(2015) 08 NCDRC CK 0065

In the National Consumer Disputes Redressal Commission

Case No : 438 of 2010

BSR CANCER HOSPITAL PVT. LTD. & ORS — APPELLANT

Vs

SMT. B.JAGDAMBA — RESPONDENT

Date of Decision : 18-08-2015

Acts Referred:

Consumer Protection Act, 1986, Section 21, Section 19, Section 17 - Jurisdiction of the National Commission - Appeals - Jurisdiction of the State Commission

Citation : (2015) 08 NCDRC CK 0065

Hon'ble Judges : J.M. Malik, S.M. Kantikar

Advocate : Peeyoosh Kalra, Manjunath H.T, Aniur Rehman

Judgement

1. On 24.10.2006, Ms Umeshwari Iyer, a lecturer (hereinafter referred to as "patient", since deceased), had a complaint of right breast lump, consulted the OP-3, Dr. Mau A. Rai, Cancer Surgeon at BSR Cancer Hospital, Durg (OP-1) After cytological and other investigations, surgery for removal of lump was fixed on 26.10.2006. The Anaesthetist Dr. Roshan Ali, OP-2, without conducting any investigation, gave an injection to her right breast at 12.05 pm, by which her condition became serious and subsequently, passed away. There was no prior discussion between Anaesthetist and the Surgeon, about pre-medication or any precautions. There was no informed consent; it was signed by patient''s sister. Thus, it was not a standard of practice. The complainant reported the matter to police and the Medical Board at Medical College. The Board opined that pre-anaesthetic check-up was not properly done; therefore, the Surgeon as well as Anaesthetist were negligent. It was further alleged that the OP did not provide the medical documents in time, documents may be tampered.

2. Therefore, alleging medical negligence, the complainant, Smt. P. Raju Iyer i.e. mother of the patient, filed a complaint before the State Commission, Pandri Raipur, on 21.12.2007 and prayed for total compensation of Rs.45 lacs from the OPs.

3. The State Commission after hearing both the parties and taking into consideration several medical literature, allowed the complaint and directed the OP- 2 and 3 Surgeon to pay Rs. 25,000/- jointly and severally to the complainant. The OP Nos. 1&2 were also directed to pay a sum of Rs.7,50,000/- be jointly and severally liable to the complainant period of 45 days from the date of this order otherwise interest @ 9% p.a. from the date of default shall also be payable. Also granted litigation cost of Rs.2000/-.

4. Hence, aggrieved by the order of State Commission, the OP filed this first appeal before this Commission, on 21.12.2010.

5. We have heard the counsel for both the parties. Learned counsel for the complainant vehemently argued that the OP did not follow the standard procedure for pre-anaesthesia check up. The patient was not completely anaesthetised, but the surgeon started the operation. Therefore, the patient suffered vasovagal shock and subsequently cardio respiratory arrest. The OP failed to treat the cardiac arrest properly, which resulted into death. The OP should have been careful, as the breast lump was very small. Due to many procedural faults during operation, it resulted untimely death of the patient. The act of OP was against the norms of the medical profession. The OP did not provide bed head ticket and other medical records. Hence, there are chances of tampering of records. The OP did not issue the bills for the fee paid. Hence, the hospital OP-1 with the doctors OPs 2 and 3 are liable for this medical negligence.

6. Mr. Anis Ur Rehman, learned counsel for OPs vehemently argued that it was a minor operation, the OP 3 performed basic pre anaesthetic check-up, like haemoglobin, blood pressure, pulse etc. and then the patient was taken for the operation. It was denied that the OP-2 had given injection to the patient, without making proper check-up. The short term anaesthesia was induced by injection 100 mg Ketamine, after 5 minutes, the OP 3 gave a small incision on the right breast of the patient, but the patient suffered convulsion. Hence, injection Eption, inj Deriphyllin and inj Dexona were given. Oxygen mask was immediately attached to ventilator and endo-tracheal tube

7. 5 mm was inserted, it was connected to ventilator, but due to sudden spasm of trachea and bronchi, SPO2 saturation could not be increased, despite giving 100% oxygen. Also, air way was applied through mouth. There was decrease in BP, Dopamine IV line started at 12 drops, per minute, but there was no improvement in condition of the patient. Therefore, lifesaving medicines such as Inj. Hydrocortisone, Inj. Soda-bi-carb were started, but the patient suffered cardiac arrest, which was noted on the monitor. Injection Adrenalin was given through IV drip and thereafter it was given Intra-Cardiac with all these resuscitated efforts. The patient died at 3.30 p.m. The OPs contended that the complication during surgery arose due to anaphylactic reaction, but not from the vasovagal shock.

7. As per counsel for the petitioner/OP, the sudden spasm in bronchi, is a very

rare incident during anaesthesia, causing cardiac arrest. All the necessary equipments were available in the operation theatre and besides Anaesthetist and Surgeon, entire team of doctors and assistants were available to take care of the patient. There was no delay in taking resuscitative measures, but the patient could not be saved, despite the best efforts of the team of doctors. 1. It is further submitted that the patient was related to Judicial Officer, Shri Prabhat Shashtri, President, District Forum, who entered the OT and misbehaved with the doctors. OP-2 subsequently reported the matter to C.G. High court, Bilaspur, District Judge, Durg and Sr. Police Officer. The patient was properly treated. There was no negligence.

2. The complainant''s main allegation was that no proper pre Anaesthetic check-up was done by the OP and there was no consultation between Anaesthetist and the Surgeon. After death, the matter was referred to experts of medical board, which gave opinion that there was negligence on the part of Anaesthetist as well as the Surgeon.

3. In the instant case, it is vital to decide, whether, the patient suffered Vasovagal Shock or Anaphylactic Shock during the operation? We haveperused medical record, operative notes, the opinion given by team of experts'' medical board, and the relevant medical literature.

4. The Post Mortem examination was conducted by Pt. N. N. M. Medical College, Raipur (C.G.).and the police had also sought opinion of a team of expert doctors, which is available on record, as Annexure A-5. The Committee of Experts consisted of Dr. R. K. Singh, Prof. & Head, Department of Forensic Medicine & Toxicology (he was also one of the doctors in the team who conducted post mortem examination of the deceased patient); Dr. K. K. Sahare, a Prof., Department of Surgery; who gave the opinion, as below:

1. She had a solitary small lump in her right breast which was diagnosed as "fibroadenoma" by clinical cytological and histological examination of the tissue. It is a benign tumor.

2. As it was not an emergency operation, surgery was planned for removal of this tumor in this case.

3. The medical check up and detail pre anaesthetic examination was necessary before giving anaesthesia as it was a planned case to be taken under general anaesthesia, but form the record it appears that such examination as not done. Documentation of such examination findings should have essentially been there as it is not required to know the patieint''s condition only but it also helps assessing the clinical status of the patient and direct the line of treatment in emergency. No such documentation is available in the record provided.

4. As per the statements of the doctors and the staff in the team including the anaesthetist Dr. Roslin Ali, the anaesthetist doctor reached to the hospital only at 12.00 O, clock on the date of operation i.e. 26-10-2006 and soon within five

minutes the operation was started. In such a very short time complete pre anaesthetic and medical check up cannot be made which are essentially required for taking patient under general anaesethsia. Further, there is no record available to indicate the anaesthetist''s examination of the patient prior to that date also.

5. The operating surgeon and his assisting doctor have stated in their statements that, the patient had suddenly clinched her teeth and retracted her legs as soon as incision was given on her breast. Such an instant reaction of the patient is characteristic of protective (defensive)_ reflex response against the acute and intense painful stimulus and is an indication of patient being not adequately anaesthetized prior to incision. The reaction was so sudden and so acute that the surgeon could not reach to the lump site. The autopsy report also confirms that the incision on her breast was not deep to the lump tissue.

6. The responses of the patient were characteristic of neurogenic cardiovascular failure/vasco-gaval crisis. These cannot be confused with hypoxic convlusions or with epileptic fits. Convulsion due to epilepsy or due to hypoxia is neither so sudden nor so acute. Moreover the patient was already on oxygenation with 100% oxygen through mask as per the record and the epileptic fits do not present like this. Further it is important to mention that the patient had no previous history of epilepsy as per the bed head ticket.

7. As per the record, the patient''s oxygen saturation was gradually failing down despite ventilation through close circuit by mask. Her blood pressure and pulse rate was also noted iwhtin normal limit. Hence, the oxygen lack may be due to some obstruction for air entry in the lungs i.e. laryngospasm/bronchospasm. Hence, injection Deriphyline was probably given to the patient to relieve spasm. These all suggest inadequate muscle relaxation prior to surgery and anaesthesia.

8. To prevent and correct the oxygen lack, endotracheal intubation was done as per treatment record which also mentions that it was allowing equal air entry both sides. But despite normal blood circulation, the patient did not recover form hypoxia as per clinical record shows some inconsistencies in the medical record of the patient. The autopsy report and histopathological examination report of the tissues also confirm hypoxia of some recognizable duration. Therefore, probably, sometime during emergency circulation was either arrested/Impeded or some procedural lapses or delay in institution of treatment to check hypoxia has taken place. This does not find a place in the medical record but as per autopsy report there was partial separation of mucosa and submucosal patch of memorrhages in the Larynx with fluid blood in the respiratory tube indicating injury to the part which could have resulted due to faulty intrusion of the endo tracheal tube. Cardia massage was done at 12.45 p.m. as per record suggesting that the heard had stopped functioning.

9. It is worth nothing that there is no documentation of patient''s condition after 12.45 p.m. to 3.30 p.m. i.e. is for about 2.30 hours 26.10.2006. Evaluation of patient to assess the treatment''s response, treatment given, dosages of the

drugs etc. are required to be mentioned in the bed head record so that there is no over dose and no omission of essential treatment.

10. It is true that achieving proper anaesthesia and adequate analgesia to the patient before surgery is primarily a job of anaesthetist but surgeon also cannot escape from his responsibility of judging the patient whether proper anaesthetisation and proper analgesia has been achieved before giving incision on the patient''s body. Opinion :-

1. The essential procedures like proper medical check-up/pre anaesthetic check-up was not done before incision and anaesthetization as per record available.

2. From the records provided, it appears that the patient was not properly anaesthetized and adequate analgesia was not achieved at the time incision was given on the patient''s body which probably had resulted into neurogenic cardiovascular failure/vasco-vagal crisis and her death.

3. This condition (mentioned in point no. 2 of opinion) was not properly diagnosed in time and therefore suitable adequate treatment could not be started resulting into death of the patient.

4. The bed head record of the patient does not appear consistent with the actual patient''s condition and her outcome.

1.1 We have perused several medical literatures onAnaphylactic reaction and Vaso vagal reaction.

3. The neurocardiogenic (vasovagal) syncope is the most common variety. Depending on its duration, ventiricular fibrillation or asystole may cause irreversible anoxic-ischemic brain damage.

The prognosis varies with

- the patient''s age

- the duration of circulatory arrest, and

- the interval before cardiopulmonary resuscitation and defibrillatingprocedures were undertaken."

Whereas, the surgical patients experiencing anaphylaxis may have early cutaneous symptoms, such as, pruritis, flushing, erythema, urticaria, or angioedema. Cutaneous signs can be followed by respiratory, gastrointestinal, or cardiovascular symptoms with hypotension and organ dysfunction. A systemic allergic response can quicklyprogress to respiratory problems with rhinorrhea, shortness of breath, cough, chest or throat tightness, wheezing, hypoxia, hypercarbia, and increased peak airway pressure. An allergic reaction during anaesthesia can suddenly occur with cardiovascular collapse, resulting in hypotension, tachycardia, dysrhythmias, shock.Vasovagal syncope is the sequence of stress, relief, faint, which makes the diagnosis, but, better, yet, the whole reaction can usually be prevented. It should be noted that although most

patients suffer no sequelae, vasovagal syncope with prolonged asystole, can produce ''seizures'' as well as ''rare incidents'' of death.

1. After careful analysis of the facts in the instant case, with correlation to medical literature; and the evidence, it is observed that the OP 3 as well as Dr. Jaya Jimnani had, in their statement to the police, stated that as OP 3 gave incision to the patient, she suddenly clenched her teeth and retracted her legs and hands.Theexpertsin para 6 of their report mentioned that'' Such an instant reaction of the patient is characteristic of protective (defensive) reflex response, against the acute and intense painful stimulus and is an indication of patient being not adequately anaesthetized, prior to incision.''Thus, the experts opined, that the patient suffered vasovagal crisis and consequently it was coincided with convulsion.

2. It is evident from the literature, that though, average dose of Ketamine is 2 mg per kg., yet, larger dose may be required, in some patients.Nothing was mentioned about the weight of patient in the medical record.Thus, it is doubtful, whether, 100 mg was an adequate dose for the patient.Larger doses may be required in some patients.It is also known that side effects of Ketamine are hypertension and tachycardia and if allergic reaction, it will be in the form of skin rashes. Bronchospasm is not a side effect of Ketamine, but the patient suffered gradual hypotension, instead of hypertension.

3. It is pertinent to note that the role of an Anaesthetist is important in OT . He is responsible for maintenance ofrecord pertaining to pre-anaesthetic check-up (PAC), the pre-medication and the dose of anaesthesia as well as management of any allergic reaction The surgeon asks the Anaesthetist, whether, the patient is ready for surgery and only after obtaining instruction/consent from the Anaesthetist, that the surgeon proceeds to operate.However, we feel, even though primarily it''s job of the Anaesthetist, but the surgeon also cannot escape from his responsibility of judging, whether, proper anaesthetisation and proper analgesia have been achieved, before giving incision on the patient''s body. Also, it is noted that no proper pre anaesthetic check-up was done, as per Standard of practice, because OPs considered it as a minor operation. Therefore, in the entirety, we hold OP-2 and 3 liable for the wrong. Therefore, in the entirety, we hold OP-2 and 3 liable for the wrong.

4. We took clue from the judgment DR. LAXMAN BALKRISHNA JOSHI VS. DR.TRIMBAK BAPU GODBOLE & ANR AIR 1969 SC 128 , the Hon''ble Supreme Court held that

The duties which a doctor owes to his patient are clear. A person who holds himself out ready to give medical advice and treatment impliedly undertakes that he is possessed of skill and knowledge for the purpose. Such a person when consulted by a patient owes him certain duties, viz., a duty of care in deciding whether to undertake the case, a duty of care in deciding what treatment to give or a duty of care in the administration of that treatment. A breach of any of

those, duties gives a right of action for negligence to, the patient. The practitioner must bring to his task a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. Neither the very highest nor a very low degree of care and competence judged in the light of the particular circumstances of each case is what the law require: (cf. Halsbury''s Laws of England 3rd ed. vol. 26 p. 17). Similarly, the Hon''ble Supreme Court in Jacob Mathew Case (2005) 6 SCC 1 elaborating on the degree of skill and care required of a medical practitioner quoted Halsbury''s Laws of England (4th Edn., Vol.30, para35). In the instant case, we are of considered view that the OP-2 and 3 did not exercise their degree of skill and care.

1. Therefore, on the basis of forgoing discussion, considering the PM report, expert board''s opinion and the relevant literature on the subject, it does not warrant us to interfere in the well-reasoned order of State Commission.We dismiss this first appeal. There shall be no order as to cost.

