do not see any negligence and deficiency of service rendered by O.P. 3, the hospital and their records and their active participation helped us to see the case in the correct light.

39. Opportunity was given at the request of O.P. 3 to cross examine Dr. Bhojraj who gave the expert opinion in the capacity of an eminent anaesthetist and the same is placed on record. The question to answer to is whether there was a deficiency in service or negligence on the part of the anaesthetist present in not giving timely care to prevent this episode of hypoxia of brain and whether continued care was given through the operation and post-operation. It is an established fact that brain is the most sensitive organ in human body and oxygen deprivation or even diminished oxygen supply can cause irreversible brain damage, which is also admitted in Dr. Bhojraj''s opinion. While remedial measures were being undertaken by O.P. 2 on the repeated enquiry from O.P. 1, the patient was extubate explaining that this was done because there is also a danger of the patient biting the tube which could result in total asphyxia, hypoxia and death. It is the say of O.P. 2 that the patient was on adequate spontaneous respiration and therefore he pulled the tube out to prevent further problems and that the patient was conscious and received sufficient oxygen naturally. Evidence of Dr. Bhojraj is based on papers and in its place, it can be evaluated. But the doctors attending on the patient, testify to another story of opposite party No. 1 drawing attention to the emergency sequel to change in the colour of the blood and Dr. Dave insisting that patient was on adequate respiration.

40. This version is not corroborated by the team of doctors at the scene who were worried through the suturing procedure being undertaken and helped O.P. 2 with intubation and it is O.P. 1 who rose to emergency and took the decision to shift immediately to ICU in a better equipped hospital. This did not come from O.P. 2 who was in charge totally for the anaesthetic oriented who should have monitored himself to see the changes taking place in the patient. Removal of the tube because patient was biting the tube, reason given by O.P. 2 is in their notes or noted by anybody in the team who were involved at the time and the fact at the Breach Candy Hospital through their notes. The first thing done was intubations the patient. O.P. 1

stated "when the intubations tube was removed, breathing became very difficult, the patient was comatose, with eyes rolled up and not responding. But Dr. Dave insisted that the patient is fine and there is nothing to worry."

41. To add to all this, O.P. 2 did not monitor the patient in the ambulance which is professionally, morally and ethically his responsibility to see no further damage is done and if so, he could have helped to resuscitate and revive the patient. The fact he was with the patient till the transfer to ambulance, he did not arrange to have the patient be on oxygen enroute is extremely relevant and not personally accompanying the patient, cannot claim any personal knowledge of what happened to the patient in transit. The admission notes of Breach Candy Hospital show that the patient was admitted in unconscious condition with severe respiratory distress without oxygen she went to prolonged hypertension, not responding to painful stimulants, pupils dilated etc. and comatose.

42. In view of all the above records and arguments, we have no doubt in our mind, O.P. 2 was negligent in not providing oxygen to a patient in emergency during the suturing and later and above all did not accompany the patient in the ambulance. In the transit the patient was not on oxygen which is a surprise to us. The present condition of the patient is the complainant has to keep a 24 hours watch on her with the nursing care. The children are deprived of her love and care and it is a permanent separation from the husband. The complainant has to maintain her present status permanently more as a humanitarian and emotional responsibility which is difficult to quantify. Husband will have to engage preferably a female servant to attend for household chores and to look after the upbringing of the children. Her remuneration cannot be less than Rs. 1,000/- per month. It comes to Rs. 12,000/- per annum. Taking multiplier of at least 25 years, the amount comes to Rs. 3,00,000/-. Rs. 50,000/- shall have to be awarded for loss of marital pleasure for husband and Rs. 50,000/- for loss of mother''s affection. Rs. 50,000/- should be awarded for costs of medicine, etc. Rs. 10,000/- should be awarded as costs. In all the complainant is entitled to Rs. 4,10,000/- by way of compensation.

ORDER

"Complainant to recover Rs. 4,10,000/- from the opposite party No. 2 Dr. C.K. Dave. The amount shall be paid within one month failing which the complainant shall be entitled to 15% interest per annum from the date of complaint till actual payment."

43. Complaint allowed.