

(2016) 03 NCDRC CK 0045

In the National Consumer Disputes Redressal Commission

Case No : 444 of 2008

DR. K. SRIKAR REDDY

APPELLANT

Vs

SRISHTI ASSOCIATES & ORS.

RESPONDENT

Date of Decision : 29-03-2016

Acts Referred:

Indian Penal Code, 1860, Section 304A - Causing death by negligence
Consumer Protection Act, 1986, Section 19 - Appeals

Citation : 2016 2 CPR 151

Hon'ble Judges : V.B. Gupta

Advocate : T.V. George, K.Maruthi Rao, ?Rupendra?Mahendra, Dr.M.Padmanabh Reddy,?R.N. Hemendra Nath Reddy,?K.S. Rama Rao, Jyoti Nagpal, ?Neeraj Singh

Judgement

1. Appellants/Complainants have preferred this appeal under Section 19 of Consumer Protection Act, 1986 (for short, "Act") against impugned order dated 29.08.2008, passed by A.P. State Consumer Disputes Redressal Commission, Hyderabad, in C.D. No.40 of 2003, vide which complaint filed by appellants was dismissed.

2. Brief facts are, that Respondent No.1/Opposite Party No.1 (R-1) is a proprietary concern and Dr.M.Padmanabh Reddy its sole proprietor. Respondent No.2/Opposite Party No.2-Hospital (R-2) is owned, managed and administered by R-1. Respondent No.3/Opposite Party No.3 (R-3) is Assistant Professor working in Government Maternity Hospital, Nayapool and also attends R-2 hospital as Consultant Obstetrician and Gynecologist. Respondent No.4/Opposite Party No.4 (R-4) was working as resident Obstetrician and Gynecologist in R-2, hospital. Respondents No.5 & 6/Opposite Parties No.5 & 6 (R-5 and 6) are Consultant Anesthesiologists of R-2, hospital. Respondent No.7/Opposite Party No.7 is the Insurance Company.

3. Appellant No.1 (A-1) is husband of deceased - Ms. Srilatha Reddy. Appellants No.2 & 3 are parents of deceased, who was their only daughter. Deceased was

B.E. in 1 first division st and did M.S (Computer Science) from Cleveland State University, Ohio State, U.S.A. from May 2000 to December 2001. During her studies at U.S.A., she secured Graduate Assistantship and was earning around \$ 10,000 per annum. A-1 married deceased on 1.8.2001. A-1 did his M.B.B.S. and by the time of his marriage, got selected in Indian Foreign Service (IFS). A-2 is a practicing advocate at Hyderabad. The deceased was working with Gateway Software Solutions as project consultant and earning Rs.25,000/- per month and was planning to accompany her husband, wherever he was posted in service in India or abroad and also to take-up employment at such places. She was expecting to earn till the age of sixty-five years. A-1 was posted for 10 years in developed countries, 10 years in developing countries and 10 years in India. The deceased would have earned US\$ 60,000 p.a. in the developed countries, US\$ 20,000 p.a. in the developing countries. In India for 20 years, she would have earned on an average a sum of Rs.40,000/- per month. Thus, she could have earned a minimum of Rs.4.72 crores during her lifetime.

4. It is stated, that for delivery deceased was admitted in Jaya Nursing Home at Narayanaguda, Hyderabad on 5.3.2003 at about 10.00 A.M. A-1 came from New Delhi around 8:30 P.M. and found that said Nursing Home did not have ultrasound facility to check fetal well being. A-1 consulted Dr.V.S.Rajesh Khanna (PW-2), who took him to R-3 at Woodlands Hospital, Barkatpura, Hyderabad at around 10.15 P.M. for advice. R-3 directed for shifting the deceased immediately to R-2 hospital, where ultrasound facility is available. R-3 instructed over telephone to R-4 to admit the deceased in R-2 hospital. Acting on the said instruction of R-3, the deceased was admitted to R-2 hospital at about 11.30 P.M. on 5.3.2003. R-4, examined the deceased and opined, that ultrasound examination is not necessary, as there was sufficient amniotic fluid (amniotic fluid is fluid surrounding the fetus in the womb) , normal fetal heart rate and deceased was in active labour with 3-4 cms. Cervical dilation (cervix is the lower segment of the uterus) and also normal vaginal delivery of baby would occur within 3 hours. R-4 also said, that they would administer epidural analgesia for relief of labour pains, since deceased complained of pain during vaginal examination.

5. Dr.V.S.Rajesh Khanna brought R-3 to hospital at 11:45 P.M. R-3 examined the deceased and concurred with the course of treatment suggested by R-4. All through, deceased was stable and in fact walked into the labour room without anybody's support. At that stage, PW-2 left for home and A-1 was with deceased in the labour room, as attendant. A-2 and A-3 were also in the hospital at the relevant time. At around 00:05 A.M., deceased was given enema. Then, R-3 and R-4 induced labour with Syntocinon drip and Artificial Rupture of Membranes (ARM). R-5 inserted epidural catheter and injected Lignocaine, Fentanyl and also injected Bupivacaine at frequent intervals. At the same time, R-4 gave drugs like Drotin, Epidosin and Buscopan intravenously at frequent intervals for cervix dilatation and acceleration of labor. The deceased

was made to lie in supine position through out. At about 2:45 A.M, R-3 and R-4 asked the deceased to bear down the baby by voluntary efforts. At about 3.00 A.M., fetal distress was noticed with fetal heart rate frequently going down to 80 beats per minute (BPM) from the normal 140 BPM. Then Syntocinon drip was stopped. Sensing alarming situation, A-1 to avoid any risk to the mother and baby, requested R-3, R-4 and R-5 to shift the deceased to operation theatre and perform immediate cesarean section. But, they declined to act on the said request saying, that nothing was serious and normal delivery would occur.

6. It is alleged, that at about 3:15 A.M. though the fetal heart rate was 110 BPM, which was far less than normal 140 BPM, Syntocinon drip was started again and deceased was again asked to bear down the baby by voluntary efforts. R-5 repeated injection Bupivacaine into epidural catheter at 3.20 A.M. stating, that delivery would take place in the next thirty minutes and this would mitigate pain that would be severe. Though deceased was in severe distress, she was forced to bear down the baby. The deceased tried hard few times and pleaded with R-3 and R-4 to do operation to take out the baby. But R-3 and R-4 still insisted the deceased, to bear down the baby by voluntary efforts.

7. At about 3.30 A.M., A-1 to his dismay noticed the deceased going into shock with cyanosis on her lips and face and losing consciousness. (Cyanosis is bluish discoloration of skin and mucous membranes like lips due to severe deficiency of oxygen with the oxygen saturation in blood falling extremely low) . A-1 insisted for checking the blood pressure, which was then 80/50. Since, condition of deceased being deteriorated rapidly, A-1 requested R-3,4 and 5 to give immediate treatment. But to his dismay, A-1 found no resuscitation equipment in the labour room. A-1 pleaded with R-3,4 and 5 to rush the deceased to the theatre and do the best possible to save the deceased and baby. But respondents were not responding to the situation properly. Then A-1 over phone, asked PW-2 at 3:30 A.M. to come to the hospital immediately, as condition of deceased was worsening.

8. It is further alleged, that deceased was shifted to operation theatre only at 3:40 A.M. By then, vital time for resuscitation of deceased and fetus was lost. PW-2 came to hospital at around 4:10 A.M. R-3 requested PW-2 to assist the attending doctors in resuscitation of the deceased. A-1 accompanied PW-2 into operation theatre, where they found the situation shocking as deceased was lying unconscious in supine position on the trolley with total cyanosis of the body. The deceased was not even shifted on to the operation table and was being given oxygen with nasal prongs, which barely supplies 30% of the required amount of oxygen instead of supply of 100% oxygen with endotracheal intubation. By then deceased, suffered convulsions, which means irreversible brain damage has occurred. Only when A-1 screamed at the attending doctors, the deceased was intubated. By then, cardiac arrest had taken place as heart was also starved of oxygen. R-5 and PW-2 started cardiopulmonary resuscitation. Then around 4:20 A.M., R-3 and R-4 were requested by A-1 to do delivery by cesarean section or

by using forceps or by ventouse extraction, which they were expected to do so, to save the lives of the mother and baby. The request of A-1 just fell on their deaf ears and this resulted in losing the last opportunity to save the deceased and the baby.

9. At around 4:30 A.M., R-6 (who is Consulting Senior Anesthesiologist of R-2 hospital) came and examined the deceased. At 4:30 A.M., deceased was having persistent cyanosis and heart rhythm was idiosyncratic with wide QRS complex (QRS is the waveform of heart contractions recorded on electrocardiogram (ECG)) . By QRS complex rhythm means, it is abnormal heart rhythm which has to be brought at normal by giving DC shock with defibrillator and/or drugs like sotalol, lignocaine, bretylium etc. They did not perform DC shock and did not give drugs to normalize heart rhythm.

10. It is further stated, that deceased was declared dead at 5:30 A.M. on 6.3.2003. The cause of death of the deceased was not mentioned in the death certificate or in the death summary. The cause of death was written in the case sheet later as "cardio pulmonary arrest due to amniotic fluid embolism". When everyone was in shock on hearing the news of sudden demise of the deceased, respondents tampered with the case sheet. They did not take steps to perform autopsy of the deceased which is a must in all cases of sudden death, especially in cases where Anaesthesia is administered. The autopsy was not done with a criminal intention to suppress the real cause of death. Thus, death of deceased and baby occurred due to gross negligence in handling the delivery of the deceased by the respondents. In the death summary, it was wrongly mentioned that labour analgesia was given on demand. In fact, Labour Analgesia was given on the insistence of R-3 and 4 and consent of A-1 was mechanically obtained. Similarly, cause of death in the case sheet was wrongly mentioned, as amniotic fluid embolism. The following commission and omissions on the part of respondents, would prove that death of mother and baby occurred due to sheer negligence and deficiency in service on their part; "(i) The deceased was administered the local anaesthetic drug Bupivacaine for epidural analgesia at frequent intervals than normally required, which have caused complications like hypotension, cyanosis etc.

(ii) For making cervix to dilate and accelerate labour they have used three drugs Drotin, Epidosin and Buscopan intravenously while the normal practice is to use only one drug. They gave all these drugs at frequent intervals intravenously, which led to drug toxicity and resulted in complications like hypotension, cyanosis etc.

(iii) There was no proper monitoring by third, fourth and fifth opposite parties after epidural analgesia was given and also the mandatory equipment like pulseoxymeter and cardiac monitor were not used, so early signs of complications were not detected. There were no resuscitation equipment and drugs available in the labour room, which is mandatory if epidural analgesia is administered. Hence resuscitation could not be performed in labour room even

though complications were developed in labour room itself.

(iv) Necessary precautions like positioning the patient in left lateral position to prevent hypotension are not taken; instead the deceased was put in supine position which is contraindicated during labour.

(v) Even after complications started manifesting to the normal observation level in the labour room from 3:00 A.M. when Syntocinon drip was stopped due to fetal distress and where resuscitation equipment was not available there was (40) minutes delay in shifting the deceased to the theatre. Even the case sheet shows that fifth opposite party, anaesthesiologist did not monitor the patient from 2:30 A.M. till 4:00 A.M. Case sheet shows that deceased was not even attended by the third and fourth opposite parties from 3:40 A.M. to 4:15 A.M. even after shifting her to operation theatre when she had already developed complications. No steps were taken to do emergency cesarean operation for which the deceased was shifted to operation theatre and the deceased was left on trolley in unconscious state and not even shifted to operation table.

(vi) As endotracheal intubation to give 100% oxygen was not done immediately even after noticing the patient in unconscious and in cyanosed condition, cyanosis persisted and progressed to Persistent Progressive Cyanosis. Even after noticing Persistent Progressive Cyanosis as 100% oxygen was not supplied immediately it lead to irreversible brain damage manifested by convulsions and progression to cardiac arrest.

(vii) Emergency delivery by way of forceps / vacuum extraction in the labour room and delivery by forceps/vacuum extraction/immediately cesarean section/perimortem cesarean section would have helped in mothers resuscitation and save both the lives. But it was not done.

(viii) Didnt perform DC shock or administer drugs to normalize Heart rate even after noticing wide QRS complex to revive the deceased.

(ix) Hospital did not have facilities to give advanced cardiac life support, which is a must if labour analgesia is administered. "

11. It is further alleged, that deceased presented with signs of cyanosis, hypotension bradycardia, loss of consciousness and convulsions leading to cardiac arrest when labour was induced with Syntocinon drip, drugs like Buscopan, Drotin and Epidosin given for cervix dilatation and acceleration of labour and epidural analgesia for relief of labour pain. The causes of the complications are as under; "I. High block/Total spinal block resulting from epidural analgesia. High block/Total spinal blockade is the complication of epidural analgesia due the puncture of dura (outer most layer covering spinal cord) with inadvertent subarachnoid (middle layer membrane covering spinal cord) , epidural injuction as drug comes in direct contact with spinal cord and cerebrospinal fluid which makes the drug to reach upper spinal cord and brain. This leads to hypotension, apnea (no breath), unconsciousness and bradycardia.

II. Durg toxicity : Three drugs were given for same effect of dilatation of cervix and acceleration of labour, which is against any norms of medical practice. Usually one drug should be used. Drotin contains drug Drotaverine 1 ampule of which should be given intramuscularly and repeated after 2 hours if necessary. But in the given instance it was given intravenously and at 1 hourly interval. Rapid intravenous injections have led to fall of blood pressure and the deceased going in to shock and cardiovascular collapse. Epidosin contains drug Valethamate 1 ampule of which should be given intramuscularly and repeated after 30 minutes only once if necessary. But in the given case the deceased was administered 1 ampule every 30 minutes. Buscopan contains drug Hyoscine Butyl Bromide, 1 ampule should be given at 1 hourly intervals. But in the given case the deceased had developed severe hypotension and went in to shock because of unregulated and unwarranted toxic doses of drugs for cervix dilation on deceased who is on epidural analgesia.

III. Vaso Vagal shock : As the patient was put in supine position (which contraindicated during labour and especially when epidural analgesia is administered) she had developed severe hypotension (due to sympathetic blockade by epidural analgesia, excessive and inadvertent dosage leading to toxicity of the drugs with lack of monitoring by opposite parties 3,4 & 5) and when the deceased was asked to bear down by voluntary efforts by Valsalva maneuver, the deceased had suffered Vaso Vagal attack, which progressed to cardiac arrest as she was not treated promptly.

Had the opposite parties not administered the drugs indiscriminately, had they taken due care and caution to detect and arrest the complications likely to occur due to the said drugs and had the opposite parties done the resuscitation measures promptly when complications occurred, life of the mother and baby would have been saved."

12. Further, even assuming that deceased suffered amniotic fluid embolism (AFE) as stated in the case sheet, which is presented with hypotension, hypoxia, pulmonary edema, tachycardia, convulsions and consumptive coagulopathy with haemorrhage, there was bradycardia instead of tachycardia and there was no pulmonary edema and hemorrhage. Convulsions must be an initial manifestation in AFE due to profound degree of hypoxia but in the present case, convulsions occurred at final stage, as brain damage occurred due to non-supply of adequate oxygen even after cyanosis was noticed. The management for AFE is ought to be as mentioned below:

"a) Supply of 100% oxygen immediately by endotracheal intubation. The first objective is to secure the patients airway and provide effective ventilation and oxygenation by endotracheal intubation and mechanical ventilation with volume-cycled respirator.

b) Immediate delivery of the baby by cesarean section, forceps or ventouse extraction before cardiac arrest and perimortem cesarean section after mother

suffers cardiac arrest. Lateral tilting should therefore be the first maneuver in the event of cardiac arrest, but if sufficient cardiac output is not achieved within five minutes, delivery of the fetus should be performed. Emptying of the uterus will increase cardiac output by 60-80% of pre-pregnancy levels and thus recovery of maternal circulation occurs and survival of both mother and fetus is ensured."

13. In the instant case, respondents did not do the above resuscitation measures. The sudden and unexpected demise of mother and baby shocked the appellants. A-1 who lost the companionship of a lovable wife within two years of marriage more particularly when he was expected to become a father of a child, is unable to come out of the shock and mental agony. The pain on account of deprivation of the said companionship would be everlasting. A-2 and A-3 brought up their daughter with love and affection and educated her in India and abroad spending a lot of money. Her sudden demise left indelible shock in their mind. A-2 is unable to come out of shock and depression and unable to carry out his professional work. The only daughter's sudden death affected A-3 to such an extent, that she became unconscious as soon as she learnt about the news of the said death. She is still depressed and under spell of shock and mental agony. She is ruminating her daughter's act from her childhood lying on the bed. She is in a state of severe depression and any amount of consolation has proved futile. The loss of deceased in the family, is felt not only in terms of pain and agony but also in terms of deprivation of the income of the deceased. The deceased with her bright and meritorious educational career, would have earned for herself and for the family, during her lifetime an amount of not less than Rs.4.72 crores. The deceased was employed abroad and here and was contributing her earnings to the appellants. A-2 and 3 were expecting to be maintained and cared by their daughter in their old age. In view of above, appellants estimate the details of damages suffered by them Rs.4,25,65,000/- as under;

- i) Transportation charges Rs. 10,000/-
- ii) Medical Treatment Rs. 5,000/-
- iii) Cremation and Obsequies Rs. 1,50,000/-
- iv) Loss of expectation of life (cannot be quantified) Rs. 25,00,000/-
- v) Consortium to Husband (complainant no.1) (cannot be quantified) Rs. 25,00,000/-
- vi) Loss of love and affection to second and third complainants (cannot be quantified) Rs. 25,00,000/-
- vii) Loss of earning power (after excluding 1/3rd towards her personal expenses Rs.3,14,00,000/-
- viii) Compensation for loss of baby Rs. 10,00,000/-
- ix) Mental agony (cannot be quantified) Rs. 25,00,000/-

Total Rs.4,25,65,000/-

14. However, appellants have restricted their claim to Rs.1,00,00,000/- (rupees one crore). O.Ps are under obligation to pay to the appellants a sum of Rs.1,00,00,000/- (Rupees one crore) jointly and severally, together with interest @ 24% per annum from the date of complaint till the date of realization and cost of the complaint. The O.Ps received consultation fee and hospital charges. Appellants have paid Rs.5,000/- to O.P. No.2 at the time of admission. O.P. No.2 promised to issue the receipt but it could not be obtained on account of the unexpected event.

15. R-1 and 2 in their written statement have stated that deceased was treated free of charge as A-1 happened to know R-5 intimately, as both studied in the same institution during their MBBS course. Further, PW-2 a close friend of R-5, had requested for admission of the deceased in the hospital and requested for treatment free of charge. Therefore, service was rendered free of charge and as such, appellants cannot be termed as consumers under the provisions of the Act. Hence, complaint is liable to be dismissed on this ground alone.

16. It is further stated, that R-2 offers highest quality of exclusive, modern facilities with more than 100% back up to facilitate provision of excellent maternity care in a supportive, comfortable and relaxed environment. It is a well planned hospital complex, that has been designed to facilitate the process of giving maternity care in a quick, effective, safe and pleasant manner. It consists of 2 well equipped Operation Theatres, 2 Labour beds, 6 Recovery beds and 6 Bed neonatal care unit. This hospital is equipped by advanced life supporting and critical care equipment like Boyles apparatus (2), Pulseoxymeter, non invasive B.P.Monitor, cardiac Monitor, Cardiac defibrillator, CTG Monitor, Ultrasound Machine, high capacity generators (2) and well qualified nursing staff and experienced resident doctors.

17. It has been admitted by R-2, that R-3 is a visiting Consultant Obstetrician and Gynecologist to their Hospital. She is often utilizing the facilities of R-2 for past two years and is acquainted with the facility and protocols of R-2. Further, R-4 is working for R-2 as a resident doctor on monthly salary basis. R-5 and 6 are consultant Anesthesiologists, whose services are regularly utilized as a group for the patients of R-2. However, services of above mentioned Anesthesiologists are also facilitated by R-2 for the patients of visiting consultants at the request of such visiting consultants. As per request of R-3 and PW-2, R-5 was called for the purpose of Labour Analgesia.

18. It is further stated, that deceased was staying at Delhi with A-1 and was visiting Hyderabad only once in a while. She was permanently residing at Delhi and as such this plea, that she was working with Gateway Software Solutions at Hyderabad and earning Rs.25,000/- per month cannot be accepted as true. It is denied, that deceased would have earned Rs.4.72 crores during her life time.

19. On the instructions received from R-3, R-4 admitted the deceased at 11-45

p.m. on 5.3.2003. The patient was in active labour with 3 to 4 centimetres of Cervical Dilatation with intact membranes and these findings were entered in the case sheet. R-4 opined, that ultrasound examination was not necessary as there was sufficient Amniotic Fluid and normal Vaginal delivery would occur within 3 hours. R-4 after examining the patient explained to A-1, that she would discuss the clinical status with the consultant. R-4 also explained about the availability of labour Analgesia facilities at the Hospital. At that juncture, PW-2 who is also an Anesthesiologist, was informed about the availability of Labor Analgesia services. After deliberations between PW-2, A-1 and deceased, PW-2 convinced them that it is a safe procedure and informed, that Epidural will be administered by one of his colleagues in the Hospital. Thereafter, R-4 called R-3 and informed her about the clinical status. Both deceased and A-1 discussed amongst themselves about the option and agreed for Epidural Analgesia and had gone through the Consent Form and signed the same. R-3 examined the deceased and as per protocol, R-4 being a resident doctor was following her instructions, as R-3 was the consultant concerned to the case. Further, A-1 was with the deceased in the Labor Room, as attendant.

20. It is also stated, that various drugs were administered in accordance with the Consultants instructions for Cervical Dilatation and acceleration of labour. The administrations of drugs etc. are recorded in the case sheet. It is denied, that deceased was made to lie in supine position throughout. It is also denied that at 2.45 A.M., R-4 alongwith R-3 had asked the deceased to bear down the baby by voluntary efforts. In fact, deceased was made to lie down on lateral position and was conversing with A-1 all the time. The condition of fetus was being monitored at regular

intervals by CTG and fetal heart sound was normal till 3.40 A.M. All vital statistics of deceased were normal till 3.40 A.M. It is also denied, that A-1 asked R-3 and 4 or R-5 to shift the deceased to Operation theatre to perform caesarian section for whatsoever reasons.

21. It is further stated, that R-4 and 5 were checking all vital statistics manually at frequent intervals, in addition to monitoring through automatic monitors. At about 3-40 A.M., R-3 noticed that fetal heart has come down to 120 to 110/mnts and was not restoring to baseline despite administering nasal oxygen and plain ringer lactate which was on flow. At that stage, R-3 took the decision of performing an LSCS and announced the same. To this decision A-1 reacted strongly, saying that he expected a normal delivery and now his wife is being taken for LSCS and questioned the decision. R-3 explained him the reasons for such decision and about the consequences of not doing LSCS. A-1 was not at all happy with the decision and walked out of labour room, stating that he would call PW-2 to deal with the situation. However, R-3 gave instruction to shift the deceased for LSCS. The deceased was asked to move over the trolley for shifting into the operation theatre but she was hesitant and refused to do so till her husband comes back. After explaining her about the risk to the baby and after

convincing her about the need of the surgery, deceased cooperated. At this juncture, R-4 informed the decision of caesarean section to Dr.Padmanabh Reddy who was requested by R-3 to come to the hospital to take care of the baby. Dr.Padmanabh Reddy rushed to the hospital at 4 A.M. He straightaway proceeded to baby resuscitation room and prepared everything and waited for the baby to arrive. Through out this time, vitals and fetal condition of deceased were being monitored continuously. The fetal heart rate before shifting to the theatre was 120 beats per minute. Hence, at about 3.55 A.M. the patient was wheeled into the operation theatre with wedge under her right hip and flank with nasal oxygen and plain ringer lactate on flow. The deceased was haemodynamically stable and was conversing with R-3 and her husband.

22. It is further stated, that patient was wheeled into operation theatre accompanied by R-3, 4 and 5. R-3 noticed cyanosis just before shifting the deceased on to the operation table. R-5 immediately applied facemask and started assisting respiration. At that stage, blood pressure was recorded and found to be low. After some time cyanosis disappeared. R-5 again connected all monitors, which were disconnected while shifting of the deceased. At that stage, R-3 went to inform the attendants about the condition of deceased and returned soon. After that PW-2 followed her after a short while. PW-2 went to the deceased and tapped on her cheek and asked how she is. Is anything wrong, to this the deceased pushed away the facemask and said "No everything is OK". PW-2 asked her to show her tongue and she obeyed. When R-5 was about to put the facemask back on her face, deceased developed convulsion. R-3 checked for the Fetal heart and it was absent. R-3 confirmed the same with CTG. Immediately after convulsions stopped, R-5 intubated the deceased and started ventilating with 100% oxygen through Boyles. The opportunity to shift the patient on the operation table never arose. The events were so sudden and so rapid, that all attending doctors were busy providing emergency care. Patient was wheeled into operation theatre accompanied by R-3, 4 and 5. As deceased was about to be shifted on to the operation table, she was found breathless, pulse was feeble, BP was 90/60 and R-5 attended to it immediately. At 4.00 A.M. fetal heart was faintly heard. R-3 noticed cyanosis and R-5 immediately started assisting respiration. At that stage, R-3 went to inform the condition of deceased to A-1. However, A-1 never entered the operation theatre till 5-50 A.M. Every effort has been put by all the attending doctors to save the deceased in all possible ways. Though early decision for caesarian section was made for the impending fetal distress but due to rapid development of material events leading to fetal collapse, which gave R-3 no scope to save the fetus. At around 4.25 A.M., Dr.Shyam Sunder (R-6) entered the operation theatre. R-6 kept the

defibrillator paddles on the chest and asked R-5 to switch on the paddle button on the defibrillator. He gave a DC shock followed by Inj. Drenaline and atropine IV. External cardiac massage was given by R-6 and R-5 were ventilating with 100% oxygen at a ratio of 5:1. ACLS was continued till 5.30 a.m. with no improvement in the deceased clinical status. At 5.30 A.M. on 6th March, 2003,

R-6 declared the deceased dead. He announced, that the cause of death was cardiopulmonary arrest antecedent to amniotic fluid embolism and R-3 agreed with the same. It is denied, that the case sheet was tampered with. It is also stated, that cause of death and the antecedent cause of the death of deceased was not mentioned in the Death Certificate or Death Summary of the deceased, as the cause was clear and same was already explained to the relatives and Dr.Rajesh Khanna and the same was agreed upon by them.

23. A-1 accompanied by R-3 and 6 and PW-2 informed the unfortunate news of death to the appellants. A-1 remained with relatives of deceased from 5-30 A.M. till 7.00 A.M., along with R-6. After the relatives settled down from initial grief, then R-1 along with R-6 in the presence of PW-2 suggested to A-2, that they would like to inform police and arrange for a post-mortem. Dr.Vikranth Reddy enquired about the postmortem with females and relatives deliberated the decision and said "NO". Hence, there has been no medical negligence on the part of R-1 and 2.

24. R-3 in her written statement has stated, that on the recommendation of PW-2, A-1 approached her expressing dissatisfaction over the facilities in Jaya Nursing Home, took a decision to shift his wife to R-2 hospital. No payment was accepted from the appellants, out of professional fraternal feeling. The patient was admitted into R-2 at 11.45 P.M. and she examined the patient in the labour room. At 12.05 A.M., she found the patient was in active labour with intact bulging bag of membranes without draining and cervical dilatation of 4 cm. Patient was diagnosed as having HROM. Consequently, R-3 did artificial rupture of membrane to see the colour of liquor which was clear at 12.20 a.m. Acceleration of labour is an accepted mode of management and labour room staff, administered the drugs sequentially and deceased was never kept in supine position throughout but kept in lateral position, which is in accordance with the routine practice to prevent hypotension and to increase the utero-placental circulation. Fetal heart was monitored continuously with electronic fetal monitor and it was documented within normal range of 132-138 beats/minute upto 3.30 A.M. R-3 was frequently updating the progress of the labour, status of the fetus and also of the mother. At 3.00 A.M., R-3 noticed too frequent uterine contractions, so to avoid further hyper stimulation, Syntocinon drip was stopped. It was also because of her close and continuous monitoring, R-3 could detect the abnormal uterine action at the earliest. It is denied, that deceased was forcibly asked to bear down at 3.15 A.M. The patient was coached and encouraged to bear-down at 3.30 A.M. The patient was never in distress, as her vitals were continuously monitored on various automated monitors and periodically monitored manually.

25. It is also stated, that deceased never requested her or R-4 and 5 to do a caesarian section. Till 3.40 A.M., the vitals documented by R-3 were within normal limits. The blood pressure was 120/80 mm/Hg, fetal heart rate was 138 BPM, Maternal pulse rate 76 PM with normal temperature. At 3.40 a.m., R-3

found that fetal heart rate was 120 BPM which persisted to 110-120 BPM, in spite of routine resuscitative procedures. Suspecting impending fetal distress, the decision for cesarean section was made and duly informed to R-4 and 5 and A-1 were informed. A-1, questioned her decision and reasons were explained to him. A-1 wanted to take the opinion of PW-2 and walked out of labour room. R-3 convinced about the need of the surgery and through out vital and fetal conditions of patient were monitored. At about 3.55 A.M., the patient was wheeled into the operation theatre with wedge under her right hip and flank with oxygen and plain ringer lactate on flow. It took 15 minutes to convince A-1 for cesarean section

and after shifting into the theatre, the patient suddenly became breathless, developed cardio-vascular collapse and cyanosis and immediately appropriate resuscitative measures were started by the team, headed by the anesthetist.

26. From 3.55 AM to 4.15 AM, the deceased suffered hypoxia for 20 minutes culminating in convulsions and cardiac arrest. At about 4.30 AM, deceased was being attended by R-3,4,5 and 6 and Dr.V.S.Rajesh Khanna. The condition of deceased became grave with persistent cyanosis and appropriate advanced resuscitative measures were performed. The patient was declared dead at 5.30 AM and cause of death was mentioned as "Amniotic Fluid Embolism"" in the case sheet and MCH intimation form. R-3 denies, that this cause of death was added as an after thought and also that they did not take steps to perform autopsy. The appellants are educated and had they asked for autopsy, respondents could have got it done. It is also stated, that R-3 in the presence of PW-2 suggested to A-2, that they would like to inform the police and arrange for an autopsy. However, patient attendants stated "NO".

27. It is further stated by R-3, that informed consent was obtained before the administration of epidural analgesia and standard protocol for labour augmentation and appropriate drugs for augmentation for cervical dilation were administered. Drug doses frequency and administration of these drugs, is as per the accepted medical practice. It is denied, that Syntocinon drip was started at 3.00 A.M. because of fetus distress, but it was because of frequent uterine contraction. R-3,4 and 5 were present between 3.45 and 4.15 A.M. and deceased was shifted to operation theatre only for performing cesarean. Amniotic Fluid Embolism is a complex disorder, a known rare complication of pregnancy during labour with no known measures to predict or prevent its occurrence with great individual variation in the clinical picture, appearing in late stages of labour or immediately after postpartum with rapid onset of hypotension, hypoxia and consumptive coagulopathy. The diagnosis is contingent upon careful exclusion. Lab tests done to diagnose the amniotic fluid embolism lack the sensitivity and specificity. There is no data that any type of intervention improves maternal prognosis with amniotic fluid embolism. Management of the amniotic fluid embolism is usually a supportive care. In mothers who are hemodynamically unstable and suffered cardiac arrest, the role of perimortem caesarean section is

very controversial and speculative.

28. Lastly, R-3 relies upon defence of R-1 and R-2 with regard to the compensation amount sought by the appellants and states, that there is no medical negligence on her behalf and seeks for dismissal of the cot with cost.

29. R-4 in her written statement, relied upon the versions of R-1 to R-3 regarding treatment accorded to the deceased and stated that there was no negligence or deficiency of service on her part.

30. It may be pertinent to note, that R-4 died during pendency of the complaint before the State Commission.

31. R-5 in its written statement also reiterated the version relied upon by R-1 to R-3. He further states that he received a telephone call from R-2 hospital at 11.50 P.M. informing him about a patient that needs labour analgesia. Immediately, he received another call from PW-2 informing him that A-1's wife was admitted in the hospital and requested him to come and provide labour analgesia. Since, PW-2 and A-1 were his college mates and also close friends and he knew them well for past seven years, therefore he accepted the call as a friend, rather than a professional

providing analgesia services free of cost. He reached R-2 hospital at 12.15 A.M. and went into the labour room. He found A-1 alongwith R-4 and other labour room staff along with patient. PW-2 entered the labour room and patient and A-1 signed the consent form for labour analgesia. All complications were explained to them and after completing pre-anesthesia check up, R-5 checked up emergency equipment, drugs and preparation for labour analgesia. During this process, R-5 over heard R-3 explaining to the patient about the advantages of labour analgesia and PW-2 recommending the same. After thorough scrubbing and under strict aseptic precautions, R-5 administered local anesthesia with 2 ml of 1% Lignocaine at L3 L4 space in sitting position. After ensuring analgesia effect 18G Tuohy needle was introduced into L3 L4 space and epidural space was identified by loss of resistance technique using 2 ml of air with glass syringe. The epidural space was obtained at 5 cms. and after ensuring that no fluid/blood was coming out, R-5 introduced epidural catheter with the bevel of needle in caudal direction and fixed at 8 cms, i.e. the catheter was lying only 3 cms. in the epidural space. Once again, R-5 waited for 5 minutes and confirmed that there were no haemodynamic changes, neurological symptoms and motor block. Then R-5 administered 10 ml of 1% lignocaine with 50 micrograms of Fentanyl, slowly over a period of 10 minutes. R-5 kept the patient in lateral and propped up position and provided oxygen supplementation, as this is a routine practice. During all this, A-1 and PW-2 were present next to the patient and A-1 provided her moral support.

32. It is further stated, that R-3 did an artificial rupture of membranes and instructed to start 5 units of Syntocinon in drip at the rate of 8 drops/minute and the same was implemented. After finding that patient was comfortable, at about

00.50 AM, both A-1 and PW-2 left the labour room stating that they are going for dinner. At about 1.00 AM, deceased complained pain and she was again given a top-up dose of 4 ml of 0.25% of Bupivacaine after ensuring that there was no aspiration of cerebrospinal fluid/blood to ensure patient controlled analgesia. R-5 has also continuously monitored BP, PR and SaO2 through monitor as well as manually at regular intervals. At 1.30, patient once again complained of pain and r-3 did a pervaginal examination and informed, that cervix was afaced and dilated to 5-6 Cms with regular fetal heart rate. Hence, R-5 kept the patient in sitting position and administered second top-up dose of 4 ml of 0.25% Bupivacaine after confirming that there was no aspiration of CSF and kept the patient to remain in sitting position for about 5 minutes. After 5 minutes, patent was made to lie down in lateral and propped up position. At 1.40 AM, A-1 came back to labour room and conversed with the patient. At 2.00 AM, patient once again complained of pain and she was administered 6 ml of 0.125% Bupivacaine via epidural catheter after keeping the patient in sitting position and after confirming that there was no CSF/Blood in the catheter, again she was made to lie down in lateral position. All the vital parameters were checked. At 2.30 AM. Patient complained of pain once again. The patient was again kept in sitting position and after confirming that there was no CSF/blood in catheter, another top-up dose of epidural analgesia of 4 ml of 0.125% Bupivacaine was administered and at this stage also, the patient conversed with A-1. At 2.50 A.M., PW-2 called R-5 on cell phone to verify the condition of the patient informed him, that the patient was stable and labour is progressing well. This was the last top-up dose of analgesia that was given to the patient at 2.30 AM. Thereafter, no further dose of analgesia was given to the patient.

33. It is further stated, that at about 3.30 AM R-5 asked the patient to bear down the baby by voluntary efforts and A-1 who was sitting beside the patient, provided moral support and asked her to bear down the baby. The vital statistics were stable and BP was 120/80, PR 76/minute. The labour was progressing uneventfully till about 3.40 AM and at that point of time R-5 noticed, that fetal heart rate has come down to 110 from 120 per minute. At 3.45 AM, she decided to perform emergency LSCS and informed the same. A-1 reacted strongly saying that he expected a normal

delivery and also reacted against the patient for not cooperating. The patient was hesitant and refused to go till A-1 comes back. R-3 explained the patient about the risk to the baby, then she agreed. At 3.55 AM, patient was deceased wheeled into operation theatre with a wedge kept under her right hip and flank. R-5 administered oxygen via the facemask with Bains connected to Boyles machine which delivers 80-100% oxygen but noticed dropping of oxygen saturation and appearance of cyanosis. The patient was breathless but was responding to verbal commands. R-5 assisted her breaths face mask with bains connected to Boyles. At 4.00 AM, there as a drop in the level of consciousness with persistent cyanosis. R-5 administered oxygen with bains circuit by mask ventilation which delivers 100% oxygen.

34. Further, R-6 was also informed about the condition of the patient. R-5 noticed, that heart rate was 40/per minute and BP was at 80/50 mm/Hg, therefore she requested R-4 to give one ampule of Inj. Atropine and to start Dopamine infusion by adding 2 ampoules of Dopamine in one bottle of normal saline and run it at 22 drops/minute and she did so accordingly. The saturation improved and cyanosis regressed and the patient was responding to verbal commands.

35. At 4.10 AM PW-2 entered the operation theatre but A-1 was not present. At that stage, the patient went into convulsions which were tonic in nature and at 4.20 AM the patient had a cardiac arrest and R-5 gave Inj. Atropine 0.6 and Adrenaline 2 mg diluted to 5 ml injections through endotracheal tube and asked R-4 to give 1mg Adrenaline and 0.6 mg of Atropine through IV and she did accordingly. R-5 also gave external cardiac massage and breaths were given by PW-2. At 4.25 AM, R-6 entered the operation theatre and immediately after seeing him, PW-2 broke down and R-5 took the ventilating bag and started ventilating. R-6 gave DC shock of 320 Joules followed by Inj. Adrenalline and Atropine IV and external cardiac massage. Once again, R-5 ventilating with 100% oxygen at a rate of 5:1 as per ACLS protocol. At 5.10 AM, R-5 administered 50 ml of Sodium bicarbonate to combat metabolic acidosis which is usually presenting patients on ACLS with cardiac arrest lasting for more than 20 minutes. ACLS was continued till 5.30 AM with no improvement in patient's clinical status. Thereafter, R-6 declared the deceased dead and announced that the cause of death was, cardiopulmonary arrest antecedent to Amniotic Fluid Embolism. The same was mentioned in the case sheet and MCH certificate. An autopsy was refused.

36. R-5 has also stated the drugs administered to the patient, keeping her in sitting position which were as follows:

Number of doses Drug Quantity Time

First dose Lignocaine 1% with 50 micrograms of Fentanyl over a period of 10 mintues 10 ml 00.15 AM

Second top up dose Bupivacaine 0.25% 4 ml 1.00 AM

Third Topup dose Bupivacaine 0.25% 4 ml 1.30 AM

Fourth Bupivacaine 0.125% 6 ml 2.00 AM

Last Topup dose Bupivacaine 0.125% 4 ml 2.30 AM

37. It is submitted, that there was no drug toxicity in the case of the deceased. The initial local anesthetic drug given was Lignocaine. The maximum limit of this drug is 2.5 ml/Kg. (Regional anesthesia, Collins P.No.1258). Maximum recommended dosage is 200 mg without adrenaline and 500 mg with adrenaline. (Table 10.4 page No.181 Wylie 6th Edition) The permissible does in the case of deceased, was $2.5 \times 60 = 150$ mg. 10 ml of 1% lignocaine contains only 100 mg

which is far less than the recommended high dosage. The next drug was Fentanyl 50 micrograms single dose. Which is not at all a high dosage because the initial dose is 50 -100 micrograms with the loading dose. (internal practice of anesthesia Vol.1) The next drug as Top-up dose given was Bupivacaine. The total amount of drug used was 32.5 mg in the case of the deceased. The maximum recommended dose is 2 mg per Kg upto 150 mg for the first 4 hrs and 400 mg over the first 24 hours. (Table 10.4 Page No.181 Wylie 6th Edition) It is therefore submitted that the allegation of over dose of Bupivacaine is totally baseless, unfounded and unwarranted. He denied all further allegations made by the complainant and reiterated his line of treatment. There was no High block/Total spinal block and if dural puncture is done by 18G epidural needle the CSF will gush like a tap of water and this was not so in this case. If the epidural catheter was improperly placed, the first sign that would appear is reflux of Cerebro spinal fluid or blood along the catheter. There was nothing like that in the case of the deceased and the last dose of Bupivacaine was given at 2.3 AM after which the patient conversed with A-1. If there was total blockage, she could not have conversed with A-1.

38. R-5, denied the allegations of vasovagal shock and states that if there was vasovagal attack, it would have accompanied by bradycardia which is not so in the present case.

39. R-5 also states, that Amniotic Fluid Embolism is a cause of death and it is a rare obstetric emergency in which amniotic fluid, fetal cells, hair or other debris enter the maternal circulation cause cardio respiratory collapse. As per the statistics, incidence of amniotic fluid embolism is 1 : 8000-30,000. Amniotic Fluid embolism occurs during labour. The mortality rate is as high as 85%. The following signs and symptoms are indicative of possible Amniotic Fluid Embolism:

Hypotension

*Dyspnea

*Seizure

*Cyanosis

*Fetal bradycardia

*Cardiac arrest

40. Further, it is stated by R-5, that deceased died due to amniotic fluid embolism and there is no specific therapy for amniotic fluid embolism and the treatment is only supportive care i.e., the patient has to be provided oxygen to maintain oxygen saturation and initiation of cardio pulmonary resuscitation if the patient arrests and also treatment of hypotension. The patient was provided 100% oxygen with face mask through Bains circuit connected to Boyles machine. Hypotension was being corrected with fluids both crystalloid and colloid. The deceased was given 1 ampoule of Inj. Atropine and dopamine infusion by adding

2 ampoules of Dopamine in one bottle of normal saline at the rate of 22 drops per minute. At one stage saturation improved and the patient was responding to verbal commands.

41. Lastly, R-5 had put all his best efforts to save the life of the deceased but could not, since the AFE not known. Hence, R-5 is not liable to amount of compensation, since there is no negligence on its part.

42. R-6 in its written version has stated, that at 4.05 a.m. when he was at his home, he received a telephone call from R-5 stating that epidural delivery patient at R-2 hospital was in a bad condition and requested him to come immediately. He rushed to the hospital and reached there by about 4.30 a.m. When he entered the operation theatre where deceased was getting treated on the trolley, he noticed a flat line on the ECG Monitor. He was informed that deceased had a cardiac arrest 20 minutes before. He was also told that no defibrillation was done so far. To ensure that, he tried every possible thing, he did defibrillation and asked R-3 & 4 to immediately evacuate the Baby. Then he noticed wide QRS complex with idioventricular rhythm with slow heart rate. His doing defibrillation after such a long gap after cardiac arrest was futile, as early defibrillation has better survival chances. The patient was declared dead at 5.30 a.m. and death was due to "Cardio pulmonary arrest". The possible cause of the complications leading to the arrest could be amniotic fluid embolism or high epidural block/total spinal block resulting from epidural analgesia or drug toxicity. He had advised that autopsy be done with which the cause of death could have been ascertainable. There has been no deficiency in service on his part and he acted as a prudent Doctor.

43. R-7 in its written version has averred, that it has issued Professional Indemnity policy to R-3 to cover the risk of medical negligence that occur while treating the patients in the Clinic/business premises situated in 143, Prathima Scolers, King Koti, Hyderabad, for a sum of Rs.5,00,000/- (Rupees Five Lakhs only). It can be noticed from the averments in the complaint, that deceased patient had undergone treatment and the alleged negligence has taken place in the R-2 Hospital, which is a different place than the address mentioned in the policy. Therefore, cause of action is outside the scope of the policy and indemnity granted under the policy to R-3, ceased to operate and answering respondent cannot be held liable under the indemnity policy. Even otherwise, liability of R-7 has to be restricted to the extent of Rs.5,00,000/- (Rupees Five Lakhs only).

44. The State Commission, vide impugned order dismissed the complaint.

45. Hence, present appeal.

46. I have heard learned counsel for parties as well as parties who have argued in person and perused the entire record including written submissions as well as the case law.

47. Appellants submission regarding negligence and deficiency in service against

R-1 and R-2 are, that R-2 hospital has no basic facilities to provide services like epidural anaesthesia as R-2 has not enough anaesthetists, equipment, etc. They allowed R-5, a junior doctor and a diploma holder with about one and half year experience, to provide anaesthesia in the absence of senior anaesthesiologist (R-6), in a ill-equipped labour room in their hospital. They tampered with the case record, in connivance with R-4, 5 and 6 and inserted cause of death as "Amniotic Fluid Embolism" (AFE).

48. R-1 and R-2 did not inform the police for conducting the autopsy even though there was no agreement on cause of death as patient died within six hours of hospital admission in operation theatre, while undergoing anaesthesia procedure. The responsibility of post-mortem is on hospital authorities and not on the appellants. One does not require consent to inform police of such unexplainable death during operative procedure and establish beyond all reasonable doubt, the cause of death. R-1 and 2 fabricated the case sheet and did not get an autopsy done as they want to misrepresent that cause of death is due to AFE.

49. It is further appellants' case, that induction of labour by ARM (Artificial rupture of membranes) and Syntocinon drip (Oxytocin) was without Informed Consent. R-3 has not taken informed consent for induction of labour by doing a invasive procedure of (ARM) and giving Syntocinon (oxytocin) drip and three drugs Drotin, Epidosin and Buscopan to accelerate the labour. R-3 gave above three drugs in toxic doses simultaneously for the same effect of dilatation of cervix and acceleration of labour, which is against norms of standard medical practice. Only one drug should have been used. Drotin was given 4 times every hourly, whereas it has to be given 2 hourly for a maximum of 3 doses and it was given intravenously, whereas it has to be given intramuscularly.

50. Further, R-3 did not monitor Fetal Heart Rate continuously as mandated for a patient undergoing delivery under epidural analgesia. Therefore, R-3 could not detect the complications early and due to this careless and reckless omission of R-3 to do proper monitoring, deceased was deprived of timely diagnosis and treatment, reducing likelihood of favourable outcome .

51. R-3 did not do delivery in the labour room when all conditions for instrumental delivery were met. Respondents continued to ignore distress to the deceased and fetus from 3 a.m. onwards. That fetus was in distress at 3 a.m., is evidenced by the case sheet as syntocinon was stopped at 3 a.m. R-3 continued to ignore distress and did not do instrumental delivery by using Forceps/Venutose even at 3.30 a.m., even though all conditions like full dilatation of cervix, epidural analgesia, empty bladder and rupture of membranes were met and recorded by the respondents. Further, no attempt was made to do caesarean section immediately after shifting to the theatre at 3:40 AM. The delivery by perimortem Cesarean section/instrumental delivery was attempted after deceased suffered cardiac arrest at 4:15 AM.

52. As attending physician, R-3 did not certify the cause of death either in the

case record or in Medical Certification of Cause of Death (MCCD) submitted to Registrar of Births and Deaths under RBD Act, 1969. As attending physician responsible for the case, R-3 did not inform police

authorities for conduction of autopsy, though she had difference of opinion regarding the antecedent cause of death.

53. With regard to negligence by R-5, appellants' case is that excess dosages of anesthetic drugs were given frequently against norm of medical practice. Informed Consent for epidural analgesia was not taken. Continuous monitoring of patient was not done as mandated. Pre-anesthetic check up and mandatory pre-loading before anesthesia was started of 1000ml fluid to prevent Hypotension low blood pressure associated with epidural analgesia was not done. R-5 also has not done proper resuscitation as per ACLS protocols timely oxygen for cyanosis-low oxygen in blood, giving proper dosage of drugs like Atropine for reviving Bradycardia-low heart rate, positioning the patient in lateral position with a Wedge, timely Defibrillation-Shock for reviving heart rate). R-5 also tampered the case record from 3 AM onwards, including not mentioning the dose given at 3.20AM and allowing R-6 to insert cause of death as "AFE" in order to save himself. R-5 admitted, that nothing in the case record from 4 AM was written after the death of the deceased at 5:30 AM. Being a junior anesthetist, he cannot give epidural anaesthesia independently in the absence of his chief anesthetist, R-6.

54. On the other hand defence of R-1 and 2 is, that R-2 hospital offers highest quality of exclusive Modern Maternity facilities with more than 100% back up to facilitate provision of excellent maternity care in a supportive, comfortable and relaxed environment. It is a planned Hospital complex that has been designed to facilitate the process of giving maternity care in a quick, effective, safe and pleasant manner. It consists of two well equipped Operation Theatres, (2) Labour Beds, (6) Recovery Beds and (6) Beds Neonatal Care Unit. The hospital is equipped by advanced Life supporting and Critical Care Equipment like 1) Boyle's Apparatus, 2) Pulse Oxymeter, 3) Non-invasive B.P. Monitor, 4) Cardiac Monitor, 5) Cardiac Defibrillator, 6) CTG. Monitor, 7) Ultrasound Machine, 8) High Capacity Generators, and 9) Well qualified Nursing staff and experienced Resident Doctors. The R-2 hospital offers various facilities, equipped and other related administrative services to various visiting Consultants.

55. R-2 hospital has provided the best facility and the service of highly qualified resident doctor to assist the Consultant. Therefore, it cannot be said that there is deficiency of service. R-2, is also equipped with advanced Life support system and Critical Care Equipment like Boyles Apparatus, Pulse Oxymeter, Non-invasive B.P. Monitor Cardiac Monitor, Cardiac Defibrillator. R-2 also provided the services of highly qualified Obstetrician and Gynaecologist as Resident Doctor to assist the Consultant, who was with the patient all through. There is no interference on the part of R-2 hospital in the clinical process of providing health care to their patients by the Consultants. As such, it cannot be said that there is deficiency of

service on the part of R-2 hospital.

56. The case of R-3 is that at about 10.15 PM, PW-2 approached her alongwith his friend stating that he also studied in the same college where she had graduated from. After the said formal introduction, A-1 told her that his wife was admitted in one Jaya Nursing Home under the care of Dr. Suvarna Ramaswamy, who was taking care of her ante-natally as well as presently. A-1 expressed his dissatisfaction regarding the facilities available there, apart from the fact that he was not being allowed into labor room. At that juncture, R-3 advised A-1 to discuss the same with the consultant and get his doubts clarified personally. However, A-1 told R-3 that being basically a medical man, he in consultation with PW-2, took a decision to shift his wife to the R-2 hospital, where better facilities are available, apart from the availability of antesident obstetrician, backup team of paediatricians and anesthesiologists. A-1 has also told that the Nursing Home is closer to

Jaya Nursing Home, facilitating easy transfer. Both R-4 and PW-2 again advised them not to take up hasty decision of shifting without consulting the consultant. But A-1 insisted that he would have his wife discharge from Jaya Nursing Home against medical advice, and had taken a conscious decision of shifting. In turn PW-2 told R-3 that all he wanted was to have her help for conduction of delivery, as pregnant woman was his close friend's wife. Consequently, when A-1 and PW-2 requested R-3 to inform about their admission to the resident doctor of R-2 hospital, as determined by A-1, he got his wife discharged against "Medical advice" from Jaya Nursing Home at 11.10 P.M. The decision of shifting the pregnant woman was taken by A-1. Consequently to which, upon the express and repeated requests of A-1 and PW-2, R-3 accepted to attend on her gratis, out of professional fraternal feeling.

57. Therefore, deceased was admitted in R-2 hospital at 11.45 PM. R-3 attended the deceased at about 12.05 a.m. During this time, deceased was lying in the labor room. R-3 examined her in the labor room after going through the findings, that were documented by R-4. In fact, R-5 administered epidural analgesia, at the request of A-1 and deceased, after proper counselling and after obtaining the informed consent in the presence of PW-2 and A-1. PW-2 left after administration of epidural analgesia. Later, A-1 returned after some time and stayed with deceased in the labor room as attendant. In fact, A-2 and A-3 were also in the hospital at the relevant time. R-3 examined the deceased and found her to be in active labor, with intact bulging bag of membranes without draining and cervical dilatation of 4 cm. It was diagnosed as primi in active labor with High Rupture of Membranes? (HROM). Consequently, artificial rupture of membranes (ARM) was done to accelerate the labor as deceased was in active labor with cervical dilation of 4 cms with history of draining per/vaginu from morning 8 AM. At 12.20 AM, an ARM was done, the color and quantity of liquor were assessed and were found to be clear and adequate. The same serve as vaginal signs for fetal condition. Labor was accelerated by Syntocinon drip at 12.30 am, in view of history of draining P/

V from 8 am. on 5/3/2003 and active labour. Labor room staff have administered drugs sequentially, as per R-3 instructions and under R-3 supervision based on the cervical response. The deceased was kept in lateral position which in accordance with the routine practice to prevent hypotension and increase the utero-placental circulation. The deceased was asked to lie in the supine position during pelvic examination. The deceased was coached and encouraged to bear down at 3.30 AM by which time the cervix was 9-10 cms dilated. R-3 stated, that drugs like Drotin, Epidosin & Buscopan are commonly used drugs for cervical dilatation during active stage of labour (i.e. acceleration) with wide margin of safety to both mother and fetus. The number of doses and their frequency were chosen till full dilatation was achieved i.e. 10 cm., the last dose of injections drotin and buscopan were given at 2;30 a.m. and last dose of injection epidosin was given at 3.00 a.m. The rate of cervical dilatation was approximately 2 cms. per hour. At 3.30 AM, it was dilated by 9-10 cms. These drugs act on the cervix specifically facilitating the dilatation and reducing the duration of the first stage of labor.

58. Further, as per R-3, fetal heart was monitored continuously with electronic fetal monitor and stethoscope and it was documented to be within the normal range of 132-138 beats/minute up to 3.30 AM. R-3 was frequently updating A-1 about the progress of labor status of the fetus and mother. The normal fetal heart is between 110-150 beats per minute. Further, labor was augmented with oxytocin. As R-3 suspected uterine hyperstimulation at 3 Am, the syntocinon drip was stopped and plain Ringer lactate was started. As hyperstimulation was corrected immediately and frequency of contractions was satisfactory, the drip was not restarted. Vitals documented by R-3 were in normal limits till 3.40 AM. At that time blood pressure 120/80 mm/hg. The deceased was conscious and was conversing with them and her husband, till she was wheeled out of the labor room. At 3.40 AM, R-3 found that fetal heart rate was 120 BPM. As the prerequisites for

an instrumental delivery were not fulfilled, R-3 decided for caesarean section for fetal indication and duly informed R-4 and R-5 and A-1. On that, A-1 reacted strongly saying that he had expected a normal delivery. At that juncture, A-1 wanted the opinion of PW-2 and walked out of the labor room. Although the deceased was hesitant to move on to the trolley till her husband came back, at 3.55 AM, deceased was wheeled into operation theatre. After shifting to the theatre, deceased suddenly became breathless and developed cyanosis, which R-3 noticed. Immediately appropriate resuscitation measures were started by R-5. Observing the deceased's level of consciousness and cardio vascular collapse (fall in blood pressure and feeble pulse), appropriate resuscitation was started immediately by the team of attending doctors. A-1 never entered the theatre. At around 4.10 AM, PW-2 assisted R-5 in the resuscitation process alongwith R-4 and R-3. A-1 did not accompany PW-2 into the theatre. Due to sudden deterioration of the deceased condition, the fetal collapse (fetal bradycardia) occurred followed by disappearance of fetal heart, R-3 updated the

attendants and PW-2. On hearing this, PW-2 barged into the theatre . Though PW-2 asked deceased to show her tongue and tapped on her cheek, she obeyed but immediately became restless and threw convulsions, followed by cardiac arrest. Despite the best efforts of R-5 assisted by other doctors, deceased had cardio vascular collapse and was hemodynamically unstable. In just 20 minutes deceased was in a state of hypoxia, inspite of resuscitation with oxygen, drugs and external cardiac massage. The clinical picture was suggestive of Amniotic fluid Embolism and deceased was managed accordingly.

59. At 5.30 AM, deceased was declared dead on 6.3.2003. The cause of death was mentioned as "Amniotic Fluid Embolism" in the case sheet and MCH Intimation form, if A-1 had any suspicion regarding the cause of death, he should have approached the concerned persons, although A-1, A-2 and PW-2 had refused autopsy. As per R-3, Amniotic Fluid Embolism is a complex disorder, a known rare complication of pregnancy during labor, with no known measures to predict or prevent its occurrence. None of the drugs used, causes cyanosis or refractory hypotension or cardiac arrest, with which the deceased suffered. Proper labor management with precautions for the management of any eventual complications was practiced using appropriate guidelines, throughout the hospital stay of the deceased by the attending team.

60. As per the defence of R-5, A-1 had shifted the deceased to R-2 hospital, under the active advice of P.W.2, who is an anaesthetist and has also submitted Thesis of Epidural analgesia. A-1 and PW-2 had already made up their mind and have mentally prepared the deceased to have Epidural analgesia. Thereafter, only R-5 was called to provide Epidural analgesia. R-5 administered Epidural Analgesia after following the due procedure of explaining the deceased about the merits, demerits and risks involved. A-1 and deceased signed the consent Form asking for Epidural analgesia. Normally labor analgesia is provided only when the patient specifically ask for it. There are certain women who refuse for labor analgesia because they want to have the experience of labor which is attached to their motherhood. Here labor analgesia was provided only at the request of the deceased and A-1, who were advised by PW-2. In fact, PW-2 telephoned R-5 and requested him to provide labor analgesia to the deceased. The allegation, that there was no informed consent is baseless and an afterthought, developed for the purpose of this case.

61. Further, it is a baseless allegation that Pre Anaesthesia check was not done. If the case sheet is perused, it may be noted at Page No.5 that, "Pt. C/C" which means patient conscious and coherent, "ASA Gr.1, means as per the standard of American Society of Anesthesiology Grading, the patient is graded as No.1. There was a recording of P.R. 90 P.M., means Pulse rate was 90 per

minute. There was a recording of B.P. also showing B.P. 120/80. R-5 conducted pre anesthetic check up and then only administered Epidural analgesia. The deceased was continuously connected to the Pulseoxymeter, ECG and NIBP monitor.

62. R-5 adjusted the upper and lower limit alarms for all parameters to monitor the deceased continuously and kept the patient under constant observation during the entire process.

63. Regarding appellants' allegation, that deceased was continuously kept in supine position, it is a wild allegation levelled against the doctors with a malafide intention for the purpose of present case. It is common sense, that no doctor would make the patient to lay down in supine position. The pregnant woman cannot lay down in supine position because it is inconvenient for her. The deceased was all the while in lateral position conversing with A-1.

64. With regard to allegation of appellants about drug toxicity, R-5 is, that he administered analgesic drugs of far lesser than the permissible limits. As a test dose, R-5 first gave 3 ml of 1.5% Lignocaine via Epidural catheter and waited for 5 minutes and confirmed, that there was no haemodynamic changes, neurological symptoms and motor block. Thereafter, he gave regular dose.

65. It is further stated by R-5, that deceased died due to onset of Amniotic Fluid Embolism (which is a rare obstetric emergency in which amniotic fluid, fetal cells, hair or other debris enter the maternal circulation, causing cardio respiratory collapse). As per statistics, incidence of AFE is 1 : 8000-30,000. and it usually occurs during labor. The mortality rate is as high as 85%. The death occurs in most of the cases within one hour of onset of AFE. The clinical study revealed, that onset of AFE is unpredictable and unpreventable event and the cause is not known. The following signs and symptoms are indicative of possible (AFE).

Hypotension

*Dyspnea

*Seizure

*Cyanosis

*Fetal bradycardia

*Cardiac arrest

The PW-2, had admitted the above said fact in his cross examination and also admitted, that hypoxia leads to bradycardia and cyanosis.

66. Lastly, as per R-5, the deceased was provided 100% oxygen with face mask through Bain's circuit connected to Boyle's machine. Hypotension was being corrected with fluids both crystalloid and colloid. The deceased was given 1 ampoule of Inj atropine and dopamine infusion by adding 2 ampoules of Dopamine in 1 bottle of normal saline at the rate of 22 drops per minute. At one stage, saturation improved and deceased was responding to verbal commands. R-5 had put all his efforts to save the life of the deceased but could not. The onset of AFE is unpredictable and unpreventable. Admittedly, the clinical picture shows that deceased suffered from Fetal bradycardia, Hypotension, Dyspnea,

Hypoxia, Cyanosis, convulsions and Cardiac arrest. The above clinical picture which was sudden in onset and which was refractory to the aggressive treatment given, is indicative of AFE. Thus, R-5 has taken utmost care to combat AFE and inspite of his best efforts, deceased could not be revived.

67. The State Commission, while dismissing the complaint in its impugned order observed;

"1) Is there any negligence with respect to taking CONSENT?

There are several issues which has been raised by the complainants with respect of medical negligence and we address them as follows.

The first contention of the complainant is that the consent form was a generalized form taken during the time of admission and not taken prior to epidural analgesia and that pre-anesthetic check up was not done to ascertain whether the patient was fit to undergo labour analgesia or not and that the same was administered without proper consent. The learned counsel for the complainants submitted that the consent of the first complainant was mechanically obtained without explaining the procedure and the consequences of administering epidural analgesia and that it was a generalized consent. It is the case of the opposite parties that the first complainant being a qualified medical doctor though not practicing had signed the consent form for labour analgesia in the presence of Dr.Rajesh Khanna after having elaborate discussions with opposite parties. The fourth opposite party was a qualified Obstetrician who had taken the consent and this contention supported by third and fifth opposite parties. It is the case of the opposite parties that the first complainant and the patient was explained about the procedures and advantages and disadvantages and also the complications of labour analgesia. We have gone through the deposition of the first complainant i.e., PW1 in which he deposed as follows:

"It is true to suggest that I have signed a consent form. My wife has also signed the consent form but the consent form is a generalized consent and it is not particular to epidural analgesia. In the consent form epidural analgesia was not there and it was subsequently added. I do not remember whether I have stated so in the complaint or not. I signed on the blank form having trust on the doctors in the hospital."

We have perused the original consent form which is a part of Ex.B1 and also the copy filed as a part of Ex.A1 filed by the complainants. The consent form states as follows;

"AUTHORIZATION FOR MEDICAL AND/OR SURGICAL TREATMENT

Place: S.M.H.

Date: 5-3-03. Time: 11.45 P.M.

I hereby authorize, Shalini Hospital to perform the following

operation or procedure on:

Name of the Patient: Mrs.Srilatha Hospital No. ----- Age: 25 Sex: Female,
Name of Operation or Procedure: Epidural analgesia .

2. The nature of my condition and the hazards of the operation or procedure including Biopsy and any unwanted untoward complications that may arise have been explained to me by my Physician(s)/Surgeon (s).

3. I consent to the administration of anaesthesia may deem advisable in my case. I also consent to the administration of any other drug relevant to the procedure.

4. I further authorize the said Physician(s)/Surgeon(s) to perform such additional operations or procedures including the administration of a blood transfusion or blood plasma as they or he may consider reasonably necessary or proper in the event of any emergency or if any unanticipated condition should be discovered during the course of the operation.

5. I hereby authorize the Hospital, its agents or devisees to dispose off any removed tissue or amputated member of my body as a result of the surgical operation in any manner deemed proper by the Hospital.

6. All the above points have been explained to me in the language which I understand.

Name of the Patient (Type or Print):

Signature of the Patient:

Srilatha

Sd/-

If the Patient cannot sign or minor

Spouse, Parent or Guardian: K.Srikar Reddy

Relationship to Patient: Hyderabad

Witness: -----

Address: H.No. 3-5-1092/7,

Sri Venkateswara Colony

Narayanguda, Hyd 29

For SRISHTI ASSOCIATES

Sd/-

(Dr.M.Padmanabh Reddy)

Proprietor "

It is apparent from the above consent form that both patient and first complainant have signed it and the name of the patient and the procedure is written and it is also pertinent to note that the first complainant is a qualified doctor and admittedly Dr.Rajesh Khanna who has referred the first opposite party hospital to the complainants is also an anesthetist. From the aforementioned signed consent form and the depositions, it is established that the first complainant was aware of the procedures of epidural analgesia and cannot state that he was unaware of the risks and complications, being a medical graduate himself, and also being referred by his own classmate Dr.Rajesh Khanna who is also an anesthetist and who was already in touch with the opposite parties. Therefore the contention of the complainants that the consent was not informed is not sustainable."

2) Is there any negligence with respect to monitoring of anaesthesia? Was there any drug toxicity?

The second contention of the complainants is that there was no proper monitoring. RW4 did not ascertain the level of anaesthesia before and after giving the dose . Top up doses of Bupivacaine were given indiscriminately every 30 minutes whereas the drug is normally given after 60 to 90 minutes depending on the level of Motor/Sensory level block. Opposite parties not only gave the drug in much shorter duration they have not even verified the level of Motor/Sensory level block to check whether the same is adequate or inadequate or excessive. Fifth opposite party did not do continuous monitoring of pulse, blood pressure and respiratory rate every five minutes and monitors like pulseoxymeter and electro-cardiogram monitor etc., were not used. Fifth opposite party did not continuously monitor the deceased for complications normally associated with epidural analgesia like chance migration of epidural catheter in to dural space or dural puncture, consequent to which high spinal/high epidural block was not recognized. First and second opposite parties did not check regularly monitor properly the fetus heart rate and progress of labour whereby early distress signs were not noticed. The learned counsel for the

complainants relied on the medical literature in Williams Obstetrics, 21st Edition, Page 375 and in Epidural Analgesia, 1978 published by Philip R.Bromage, page 237 & 238 in which it is stated as follows:

The amount of local anesthetic needed to keep the segmental level of analgesia constant is about one half the initial induction dose, and this top up dose needs to be given when the upper level of analgesia has receded one or two dermatomes.....Segment-time diagrams are constructed for the onset and decay of analgesia in each patient, a pin-prick being used to determine the upper and lower margins of sensory analgesia.....the total duration was three hours, but the upper level of analgesia began to recede at 90 minutes after the block was complete, and it has fallen two dermatomes 10 minutes later. This point, the point of recession of two dermatomes is the relevant clinical landmark at which a

reinforcing dose of local anesthetic must be injected in order to maintain an effective level of surgical analgesia ."

The learned counsel for the complainants further argued that PW2 deposed in his affidavit evidence that the level of anesthesia should be ascertained before and after giving the dose. Top up doses should be administered only if the level of anesthesia comes down by two segments which will be normally after 90 minutes to 2 hours and that no recordings have found in the case sheet Ex.A1.

The learned counsel for the fifth opposite party contended that there was continuous monitoring and denied that pre-anesthesia check up was not conducted. It is noted in the case sheet at page 5 as Pt.C/C which means patient conscious and coherent, ASA Gr.1, means as per the standards of American Society of Anesthesiology Grading, the patient is graded as No.1. There was a recording of B.P. also showing BP 120/80. Fifth opposite party conducted pre-anesthetic checkups and then only administered Epidural analgesia and the patient was continuously connected to the Pulseoxymeter, ECG and NIBP monitor and it is the case of the fifth opposite party that he adjusted the upper and lower limit alarms for all parameters to monitor the deceased continuously and denies that there was no pre-anesthetic check up.

We have observed from the record that fifth opposite party has stated that he has given the following doses at the following specified times.

As per record, O.P. No.5 has gave the following doses at the following specified times;

Number of doses Drug Quantity Time

First dose Lignocaine 1% with 50 micrograms of Fentanyl over a period of 10 mintues 10 10 ml 00.15 AM

Second Topup dose Bupivacaine 0.25% 4 ml 1.00 AM

Third Topup dose Bupivacaine 0.25% 4 4 ml 1-30 AM

Fourth Bupivacaine 0.125% 6 6 ml 2.00 AM

Last Topup dose Bupivacaine 0.125% 4 4 ml 2.30 AM

Fifth opposite party also submitted that the permissible dose in the case of the deceased is $2.5 \text{ mg} \times 60 = 150 \text{ mg}$. and 10 ml of 1% lignocaine contains only 100 mg which is far less than the recommended high dose. The next drug that was used was Fentanyl 50 micrograms and it is the case of fifth opposite party that initial dose is 50-100 micrograms with the loading dose and he relies on the medical literature Internal Practice of Anesthesia Vol.-I which states as follows:

"Fentanyl is the opioid which has been widely used in combination with local anaesthetics to reliee labour pain. Clinical experience suggests that fentanyl in an initial does of 50-100 micrograms with 0.125% bupivacaine produces good analgesia, which can be extended with continuous infusion. The combination of

sufentanil-bupivacaine has received considerable interest, due to sufentanil's higher lipid solubility and greater receptor-binding compared with fentanyl. Epidural injection of 10 ml 0.125% bupivacaine with adrenaline, with either 7.5 or 15 micrograms sufentanil, significantly shortened the onset and increased the duration and intensity of analgesia compared with bupivacaine with adrenaline. However, there are reports of neonatal depression when doses greater than 30 micrograms have been used."

With respect to Bupivacaine the amount of drug used by 32.5 mg and the maximum recommended dose is 2 mg per Kg upto 150 mg for the first 4 hrs and 400 mg over the first 24 hours. (Table 10.4 page no.181 Wylie 6th Edition.

This table 10.4 states that the actual dose is as follows;

Actual Dose -----Recommended Dose

10 ml of Lignocaine = 100mg ---- 200 mg without Adrenaline 500500 mg with Adrenalin

50 Micrograms of Fentanyl ---- 50-100 Micrograms with loading dose

32.5 mg of Bupivacaine in 2 Hrs. ----- 1) 2mg for Kg. of body weight upto 150 mg. in 4 Hr.

32.5 mg. in two hours in fact 2) 400 mg. in 24 Hours"

Less than recommended dose

"It is pertinent to note that PW2 in his cross examination at page 179 submitted that the maximum dose of Lignocaine that can be given to a pregnant woman is 3 mg to 7 mg per kg of body weight and maximum dose of Bupivacaine that can be given in epidural analgesia is 2 mg per kg of body weight. 4 ml of 0.125% of bupivacaine is equal to 5 mg of bupivacaine and administration of 5 mg of bupivacaine is not at all a toxic dose. The last top up dose was given at 3.20 A.M.

We find force in the contention of fifth opposite party that the Patient Controlled Epidural Analgesia is a safest and most effective analgesia method and to support his arguments he relied on medical literature of OBSTETRIC ANALGESIA BY A.L.HOLLMEN AND T.A.THOMAS and is as follows:

"Patient controlled epidural analgesia (PCEA) is an alternative method of epidural analgesia which has recently attracted interest. Labour pain varies between patients, and over the course of labour and delivery, therefore close titration is needed to achieve effective pain relief with good patient satisfaction, haemodynamic stability and the ability to push effectively during the second stage. The careful titration of drug has mainly been the responsibility of the anaesthetist, and has been costly in staffing levels. PCEA transfers part of that responsibility to the patient. Some patients prefer to have the sensation of their contractions and be actively involved in the second stage. This kind of control of

analgesia is difficult to achieve by CIEA. The preliminary studies suggest that PCEA can be a safe and effective analgesia method offering good patient satisfaction and diminishing personal requirements."

We also rely on the requisites of the medical practitioner as described by Halsburys Laws of England:

The degree of skill and care required by a medical practitioner is so stated in Halsburys Laws of England (Fourth Edition, Vol.30, Para 35):-

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

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

Keeping in view the arguments, the material on record and the medical literature filed we are of the considered opinion that the complainants failed to establish that anesthesia was not administered properly and there was no proper monitoring and also that there was drug toxicity.

" The next contention of the complainants is that there was High Block/Total Spinal Block resulting from epidural analgesia . High Block/Total Spinal Block is the complication of epidural analgesia due to puncture of dura with inadvertent subarachnoid , epidural injection as drug comes in direct contact with spinal cord and cerebrospinal fluid which makes the drug to reach upper spinal cord and brain. This leads to hypotension, apnea, unconsciousness and bradycardia. As against this contention fifth opposite party submitted that only after thorough scrubbing and under strict aseptic precautions he administered local anesthesia with 2 ml of 1% Lignocaine at L3 L4 space in sitting position. After ensuring analgesia effect 18G Tuohy needle was introduced into L3-L4 space and epidural space was identified by loss of resistance technique using 2 ml of air with glass syringe. The epidural space was obtained at 5 Cms and after ensuring that there was no fluid or blood, he introduced epidural catheter with the level of the needle in caudal direction and fixed at 8 Cms i.e., the catheter was lying only 3 Cms in the epidural space. He submitted that he aspirated and checked the epidural catheter for any blood or CSF fluid and administered 3 ml of 1.5% Lignocaine via epidural catheter as a test dose. After waiting for 5 minutes and after confirming

that there were no haemodynamic changes, neurological symptoms and motor block he administered 10 ml of 1% lignocaine with 50 micrograms of Fentanyl slowly over a period of 10 minutes. The patient was kept in lateral and propped up position and provided oxygen supplementation as routine. During all this time first complainant and Dr.Rajesh Khanna were present next to the patient and the first complainant was talking to and providing moral support to her.

We observe from the record that the first complainant in his deposition admitted that he was present in the labour room till the patient was shifted in the operation theatre

excepting for a brief period of 10 minutes he was giving moral support and he was talking to the patient on and off. If there was high spinal or total block there is no chance of patient talking to the first complainant. Dr.Rajesh Khanna, PW2 stated in his deposition as follows:

"It is true that the symptom of High Spinal or Total block would appear immediately after accidental injection of analgesic drug into subarachnoid space."

We observe from the case sheet that fifth opposite party gave first dose at 12.30 A.M. and last dose given at 2.30 A.M. and as per the deposition of PW2 if there was a high spinal or total block it ought to have appeared immediately after 2.30 A.M. Therefore we are of the considered opinion that the complainants failed to establish that because of administration of analgesia by fifth opposite party there was total spinal or total block and this Spinal Block resulted in death of the patient."

Now we address ourselves to the contention of the complainants that there was vasovagal shock.

" It is the contention of the complainants that the patient was put in Supine position and she has developed severe hypotension and that the deceased was asked to bear down by voluntary efforts, the deceased suffered vasovagal attack which progressed to cardiac arrest. The learned counsel for the complainant submitted that during epidural analgesia patient should be placed in lateral position with a Wedge to prevent Hypotension but the patient was left in supine position all the while in labour room and even on the stretcher in the operation theatre without placing a wedge, opposite parties continued their treatment. He relied on the medical literature in International Practice of Anesthesia 1996 Vol-II Page 2/94/2 and 2/96/2 wherein it is mentioned as follows :

"Cavan occlusion occurs when the mother is placed in the unmodified supine position and the gravid uterus rests on the inferior vena cava, thus obstructing the return of the blood to the heart Pregnant mothers at term will not lie supine, but will do so if requested by medical nursing staff. Adverse reactions are even more pronounced in the presence of sympathetic block resulting from effective epidural or spinal analgesia. Maternal hypotension is one of the more common complications but the frequency is very low when aorto-caval compression is

avoided (lateral position throughout labour) and volume loading with lactated Ringers solution (10-15ml/kg) is given before block."

In Text Book of Anaesthesia, ELBS, 2nd Edition, Page 546 -547 it is mentioned that Caval occlusion must be avoided at all times and " the mother must be nursed in either a lateral position or in modified supine position using a Crawford Wedge" .

In Anaesthesiology Clinics of North America, Vol-8, No.1, March 1990 Page 59 it is mentioned that the hemodynamic effects associated with epidural analgesia for labour and delivery may represent a great hazard for mother and baby. Most of the effects are caused

by blockade of the sympathetic fibres. Sympathetic blockade result in vasodilation of the resistance and capacitance blood vessels. There is venous pooling and a decrease in venous return to the heart. The cardiovascular complications of epidural blockade are often preventable. Aortocaval compression in the term parturient is the rule and not the exception. It is the most dangerous vascular feature of the pregnant patient.

The learned counsel for the complainant submitted that RW4 during her cross examination stated that the patient should be kept in the left lateral position with a wedge and that it was done in the present case. Therefore admitted resuscitation in supine position is futile and that there would be obstruction to venous blood return due to aorta caval compression. The question whether the wedge was placed or not until sixth opposite party arrived is the brief point for consideration in this contention . It is pertinent to note from the record that there is absolutely no evidence that the patient was put in a supine position through out and that position was not changed and no wedge was placed. We find force in the contention of third opposite party that the mother would not at all be comfortable in a supine position and the mother is always placed in a lateral and not supine position. Moreover it is an admitted fact that the first complainant who himself is a qualified doctor was present in the labour room and talked to his wife to make her comfortable and discomfort, if any, with respect to supine position has not complained then at that point of time and there is no documentary evidence to state that the patient was kept in supine position through out and that no wedge was placed when the allegations of the complainant is not proved by any documentary evidence we are unable to find any force in their contention."

Now we address ourselves to the contention of the complainants that third and fourth opposite parties asked the patient to bear down the baby by voluntary efforts.

The learned counsel for the third opposite party submitted that as the cervix was not fully dilated at 2-45 a.m., the deceased was not asked to bear down. At 3-30 am as the cervix was dilated to 9-10 cms, the deceased was coached and encouraged to bear down. Third and fourth opposite parties accelerated the

labour with oxytocin and artificial rupture of the membrane. Ex.A1 is the case sheet states that the cervix was dilated to about 3-4 cms with bulging fore waters and history of draining since 8.00 a.m. It is the allegation of the complainants that if the membrane was intact, it is a recommended practice in both induction and augmentation of labour to perform artificial rupture of the membrane. The learned counsel for the third opposite party submitted that at one instance the complainant says that labour was unnecessarily induced with ARM and on the other hand he says ARM should be done as per recommended practice, ARM was done in view of the indications of active labour and draining since 8.00 a.m. The learned counsel for third opposite party relied on Role of ARM, Arul Kumarans the Management of Labour, Chapter 2 (Volume III, Page 68 wherein it is stated once the active phase has started, i.e., when the cervix is more than 3 cm, the membranes may be ruptured. This procedure is popular in centers which believe in the active management of labour.

We rely on the judgment of the Apex Court reported in I (2002) CPJ 4 (SC) in Vintha Ashok Vs. Lakshmi Hospital and Others wherein it was been held that when established medical treatments are available and if the doctor follows one, it cannot be termed as negligence.

Keeping in view that there is absolutely no evidence to state that third opposite party has unnecessarily done ARM, the allegation of the complainant that labour was unnecessary induced is not sustainable.

We now address ourselves to the contention of the complainants that the cesarean was not immediately done to save the lives of the mother and child and also that the death was not caused by AFE.

It is the opposite parties case that due to sudden collapse of the patient after shifting to the theatre, though they resorted to appropriate resuscitation measures, due to non-responsiveness of the mother, and due to AFE, the fetal heartbeat disappeared and even performance of cesarean section would not have served the purpose and therefore in that situation, cesarean could not be done. The mother's condition was grave and the opposite parties admitted that there is no data that any type of intervention would meet maternal prognosis with AFE. Had it been cardiac arrest and fetal heart was present then cesarean could have been done. It is an admitted fact of the opposite parties that fetal heart disappeared and therefore the contention of the complainants that the performance of the cesarean section was possible in those circumstances and was yet not performed by the opposite parties is not sustainable.

We have gone through the medical literature on AFE analysys of the national registry by Steven L.Clark, Internal Page 1160, Vol.III, pageNo.108 to 110 in which it is stated that amniotic fluid embolism is an often-devastating obstetric syndrome occurring in 1 in 8000 to 1 in 80,000 pregnancies. This condition is responsible for roughly 10% of all maternal deaths and it is most common cause for peripartum death. The most common clinical features of AFE are collapsing

before delivery is a seizure or seizure like activity dyspnea, fetal bradycardia, hypotension and cyanosis. In William Obstetrics, 21st Edition, Chapter 25 Obstetrical Hemorrhage, Internal page 660, 661 and 662 Volume No.III, Page 112 and 113 which states that AFE is a complex disorder classically characterized by the abrupt onset of hypotension, hypoxia and consumptive coagulopathy. The physiological processes in AFE are still poorly understood, and hence the management of suspected AFE is almost entirely supportive, being derived from basic principles.

We observe that A.P.Medical Council had vide its letter dated 11.2.2004 come to the conclusion that the cause of death of the deceased was due to rare complication of AFE that the entire clinical picture supports the said diagnosis and that there was no negligence on the part of the obstetrician, anesthetist and gynecologist. Aggrieved by the same the complainant had filed an appeal before Medical Council of India which also ruled that the cause of death was AFE. These reports are however not binding; we address ourselves to the nature of medical negligence only if any, before this Commission. Even otherwise the medical literature supports the symptoms aforementioned which states that the cause of death was AFE.

We rely on the judgment of the National Commission reported in Page 52 Vol.II Part A in S.C. and N.C. on Medical Negligence & Insurance under Consumer Protection Act in O.P.No.250 of 1997 dated 24.10.2005 wherein the National Commission has specifically dealt with AFE. In this case the deceased was a young patient aged 29 years

and labour pains were induced by drugs and she even delivered a male baby and yet died due to AFE. The National Commission quoted Clarkes Clinical Presentation on Critical Care Obstetrics as hereunder.

" In the typical case of AFE, the woman is laboring vigorously, or has just done so, and is in the process of being delivered when she develops varying degrees of respiratory distress and circulatory collapse ." If the woman does not die immediately, serious hemorrhage with severe coagulation defects is soon evident from the genital tract and all other sites of trauma.

Treatment : THERAPY FOR AMNIOTIC FLUID EMBOLISM IS NOTORIOUSLY UNSUCCESSFUL.

The National Commission dismissed the complaint observing that there was no medical negligence of the opposite parties.

The learned counsel for the complainants submitted that the death was not due to AFE but only because of negligence of opposite parties. The first complainant is a qualified medical doctor and the second complainant is a practicing advocate and they are both aware of the procedures of autopsy and ought to have taken steps to get an autopsy performed if they had any suspicion. This was not done in the present case the complainants have failed to establish that the cause of

death was not AFE.

In the instant case it is an admitted fact that the cyanosis, seizure and Hypertension were present in the patient and as per the medical literature aforementioned these symptoms are symbolic of AFE and in the absence of any other evidence to prove otherwise we conclude that the cause of death is AFE and we also rely on the judgment of Apex Court in Jacob Mathew, Vs State of Punjab and another reported in AIR 2005 SUPREME COURT 3180 in which the Apex Court dealt with the medical negligence both as Tort and as a crime in a detailed manner and defined Negligence.

According to Charlesworth and Percy on Negligence (Tenth Edition, 2001), in current forensic speech negligence has three meanings. They are: (i) a state of mind, in which it is opposed to intention; (ii) careless conduct; and (iii) the breach of duty to take care that is imposed by either common or statute law. All three meanings are applicable in different circumstances but any one of them does not necessarily exclude the other meanings. (Para 1.01) The essential components of negligence, as recognized, are three: duty:, breach and resulting damage, that is to say:-

1. The existence of a duty to take care, which is owed by the defendant to the complainant;
2. The failure to attain that standard of care, prescribed by the law, thereby committing a breach of such duty; and
3. Damage, which is both causally connected with such breach and recognized by the law, has been suffered by the complainant. (Para 1.23).

In the instant case the opposite parties have failed to establish that the opposite parties did not take proper care of the patient as per then normal medical standard prescribed by law thereby committing a breach of duty. From the medical evidenced on record we do not see any recklessness or rashness or any desire to cause harm to the patient.

The Apex Court has stated as follows:

"A professional may be held liable for negligence on one of two findings; either he was not possessed of the requisite skill which he professed to have possessed, or, he did not exercise, with reasonable competence in the given case, the skill which he did possess. The standard to be applied for judging, whether the person charged has been negligent or not, would be that of an ordinary competent person exercising ordinary skill in that profession. It is not necessary for every professional to possess the highest level of expertise in that branch which he practices . In Michael Hyde and Associates V. J.D.Williams and Co.Ltd., (2001) P.N.L.R. 233, CA, Sedley L.J. said that where a profession embraces a range of views as to what is an acceptable standard of conduct, the competence of the defendant is to be judged by the lowest standard that would be regarded as acceptable. (Charlesworth and Percy, *ibid.* Para 8.03)

In the opinion of Lord Denning, as expressed in *Hucks V. Cole*, (1968) 118 New LJ 469, a medical practitioner was not to be held liable simply because things went wrong from mischance or misadventure or through an error of judgment in choosing one reasonable course of treatment in preference of another. A medical practitioner would be liable only where his conduct fell below that of the standards of a reasonably competent practitioner in his field."

In the instant case except for the allegation of the complainant that the patient died due to negligence of the opposite parties in administering anesthesia, in using strong drugs leading to drug toxicity, not performing emergency cesarean delivery, not giving DC shock, non-supply of oxygen to prevent progressive cyanosis and the patient being kept in supine position, their contentions are not supported by any documentary evidence wherein the complainants could establish that the opposite parties course of treatment fell below the standard of a reasonable competent practitioner in that field. To reiterate the first complainant himself is a doctor and the husband of the patient who was present throughout the procedure and it is also pertinent to note that the opposite parties treated the patient only that crucial night and have acted in accordance with the practice accepted as proper by a responsible body of medical men skilled in that particular act even though a body of adverse opinion also existed among medical men. A medical practitioner faced with an emergency ordinarily tries his best to redeem patient out of his suffering. He does

not gain anything by acting with negligence or by omitting to do an act. Obviously, therefore, it will be for the complainant to clearly make out a case of negligence before a medical practitioner is charged with negligence.

We find it relevant here to rely on the decision of the Apex Court in *Dr.Laxman Balkrishna Joshi v. Dr.Trimbak Bapu Godbole and Anr .* (1969) I SCR 206 discussed the duties which a doctor owes to his patients. The Court held that a person who holds himself out ready to give medical advise and treatment impliedly undertakes that he is possessed of skill and knowledge for that 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 be given 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.

In the instant case the complainant did not establish that the opposite parties have performed any breach of these duties which gives right of action for negligence to the patient.

The Apex Court in *INDIAN MEDICAL ASSN. v. V.P.SHANTHA* (1995) 6 SCC 651 the court approved a passage from *Jackson and Powell on Professional Negligence* and held that;

"The approach of the courts is to require that professional men should possess a certain minimum degree of competence and that they should exercise reasonable

care in the discharge of their duties. In general, a professional man owes to his client a duty in tort as well as in contract to exercise reasonable care in giving advice or performing services."

Supreme Court then opined as under:

"The skill of medical practitioner differs from doctor to doctor. The very nature of the profession is such that there may be more than one course of treatment which may be advisable for treating a patient. Courts would indeed be slow in attributing negligence on the part of a doctor if he has performed his duties to the best of his ability and with due care and caution. Medical opinion may differ with regard to the course of action to be taken by a doctor treating a patient, but as long as a doctor acts in a manner which is acceptable to the medical profession and the court finds that he has attended on the patient with due care, skill and diligence and if the patient still does not survive or suffers a permanent ailment, it would be difficult to hold the doctor to be guilty of negligence."

To sum up, based on the evidence and the pleadings put forward and also the medical evidence on record, we see no negligence on behalf of the opposite parties and this complaint is liable to be dismissed. We also observe that no cause of action can arise against opposite party No. 4 who expired during the pendency of the complaint. In the result this complaint is dismissed without costs."

FINDINGS

68. It is well settled law, that in the case of medical negligence initial burden to prove medical negligence lies on the complainant. Mere averment in the complaint, are not evidence. Just a bald statement cannot be accepted as held by Hon"ble Supreme Court in the following cases; " i. C.P. Sreekumar (Dr.) M.S. (Ortho) Vs. S. Ramanujam, (2009) 7 S CC;

ii. Nizam Institute of Medical Sciences Vs. Prasanth S. Dhananka & Ors.; 2009(3) CPR 81 (SC) and

iii. Jacob Mathew Vs. State of Punjab & Ars., 2005(3) CPR 70 (SC)"

69. It is also well settled law as observed by Hon"ble Apex Court in Kusum Sharma and Others Vs. Batra Hospital, 2010 (1) CPJ 29(SC) that; "Negligence cannot be attributed to a doctor so long as he performs his duties with reasonable skill and competence. Merely because doctor chooses one course of action in preference to the other one available, he would not be liable if the course of action chosen by him was acceptable to the medical profession. Medical practitioner would be liable only when his conduct fell below that of the standards of a reasonably competent practitioner in his field."

70. Further, in " Martin F. D" souza vs. Mohd. Ishfaq ", 2009 CTJ 352 (Supreme Court) (CP) Hon"ble Supreme Court was pleased to observe:-

" 41. A medical practitioner is not liable to be held negligent simply because

things went wrong from mischance or misadventure or through an error of judgment in choosing one reasonable course of treatment in preference to another."

" 49. When a patient dies or suffers some mishap, there is a tendency to blame the doctor for this. Things have gone wrong and, therefore, somebody must be punished for it. However, it is well known that even the best professionals what to say of the average professional, sometimes have failures. A lawyer cannot win every case in his professional career but surely he cannot be penalized for losing a case provided he appeared in it and made his submissions."

71. Similarly, in *Malay Kumar Ganguly vs. Sukumar Mukherjee (Dr.) & Ors.* III (2009) CPJ 17 (SC) it was held as under:

"35. Charge of professional negligence on a medical person is a serious one as it affects his professional status and reputation and as such the burden of proof would be more onerous. A doctor cannot be held negligent only because something has gone wrong. He has also cannot be held liable for mischance or misadventure or for an error of judgment in making a choice when two options are available. The mistake in diagnosis is not necessarily a negligent diagnosis."

72. It is an admitted case of the appellants, that deceased was earlier admitted in Jaya Nursing Home at Narayanaguda, Hyderabad on 5.3.2003 at about 10.00 a.m. A-1 came from New Delhi around 8.30 p.m. and found that the said Nursing Home was not having ultrasound facility to check fetal well-being.

73. Thereafter, A-1 consulted PW-2 who took A-1 to R-3 at Woodland Hospital, Barkatpura, Hyderabad around 10.15 p.m. for advice. It is also appellants' case, that R-3 directed for shifting the deceased immediately to R-2 hospital, where ultrasound facility was available and R-3 instructed over telephone to R-4 to admit the deceased. Thus, deceased was shifted to R-2 hospital in an emergent situation. It is also an admitted fact, that no treatment details of Jaya Nursing Home were provided from the period deceased became pregnant by the appellants at the time of admission of deceased in R-2 hospital. Therefore, adverse inference has to be drawn against appellants.

74. The deceased was admitted in R-2 hospital at about 11.30 p.m. on 5.3.2003 only after A-1 had consultation with PW-2. In R-2 hospital, R-4 examined the patient and opined, that ultrasound examination is not necessary as there was sufficient amniotic fluid and normal vaginal and delivery of baby would occur within three hours. OP-4 also stated, that they have administered epidural analgesia for relief of labour pains, since patient complained of pain during vaginal examination.

75. Thus, deceased was shifted by A-1 from Jaya Nursing Home on the sole ground, that Jaya Nursing Home was not having ultrasound facility to check fetal well-being.

76. A-1 in cross examination admitted, that Jaya Nursing Home did not advise

his in-laws to shift deceased from Jaya Nursing Home and he got the deceased discharged from Jaya Nursing Home, against medical advice.

77. As per case record of Jaya Nursing Home, the expected date of delivery was 14.3.2003 and A-1 was having hypertension and deceased was being diabetic. On 5.3.2003 at 10.00 a.m., deceased was admitted for delivery in Jaya Nursing Home. The deceased was complaining of draining since morning. As per monitoring chart of Jaya Nursing Home, deceased was having fluctuating blood pressure on 5.3.2003 as 140/100 bpm, 130/90 bpm, 130/100 bpm and 120/100 bpm. After admission in R-2 hospital, A-1 remained throughout with deceased even in the labour room., except for a brief period when deceased was taken to the operation theatre, till her death.

78. As per A-1, at about 3.00 a.m. fetal distress was noted with fetal heart rate frequently going down to 80 bpm per minute from 140 bpm. Thus, till 3.00 a.m. condition of the deceased was stable while being in the labour room. It was only about 3.15 a.m. the fetal heart rate was 110 bpm, which was less than normal. Then certain drugs, were administered to the deceased . It

is also A-1's case, that at 3.40 a.m. deceased was shifted to the operation theatre where later on she died at 5.30 a.m.

79. In cross examination A-1 has stated, that his wife was about 37 weeks pregnant at the time of admission and he was not aware of the facilities at Jaya Nursing Home. He never accompanied his wife at any point of time for anti-natal check ups. Further he stated that delivery was induced in the morning and as there was no progress the drip given for inducing delivery was stopped. Since, there was not much progress, therefore he wanted to take a second medical opinion till what time one can wait for a normal delivery through induction or when a caesarean delivery can be done and whether ultra sound was necessary. These are all improvement made by PW-1 in his cross-examination, as this was never the case of appellants as per their complaint .

80. With regard to cause of death, A-1 in cross-examination has stated that he was not informed about the cause of death of his wife. Since, he was in a state of shock, he did not make any attempt to know the cause of death. He also did not make any complaint to any authority suspecting the cause of death. Thus, again A-1 has made improvements in his evidence and has contradicted its own case, as per averments made in the complaint.

81. Regarding tempering of the case sheet, A-1 has stated that he is of the opinion that case-sheet was tempered, because the death certificate and the death summary issued by R-2 do not mention any cause of death. Therefore, A-1 simply on the basis of his own opinion, is alleging that there was tempering of the case sheet. But there is no cogent evidence to this effect. With regard to autopsy, A-1 admitted, that he has not given notices to the respondents with regard to non-conducting of the autopsy.

82. A-1 has admitted in his cross examination, that he did not object for administering epidural labor analgesia. A-1 also admitted in his statement, that he knew R-5 (Dr. S. Sudhakar) for last 15 or 16 years and both of them were class mates in the Intermediate. A-1 has also admitted, that he went to R-3 on the advice of PW-2.

83. It would be pertinent to observe here, that in the cross-examination of A-1, following question was put to him and the answer given by A-1 in this respect is reproduced as under; Q: You have prepared the chief affidavit on your own? A: Yes after consulting senior doctors, text books from the library and with the help of my counsel.

84. As per above answer given by A-1, it clearly shows, that A-1 is a tutored witness. He has not filed his affidavit by way of evidence on his personal knowledge. On the other hand, A-1 has filed affidavit of his evidence, only after consulting senior doctors, textbooks from library and with the help of his counsel. Therefore, legal brain had been working behind A-1 in filing the affidavit by way of evidence filed by him. Under such circumstances, not much credence can be given to such type of evidence.

85. Now coming to the evidence of PW-2, who has stated, that at 10.15 PM he took A-1 to R-3 for advice who was at that time at Woodland Hospital, Hyderabad. He admitted that R-4 who examined the deceased, had opined that ultra sound examination is not necessary as there was sufficient amniotic fluid and deceased was in active labor. PW-2 also stated that he brought R-3 to

the hospital at 11.45 PM and R-3 concurred with the diagnosis and course of treatment suggested by R-4. Further, after deceased had walked into the labour room, he left for his home.

86. PW-2 also stated, that he is not aware about the facilities available in R-2 hospital. However, PW-2 admitted, that he took the initiative to meet R-3 by calling her over the phone. PW-2 also stated, that after he entered the operation theatre, only there after 2 to 3 minutes the deceased had convulsions. PW-2 had admitted that deceased suffered cardiac arrest subsequently. PW-2 also admitted, that deceased was intubated prior to cardiac arrest and the consequence of events were within a few seconds and as such, it is difficult to state, which came first and later. PW-2 also admitted, that cardiac arrest after series of other complications, is a terminal event. PW-2 also admitted, that they did not demand for autopsy as they were in a state of shock. PW-2 also admitted that AFE is a rare obstetric problem with great variation in the clinical picture.

87. In the light of above principles of law laid down by the courts, first question for consideration is; (1) Whether consent taken in this case was proper or not?

88. It is the case of appellants, that consent form was a generalized form taken during the time of admission and not taken prior to epidural analgesia. No pre-anesthetic check up was done to ascertain whether the deceased was fit to

undergo labour analgesia or not and same was administered without proper consent. Thus, consent was mechanically obtained without explaining the procedure and consequences of administering epidural analgesia and it was a generalized consent.

89. On the other hand, it is respondents' case that A-1 being a qualified medical doctor though not practicing, had signed the consent form for labour analgesia in the presence of PW-2 after having elaborate discussions with respondents., R-4 was a qualified Obstetrician who had taken the consent. Respondents also explained to A-1 and deceased, about the procedures, advantages and disadvantages and complications of labour analgesia.

90. In this regard, A-1 has deposed as under; "It is true to suggest that I have signed a consent form. My wife has also signed the consent form but the consent form is a generalized consent and it is not particular to epidural analgesia. In the consent form epidural analgesia was not there and it was subsequently added. I do not remember whether I have stated so in the complaint or not. I signed on the blank form having trust on the doctors in the hospital."

91. As observed above, A-1 himself is a qualified doctor and deceased was also an educated person. If consent was mechanically taken by the respondents, then A-1 and deceased could have made note in this regard on the consent form itself. As per complaint, it is nobody's case that PW-1 signed the blank consent form having trust in the doctors of R-2 hospital. It is well settled, that persons can tell lie but documents cannot. Now after signing the consent form with open eyes, it does not lie in the mouth of PW-1 to discard the consent form duly signed by him.

92. The State Commission in its impugned order has reproduced the consent form. As per the consent form, it is manifestly clear that A-1 and deceased signed the same. Further, in the consent form it has been clearly mentioned that it is for "Epidural analgesia". It would also be pertinent to note, that A-1 remained with deceased throughout in the hospital, except for a brief period. So, it cannot be said that consent of deceased was obtained at the back of A-1. There is nothing on record to show, that A-1 who had been guiding the doctors in the labor room and was having consultation with them, did raise any objection with regard to terms of the consent form. Now, the story put forward by appellants in this regard, is clearly an after-thought. Nothing stopped A-1 from not signing the consent form, if he had any doubt about the same. Therefore, I have no hesitation in holding that consent was given by A-1 and deceased, on their free will and consent was obtained after following the due procedure and A-1 and deceased had signed the consent form with open eyes. Now appellants cannot shift the blame on the respondents.

93. Copy of admission form and Progress sheet of deceased after her admission in R-2 hospital, are reproduced as under;

OBSETRIC ADMISSION FORM

"Name : Mrs. Srilatha

Age 25 yrs Date : 5/03/03

Time : 11.45 PM

I.P. No .967

Consultant : Dr. Malathi

Complaints : Draining P/V Since morning 8 AM

Admitted at Jaya Nursing Home

Treatment details not available

G1 P L A D

LMP: 07:06:02

EDD:14:03:03

SCAN: EDD:

GA:38+

Previous History :

Antenatal Checkups : with Suvarna Ramaswamy

Immunisation : Yes

Previous Admission : Nil

Complications : Nil

Past History

Medical : Nil

Surgery : Nil

Family History:

General Examination

Temp :N

PR :98/Min

BP :110/80

RR :N

Pallor :-

Icterus : -

EDEMA :-

Varicose Veins: -

Heart:

Lungs :

Breast:

Liver/Spleen: -

Knee Jerks: -

Urine output : -

Weight Gain: -

Obstetric Exam :

Fundal Height : Term

Presentation : Cephalic

Position : LOA

FHR : +142/Min

Liquor : Adequate

Crichton"s Level :3/5

Vaginal Exam:

Cervical Effacement : DE Position :LOA Midposition Consistency : Soft

Dilatation : 3-4 cm

Membranes : +bulging fore waters

Presenting Part : Vx

Station : 2 -1

Pelvis : adequate

Liquor :

No draining

Diagnosis : Primi with FTP in active labor with ? HROM.

Investigation:

Blood Grouping & typing : O+ve

HIV : -ve

Hbs As : -ve

Hb% : 13.9gm18/2/03) 12.1gm(10/12/02)

Urine C/S sterile(10/8/02)

Treatment Instructions:

Consultant Dr. Malathi Informed

1. Enema
2. Prepare
3. NST
4. Hydrate 2 RL
5. I.V. Refin 1 gm BD
6. Rantac + Zofer
7. Epidural

PROGRESS SHEET

Anesthesia notes

6/03/03 Labour Analgesia for vaginal Delivery

12:15

AM Pt C/s AsAg II

PR 90/min

BP :120/80 H/L : NAD

Time----- PR----- BP-----Drug

12:30 AM 92/min 130/80 10 cc of 1% lignocaine + fentanyl 50ug

1:00 AM 90/min 110/80 4 cc of 0.25% Bupivacaine

1:30 AM 90/min 110/80 4 cc of 0.25% Bupivacaine

2:00 AM 90/min 110/80 6 cc of 0.125% Bupivacaine

2:30 AM 90/min 110/70 4 cc of 0.125% Bupivacaine

Pt. Alert, Hemodynamically stable, Cx d 9 cm

3:00 AM Syntocinon stopped

4:00 AM Pt. Suddenly decreased level of consciousness, breathlessness, supplemental oxygen given Persistent progressive cyanosis

Pt. Shifted to O.T. Fetal bradycardia

4:10 AM hemodynamically unstable : bradycardia, Hypotension Supplemental O₂ alongwith Dopamine started: Atropine 0.3mg/i.v/given, x 3 times

4:15 AM Pt. Had tonic clonic convulsions, Pt. Intubated and 100%

O2 administered through Boyles machine

ACLS continued, External Cardiac massage continued

Pharmacological support

Inj Atropine 0.3 mg x 5 times IV given

Inj Adrenaline 1 mg x 5 times IV given

2 mg Endotracheal

4:30 AM Persistent cyanosis Heart rhythm idiosyncratic with wide QRS complex.

4:40 AM Persistent hypotension inspite of high dose of dopamine and IV fluids
ACLS continued

5:10 AM ECG showed wide QRS complex ACLS continued Inj NaHCO₃ 50 mg/IV/
Given

5:20 AM Pupils dilated and fixed No pulse No BP Foetus insitu ACLS continued

5:30 AM Pt. Declared dead to PT Attendant as patient could not be revived after
ACLS for 45 minutes.

Cause of death : Cardio-pulmonary arrest

Antecedent cause: Amniotic fluid embolism"

94. As per above documents, respondents have not hid any facts about the treatment given to the deceased. The cause of death has been mentioned clearly as "AFE". According to all medical literatures "Amniotic Fluid Embolism" is a rare but severe complication of pregnancy. Entry of amniotic fluid into the maternal circulation was first described in 1926 by J.R. Meyer. However, the first recorded maternal death from AFE was not until 1941. The true incidence of AFE, however, is difficult to determine because the diagnosis of this syndrome remains one of exclusion, with possible underreporting of nonfatal cases. On the other hand, it is possible that AFE is over-diagnosed for medicolegal reasons, since this complication is widely considered to be an unavoidable cause of maternal death.

95. Section VII Common complications of Pregnancy Text Book of Williams 21 edition, it describes Amniotic Fluid Embolism as a complex disorder with abrupt onset of hypotension, hypoxia and consumptive coagulopathy. There is great individual variation in its clinical

presentation. Classically a woman in the late stages of labour or immediately postpartum begins gasping for air and then rapidly suffers seizure of cardiopulmonary arrest seizure or cardiopulmonary arrest complicated by disseminated intravascular coagulation massive haemorrhage and death. There appears to be great variation in clinical presentation of this condition.

Pathogenesis: Amniotic fluid enters the circulation as a result of a breach in the physiological barrier that normally exists between maternal and fetal components. In most cases these events are innocuous. In certain woman however such exposure initiates a complex series of physiological reactions mimicking those seen in human anaphylaxis and sepsis.

Diagnosis : Is generally made by identifying clinically characteristic signs and symptoms.

Management : There are no data that any type of intervention improves maternal prognosis with amniotic fluid embolism. In undelivered woman suffering cardiac arrest consideration should be given to emergency perimortem caesarean section in an effort to improve newborn outcome. However, for the mother who is haemodynamically unstable who has not suffered arrest such decision making becomes more complex.

Prognosis : Wiewen (2000) has provided preliminary data from 38 cases in the Suzhou region of China, and almost 90 percent of these women died. Death can be amazingly rapid, and of the 34 women who died in the series from China, 12 died within 30 minutes.

96. Thus, there is no doubt in the present case, that deceased has died due to "AFE". Further, as per above medical literature, "AFE" is a rare but severe complication of pregnancy. The incidence of "AFE" is difficult to determine and death can be rapid. Therefore, I am in complete agreement with the detailed reasonings given by the State Commission in its order, in which it had considered all the relevant medical evidence and literature on the points in issue. I fully concur with the decision of the State Commission, that deceased had died due to Amniotic Fluid Embolism and there has been no medical negligence on the part of R-1 to R-6.

97. Lastly, it is an admitted fact, that A-2 had initiated also criminal proceedings against R-1 to R-6, vide C.C. No.171 of 2014 before Chief Metropolitan Magistrate, Hyderabad. In the said case, charge-sheet was filed under Section 304A of IPC etc.

98. Thereafter, R-3 as well as R-5 filed Petitions (No.5056 and 5077 of 2014) respectively, under Section 482 of Cr.PC for quashing before High Court at Hyderabad.

99. The High Court vide its common order dated 25.6.2014, allowed those criminal proceedings and quashed the proceedings in C.C. No.171 of 2014 on the file of Chief Metropolitan Magistrate, Nampally in respect of R-3 and R-5. The High Court in its order observed;

"Here in this case, there is absolutely no evidence to show the cause of death, as no Post Mortem was conducted. It is not in dispute that complainant is a senior advocate and the husband of the deceased is a senior bureaucrat and both of them have not insisted for Post Mortem and took the dead body and they have

not raised their little finger nearly for

about one year and this aspect would show the malafide intention of the complainant in order to harass the petitioners. It is also not in dispute that complainant has urged in the grounds of appeal before the National Consumer Disputes Redressal Commission, that Post Mortem is a must to know exact cause of death. Admittedly, there is no Post Mortem and therefore, there is no material to know the cause of death. Coming to Sworn statements of four doctors, they are only opinion expressed by them on the basis of case sheet. When Medical Council of Andhra Pradesh and Medical council of India basing on the same case sheet by taking into consideration opinion of experts in the field who are independent and unbiased held that there is no negligence on the part of these two doctors and therefore, the allegations in the complaint are only allegations which are not supported by any acceptable and legal evidence."

High Court further observed;

" In MALAY KUMAR GANGULY Vs. DR. SUKUMAR MUKHERJEE AND OTHERS

., Honourable Supreme Court formulated certain points to be determined by the courts while fixing individual liability of doctors observed as follows:

There cannot be, however, any doubt or dispute that for establishing medical negligence or deficiency in service, the courts would determine the following:

(i) No guarantee is given by any doctor or surgeon that the patient would be cured.

(ii) The doctor, however, must undertake a fair, reasonable and competent degree of skill, which may not be the highest skill.

(iii) Adoption of one of the modes of treatment, if there are many, and treating the patient with due care and caution would not constitute any negligence.

(iv) Failure to act in accordance with the standard, reasonable, competent medical means at the time would not constitute a negligence. However, a medical practitioner must exercise the reasonable degree of care and skill and knowledge which he possesses. Failure to use due skill in diagnosis with the result that wrong treatment is given would be negligence.

(v) In a complicated case, the court would be slow in contributing negligence on the part of the doctor, if he is performing his duties to the best of his ability. Bearing in mind the aforementioned principles, the individual liability of the doctors and hospital must be judged.

Both State Consumer Disputes Redressal Commission and the State Medical Council found that there is no negligence on the part of doctors and the patient died due to Amniotic Fluid Embolism. There is no Post Mortem examination and the cause of death is not known except the presumptions and assumptions of the complainant. Even the sworn statements of four doctors is only their opinion in

respect of case sheet, which document was already considered by Consumer Disputes Redressal commission and State Medical Council and Medical Council of India in respect of A.1., the Consumer Redressal commission and State Medical Council of India in respect of A.3 and these forums after

considering the opinion of experts in the field found that there was no negligence of any kind on the part of these two doctors. Further from the material, it is clear that petitioner i.e., A.1 is not a residential doctor of Shalini Maternity Hospital and she only accommodated as she was requested by one of her colleague who happened to be classmate of husband of deceased.

It is not in dispute before this court that the inherent jurisdiction of Section 482 Cr.P.C. can be exercised to quash proceedings in an appropriate case either to prevent abuse of process of court or otherwise to secure the ends of justice. Abusing the process of court is a term generally applied to a proceeding which is wanting in bonafides and is frivolous, vexatious and oppressive. In other words, it is a word used in connection with action for using some process of court maliciously to the injury of another person. Simply stated abuse of process of courts would mean an improper use of legal process with a view to obtain unfair advantage or undeserving benefit.

Taking the facts and circumstances of the case and the material filed along with quash petition and the principle laid down by Supreme Court into consideration, I am of the view that there is no material showing gross negligence or recklessness on the part of these two petitioners for the death of deceased and the ingredients of Section 304-A I.P.C. are not at all attracted, against the petitioners.

Here in this case, the material relied on by the petitioners is definitely sound reasonable and would rule out the assertions that are made in the complaint against them. Therefore, applying the four steps that are indicated by Honourable Supreme Court in the above referred decision to the facts of this case, I am of the view that this is a fit case to exercise powers of this court under Section 482 Cr.P.C. to prevent abuse of process of court and also to save precious time of the court.

For the reasons stated supra, both the Criminal petitions are allowed and proceedings in C.C.No.171 of 2014 on the file of the Chief Metropolitan Magistrate, City Criminal Courts, Nampally are quashed, in respect of petitioners i.e., A.1 and A.3.

As a sequel to the disposal of this Criminal petition, the Miscellaneous Petitions, if any, pending, shall stand dismissed."

100. Special Leave Petition filed by appellants against above order of High Court, was also dismissed by Hon"ble Supreme Court.

101. Further, an enquiry was conducted against R-5 by Professor of Anaesthesia, Health, Family and Welfare, Government of Telangana. In that enquiry, R-5 was

also exonerated. The copy of enquiry report is reproduced as under;

"With reference cited above, I have conducted enquiry with the Anaesthesiologists who had administered anaesthesia to the wife of Sri K. Srikar Reddy, who died on 6.3.2003. Their statements were taken with their signatures on 2.1.2004.

The pregnant wife of Sri K. Srikar Reddy, was admitted at Shalini Hospital, Barkatpura, for delivery on the night of 5.3.2003. The patient and her husband was explained by the Anaesthetist and attending Obstetrician for painless delivery by continuous epidural analgesia. The husband of the patient also agree for continuous epidural analgesia. She was examined by Anaesthetist. She was found absolutely normal. Her BP and PR were normal. No cardiovascular or respiratory diseases were found. Investigations were found normal. She was ASA Grade I. Under aseptic conditions, epidural needle was passed in epidural space and a catheter passed.

At 12:15 A.M., 1 dose of 10 ml. of 1% Xylocaine with 50 mcg of Fentanyl was given. The effect and extent of analgesia was assessed. BP and PR were monitored. Then 4 ml. of 0.25% Bupivacaine were given at a gap of half an hour upto 1:30 A.M. After that 4 ml. of 0.125% of Bupivacaine was given upto 2:30 A.M. at a gap of half an hour. Again 4 ml. of 0.125% Bupivacaine was given upto 2:30 A.M. at a gap of half an hour. The patient was alright upto 3:55 A.M. No hemodynamic changes were noticed till 4 A.M. Respiration was normal. The patient was conscious and coherent.

At 4:00 AM the patient suddenly developed breathlessness and cyanosis. On examination, PR-60/mn, BP-90/60. At that time the patient was conscious and coherent and responding to verbal commands. The remedial measures were taken immediately: 100% oxygen was given by face mask. Dopamine drip started, Inj. Atropine 0.3 mg. IV given. In spite of these measures, there was no improvement in patient's condition. At 4:10 A.M., the patient developed clonic convulsions. Then endotracheal intubation was done and 100% oxygen given at 4:20 A.M. Cardiac arrest occurred in spite of these measures. ACLS was done. Inj. Adrenaline 1 mg. was given 5 times ECM done. The patient died at 5:30 A.M.

As per the statement of Anaesthetist and my enquiry, it shows that they have not given overdose of anaesthetic drugs and what they have given was suboptimal dose. It only causes analgesia not anaesthesia. So my inference after going through all these things, it may not be death due to anaesthetic drugs overdose. May be some obstetric cause with embolism (Amniotic). As Autopsy was not conducted at that time, I can not pin point the cause of death. The cause of death may be any of one of the following;

1. Embolism (amniotic fluid embolism)
2. Pulmonary Embolism

3. Silent Myocardial infarction."

102. In view of the above facts and circumstances of the case, application filed by the appellants for filing additional affidavits of experts is not maintainable at this appellate stage.

103. Before parting with, I must make a mention that it is an unfortunate case where deceased had died at the operation table at the time of delivery. However, no fault lies at the door of the respondents. Most of doctors involved in the treatment, when the deceased was brought for R-2 hospital were not there. Some of the doctors being acquaintance of A-1 and PW-2, immediately rushed to R-2 hospital in the dead of night. They all made efforts to the best of their ability and capability for about 5 hours to have the safe delivery. In addition, no fee nor any amount whatsoever was charged by any of the respondents (no.1 to 6) from any of the appellants. Unfortunately due to unforeseen complications, they failed in their mission and deceased died at the operation table itself.

104. Therefore, looking from any angle, I do not find any medical negligence on the part of any of the respondents. Hence, no fault can be found with the well reasoned order passed by the State

Commission, which has considered all the aspect of the case in great depth. I fully concur with the reasoning given by the State Commission and find no reasons to disagree with the same.

105. Consequently, I hold that as there is no infirmity or illegality in the impugned order and as such, the present appeal stand dismissed.

106. Parties shall bear their own cost.