

(2016) 04 NCDRC CK 0044

In the National Consumer Disputes Redressal Commission

Case No : 1149 of 2014

CHIEF MEDICAL OFFICER, YASHODA HOSPITAL

APPELLANT

Vs

D. UMA DEVI & 3 ORS.

RESPONDENT

Date of Decision : 11-04-2016

Acts Referred:

Citation : 2016 2 CPR 559

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

Advocate : B. Ram Mohan Reddy, Y. Rajagopala Rao

Judgement

Anaesthesiologist, are like aeroplane pilots, are essentially 99% of the time in a "watchful waiting mode". It is when an untoward event occurs that they are called into action, their level of alertness, skill and response is critical. It is not the drug Propofol itself that is the culprit for it is an effective and fast acting anesthetic agent. It is the monitoring of the patient and the ability of an attentive physician to promptly act with the necessary staff and equipment that can make the difference between life and death.

Michael Jackson and Joan Rivers both lost their lives secondary to the anesthetic agent, Propofol...!!

1. Mr. D. Sadasiva Reddy, hereinafter referred as a patient, was suffering from Jaundice. He got admitted in Yashoda Hospital, Hyderabad/opposite party No. 1 on 13.5.2008. He was advised ERCP (Endoscopic Retrograde Cholangio-Pancreatography) with CBD endoscopy. Accordingly, on 14.5.2008, during ERCP procedure, the doctors administered anesthesia, which resulted in to fatal complications in the patient, therefore ERCP procedure was abandoned. The patient was brought out of the Operation Theatre in an unconscious (comatose) state. He never recovered from coma. The hospital authorities informed that, the patient would come back as normal within 5 days but, he became brain dead. The OP 1 attributed this sorry state of affairs to the sudden cardiac arrest while conducting ERCP procedure.

2. Thereafter, OP refused to treat and decided to discharge the patient. Smt. D. Uma Devi, his wife, the complainant approached Human Rights Commission, which directed the OP to extend the treatment till 21.1.2009 and also directed the complainant to approach Consumer Commission for redressal of her grievances under Consumer Protection Act, 1986. After long struggle of 2 ? years, the patient died on 12.10.2010.

3. Therefore, alleging medical negligence of OP hospital which was responsible for the pathetic condition of the patient, the complainant filed a complaint before the State Commission, Hyderabad against Yashoda Hospital/OP 1.

4. The State Commission allowed the complaint and directed the OP- 1 to pay Rs. 10 lakhs with interest @9% per annum from the date of filing of the complaint with Rs.10,000/-, as costs.

5. Aggrieved by the impugned order, both the parties filed cross appeals before this Commission. The complainant filed FA 1169/2014 for enhancement of compensation whereas; the OP filed FA 1149/2014 for dismissal of the complaint.

6. We have heard learned counsel for both the parties. The main question which swirls around the controversy is, "whether doctors at OP hospital followed the standard guidelines during ERCP procedure and whether the dose of anesthesia administered was correct?"

7. Learned counsel for OP raised objections on the expert report of Dr. Mahender Vyasabattu. He submitted that, Dr. Vyasabattu is neither a competent nor qualified to give such expert opinion. The expert opinion from the Osmania Medical College, mentioned that ACLS guidelines were followed by the doctor at OP 1. There was no negligence.

8. The rival arguments by the learned counsel for the complainant that, the State Commission has not ordered any expert committee, but it was the OP itself which constituted the expert committee. The expert committee did not consist of any gastroenterologist. The counsel contended that the compensation awarded by State Commission awarded is on lesser side, as the salary of deceased was Rs.21,000/-, he was about 42 years of age at the time of death.

9. To understand the procedure, we have perused the guidelines issued by Royal College of Anesthetists during ERCP, are reproduced as under: "The Royal College of Anaesthetists, London issued the following guidelines for the use of Propofol Sedation for Adult patient undergoing Endoscopic Retrograde Cholangio-pancreatogrpahy (ERCP) and other Complex Upper GI Endoscopic Procedures.

At the present time in the UK, the administration and monitoring of propofol sedation for such potentially complex endoscopic procedures should be the responsibility of a dedicated and appropriately trained anesthetist, or an appropriately trained Physicians" Assistant (Anaesthesia) working under the supervision of a consultant anaesthetist at all times; this will ensure that the potential complications of sedation and anaesthesia in such patients are

appropriately managed."

Therefore, it is clear that "Propofol" would be fatal to the patient; if it is not handled by a trained person and if proper precautionary measures were not taken before administration of said drug. It is pertinent to note that the anesthetist at OP 1/hospital, has not filed any affidavit before State Commission, but filed an affidavit of Gastroenterologist Dr. Shivanand Patil only.

Therefore, we have difficulty to comment on condition of patient

10. In the instant case, the State Commission observed as following; that during ERCP procedure the patient developed sudden cardiac arrest, whereby the doctors who were attending on the patient abandoned the procedure, and moved the patient to Emergency Unit for necessary resuscitative measures. The principle of Res Ipsa Loquitur aptly applies in this case for the reason that; firstly it seems the doctors who have attended on the patient did not conduct necessary exercise before administering "Propofol". The American Society for Gastrointestinal Endoscopy emphasizes the need for endoscopist to accurately assess the clinical appropriateness of ERCP, it is important to have a thorough understanding of the potential complications of this procedure.

Secondly, it is not a case where the patient came with multiple complications and that some unknown complications have arisen during the course of administration of said drug, and thirdly it is apparent on the face of record that medical record filed by OP 1 i.e. Ex. B18 is silent as to what had happened during the crucial period between 3.30 and 3.50 p.m . Mishandling or negligence for a spur of moment would adversely affect the life of a patient. In the instant case, as opined by experts, within no time, immediately after administration of said propofol drug, the patient developed cardiac arrest, which ought to have been avoided, had the doctors made proper precautions before administering the said drug. In other words, they ought to have enquired with the patient and made appropriate assessment as to whether the said drug can be administered or not . It seems in a routine manner the doctors administered the said drug and the consequential results are before us. The anaesthetist ought to have taken due care and justification before administering the said drug, and the carelessness on his part ultimately landed the patient in a state of awake in to coma. The British Society of Gastroenterology and the American Society of Anaesthesiologists (ASA) have stated that "the use of Propofol for sedation requires special attention. According to the Royal College of Anaesthetists the techniques using multiple drugs/anaesthetic drugs should only be considered where there is a clear clinical justification, having excluded simpler techniques.

11. In >this context, we rely upon the judgment in Laxman Balkrishna Joshi (Dr.) Vs. Dr. Triambak Bapu Godbole, AIR 1969 SC 128, it was held that a doctor when consulted by a patient owes him certain duties. It has held as under: 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 certain duties, namely, a duty of care in deciding whether to undertake the case, a duty of care in deciding what treatment to give, and a duty of care in the administration of that treatment.

In the instant case, the doctors at OP hospital, are qualified but, failed in their duty of care during ERCP procedure.

12. It is evident that, the expert committee was constituted by Superintendent of Osmania General Hospital on the instructions of police authorities. It consists of professor from Medicine Surgery, Gastrology and Anaesthesia, which categorically opined that, that there was no negligence during surgery. But, the State Commission clearly observed that, the Ex. B-18, a medical record establishes clear lacuna that there is no recording maintained between 3.30 to 3.50 p.m. on the date of incident. We are surprised that, why expert committee is silent about it?

13. It is an admitted fact that, the patient was under AAROGYA BHADRATHA SCHEME. It is for police personnel, the cost of treatment will paid by the scheme. It is disgusting to note that, OP 1 hospital siphoned of government funds to the tune of Rs. 12 lakhs towards his treatment and when the outer limit of providing medical aid to the patient, got exhausted, started demanding money from the complainant for further treatment otherwise, the patient would have been discharged from the hospital. As the patient was in the state of coma, Human Right Commission directed the OP 1 to treat the patient till 21.1.2009. Therefore, in our view, it was an unethical act of OP. In addition, the ERCP procedure was not followed by OP doctors as per standard guidelines, the Propofol was administered without monitoring and caution. The cardiac arrest was not managed properly, therefore patient suffered coma. Thus, it is the case of medical negligence.

14. In this context, we have perused medical literature on Propofol, and took reference from text book Miller's Anesthesiology . As per medical literature, Propofol has a narrow therapeutic window, and a small increase in dosage may cause a patient to progress from deep sedation to a state of general anesthesia. This is an important reason why some authorities such as the Royal College of Anesthetists in the UK maintain that patients undergoing deep sedation require the same level of care as those under general anesthesia. An important consideration that, the actual level of sedation in patients may easily fluctuate, depending on the amount of drug used and sensitivity of the patient. For instance, a significant number of patients under conscious sedation may progress unintended to a level of deep sedation. Deep sedation, as defined by the ASA, can require airway intervention, and spontaneous ventilation may be inadequate to maintain oxygenation and gas exchange. Significant complications such as hypoxemia, hypotension, and aspiration are potential risks in patients undergoing ERCP procedures, and important factors that can modify the severity of these events include patients' ASA status, patients' hydration and oxygenation status, and monitoring techniques used during the procedure.

15. Major Anaesthesia Organisations framed guidelines for ERCP .The Royal College of Anaesthetists (UK) in conjunction with the British Society of Gastroenterology has issued guidance for patients undergoing propofol sedation for procedures such as ERCP. The American Society of Anesthesiologists has also issued a guidance statement for the safe use of propofol in the context of sedation. The specialist bodies' opinion is that propofol sedation requires specific training and skills for the following reasons.

(i) Propofol has potential to cause rapid and profound changes in sedative/ anaesthetic depth.

(ii) Propofol has no specific antagonists.

(iii) Propofol can have marked synergy with other drugs.

16. Therefore, briefly, as per the recommendation propofol sedation is ideally administered by dedicated and appropriately trained anaesthesia personnel. The hospital procedure required the monitoring and recording of a patient's vital signs before and during the procedure. Some vital signs such as blood pressure, oxygen saturation, and pulse rate could be monitored by a protocol machine. Other vital signs were required to be noted and handwritten on the patient's chart. In the instant case, there were no records of patient's vital signs during the ERCP procedure. Therefore, the absence of any such record leads to the adverse-inference.

17. In some of cases, an anaesthesiologist, or in some instances, a nurse anaesthetist, administer and oversee the sedation process. They must carefully watch for changes in blood pressure, oxygenation, patient reaction, and a myriad of other data. They are required to carefully document the process on virtually a minute to minute basis. In some hospitals the anaesthesiologists are allowed to read books during the surgery or, if not allowed, in fact will be seen doing that. Others have license to wear their headphones and listen to music. Under these circumstances, the unconscious patient is unable to appreciate the lack of attention that he or she might be entitled to.

18. The complainant filed FA 1169/2014 for the enhancement of compensation awarded by State Commission. In this context, we would like to rely upon recent judgment of Hon''ble Supreme Court, namely, Balram Prasad and Ors. Vs. Kunal Saha (2014) 1 SCC 384 in which the method of compensation was discussed. No doubt that the compensation in medical negligence cases has to be just and adequate. Due to the changing scenario of medical advancement and expectation of the patients/ people, it's legitimately expected by the patients or their attendants that the doctor or hospital need to be accountable to a certain degree. If the hospital is having super specialty facilities, higher level of treatment facilities and cost of treatment; there will be higher expectations of treatment and care.

19. It is relevant to consider the evidence of Dr. Mahendra Vyasbattu, the expert,

on behalf of the complainant. He is Indian Origin Physician residing in USA, trained in Cardiology, respiratory medicine. He has opined the patient's condition after visit to the patient. He categorically stated that "ERCP procedure was conducted few days after the admission. The doctor could have waited for some more time before conducting the ERCP procedures as the risk was high. He gave the opinion on the basis of medical documents; he noticed the documents are devoid of vital monitor recordings of the patient at the time of procedure. Also, the sequence of event leading to cardiac arrest was not there. He also submitted that the evidence from the case sheet shows that young healthy patient under anesthesia sustained cardio-respiratory arrest and brain damage that indicates that anaesthesia was excessive and timely intubation was not done for the patient, there are no reading between 3.30 p.m. to 3.50 p.m. i.e. for 20 minutes on 14.05.2008. The patient was hale and healthy, not suffering from liver and renal problems.

20. It is true that compensation cannot be calculated in a perfect mathematical sense, cannot be precise and accurate, but has to be within certain broad guidelines, and within certain broad parameters. We have to consider compensation including loss of income and employment, as well as damages for mental anguish, emotional distress, and pain and suffering. It was observed by the Supreme Court in *Sarla Varma & Ors. vs. Delhi Transport Corporation*, civil appeal No. 3483 of 2008 decided on 15.4.2009. "While it may not be possible to have mathematical precision or identical awards, in assessing compensation, same or similar facts should lead to awards in the same range. When the factors/inputs are the same, and the formula/legal principles are the same, consistency and uniformity, and not divergence and freakiness, should be the result of adjudication to arrive at just compensation."

21. Therefore, no amount can be just and adequate in an absolute sense. It all depends on the circumstances and the context and the courts must be open to treating each case in a different manner so that the decisions are just, equitable, reasonable and prudent. There is no fixed solution.

22. In the instant case, bearing in mind the broad principles and the formula devised in *V. Krishnakumar Case 2015 AIR (SCW) 4283*, we advert to the question of adequate compensation for the medical expenses incurred, financial hardship on account of loss of future earnings and care and inflation, etc. suffered by the family of the Patient. The deceased was about 42 years of age at the time of death, working in the police department. As per the salary pay slip of deceased, his gross salary was Rs.21,000/- per month. The deceased left behind the unmarried daughter and her son, a student of engineering and her old mother as dependents. Considering the age of retirement as 60 years, his remaining service was almost 18 years. With the application of formula used in *V.Krishnakumar's Case*, total loss of income would be Rs.47,02,294.95/-. (Rounded to Rs. 47,00,000/-) No doubt, it is an admitted fact that, the medical expenses were not covered under Govt's Arogya Bhadrata Scheme, therefore,

the complainant is not entitled to receive the medical expenses. In the view of above discussion, we deem it imperative to enhance the quantum of compensation. Accordingly, the compensation amount of 10 lacs is increased to Rs 47 lacs.

23. Therefore, on the basis of entirety of facts and evidence, we allow the FA 1169/2014 and the FA 1149/2014 is hereby dismissed. The OPs shall pay Rs.47 lacs within 90 days, from the date of receipt of this order, failing which the entire amount will carry interest @ 9% per annum from the date of this order till its realization. The parties are to bear their own cost.