
(2002) 02 KL CK 0039
In the High Court Of Kerala
Case No : A.S. No. 395 of 1994

Leela Bai

APPELLANT

Vs

Sebastian

RESPONDENT

Date of Decision : 18-02-2002

Acts Referred:

Citation : (2002) 2 ACC 386 : (2003) ACJ 588 : AIR 2002 Ker 262 : (2002) 1 ILR (Ker) 500 : (2002) 1 KLJ 386

Hon'ble Judges : S. Sankarasubban, J; R. Bhaskaran, J

Bench : Division Bench

Advocate : K. Ramakumar and Sreelal N. Warriar, for the Appellant; P. Jayasankar, Government Pleader and M.V. Mathew, for the Respondent

Judgement

S. Sankarasubban, J.—Both these appeals are filed against the judgment and decree in O.S. No. 102 of 1988 of the Additional Sub Court, Alppuzha. While A.S. No. 395 of 1994 is filed by the first defendant, the other appeal, A.S. No. 694 of 1994 is filed by the second defendant. The suit was filed for compensation by the husband of one Elsamma on his behalf and on behalf of the minor daughter.

2. According to the plaintiffs, Elsamma was admitted in the Women & Children Hospital, Alppuzha at 2 P.M. on 22.4.1985 for delivery. At about 8.20 P.M. she gave birth to the second plaintiff. In the night by about 9.30 she started bleeding. The duty Doctor removed the patient to the operation theatre for an emergency operation. The first defendant was the Doctor-in-charge of the hospital on that day. The first respondent was called. She came to the hospital late. Thereafter, it was decided to refer her to the Medical College Hospital, Alppuzha. There she was admitted at 2 P.M. After the operation was over, she never regained consciousness and she was declared dead at about 7 A.M.

3. The case of the plaintiff is that Elsamma died due to the negligence of the first defendant. According to the plaintiffs, it was because of the delay caused in referring the patient to the Medical College Hospital that the death occurred. Further, it was stated that after preparing Elsamma for operation in the Women &

Children Hospital without any basis the first defendant waited and did not allow the surgeon of the hospital to conduct the operation.

4. First defendant file a written statement denying that there was any negligence on her part. She contended that after the delivery, she saw the mother and child. She went home. She was called by amount 10.00 P.M. Immediately she came and gave medicine to stop bleeding. It was then decided to conduct operation to remove the uterus. The patient's blood was O-. That was not available. When she was taken to the operation theatre, it was found that there was no Anaesthetist in the hospital. Even though the Doctors present were prepared to give oral ether on expert consultation, it was found that oral ether cannot be administered to the patient as the patient was suffering from Asthma. Hence, it was decided to refer the patient to the Medical College Hospital. The first defendant contended that there was no delay on her part. She has stated that as soon as she was informed, she came to the hospital and examined the patient. She called the Physician to find out whether the patient can be operated on. Since the Anaesthetist of the hospital was not available, she called the Anaesthetist of the District Hospital. He gave opinion that the patient cannot be operated in the District Hospital and it has to be done in the Medical College Hospital. It was in that circumstance that the patient was referred to the Medical College Hospital, Alappuzha. The second defendant also contended that there was no negligence on the part of the second defendant.

5. The Court below, after going through the evidence, found that there was delay on the part of the first defendant to send the patient to the Medical College Hospital. If the patient was taken to the hospital earlier, she would have been survived. The court decreed the suit for an amount of Rs. 1,37,750/-. The decree was allowed to be recovered from the defendants. It is against the above decree that the above two appeals have been filed.

6. Sri Sreela N. Warriar appearing for the first defendant/appellant in A.S. No. 395 of 1994 contended that the entire approach made by the court below is erroneous. He contended that a professional is expected to exercise his/her duty with due care and caution. Even after the duty is exercised with due care and caution, patient dies, the Doctor cannot be mulcted with the negligence. Learned counsel contended that the evidence in this case will show that the first defendant had promptly arrived at the hospital and had seen the patient and also administered the necessary medicine to bring down the pressure. Since it was the first delivery, the decision to conduct operation for removing the uterus was not taken immediately. All the Doctors are of opinion that in such cases, the first attempt will be to be seen whether the bleeding can be stopped by any other way. It was the attempt that was made by the first defendant. But when it was found that the condition of the patient became serious, the Doctor decided for the operation. Immediately, the Chief Physician was called to find out whether the patient was medically fit for operation. The patient's relatives and others were asked to get the necessary blood, which was O-. It was found that all the

preparations were made for operation. Then it was found that the Anaesthetist of the hospital was not available.

7. It is true that PW3 had said that she used to give ether anaesthesia. But the learned counsel contended that PW3's evidence will show that she does not know anything about anaesthesia. When the qualified Anaesthetist was not available, the first defendant called Dr. Mallan, Anaesthetist of the District Hospital. It is true that Dr. Mallan was the husband of the first defendant. But that does not mean that the first defendant cannot call for the service of the Anaesthetist of the District Hospital. Dr. Mallan opined that the seriousness of the patient requires anaesthesia to be given by a qualified Anaesthetist. It was in such circumstances that the patient was referred to the Medical College Hospital.

8. Sri. Warriar further contended that the cause of death is not disclosed. The patient was alive when she was taken to the Medical College Hospital. The records of the Hospital show that the patient did not recover from anaesthesia. The death may be due to the negligence in the operation table of the Medical College Hospital or it may be due to various reasons. No post-mortem was conducted to find out the reasons for the death. To attribute the cause of death merely the delay in sending the patient to the Medical College Hospital is without any basis.

9. Sri. Jayasankar, learned Government Pleader appearing on behalf of the Government in the appeal submitted that all that was possible was done to the patient. It is true that the qualified Anaesthetist of the hospital was not available. In such circumstances, it was right on the part of the first defendant to call for the opinion of Dr. Mallan. It cannot be said that too much delay was caused. After all, it is a case where a major operation was necessary. That decision cannot be taken without taking into account all the possibilities. Without a qualified Anaesthetist, such an operation cannot be conducted in that hospital. That opinion is binding on the Doctor and in such circumstance, the patient was referred to the Medical College Hospital. He also contended that since the patient died in the Medical College Hospital, negligence of the first defendant cannot be inferred unless there are strong circumstances for it. Both the counsel contended that the compensation awarded is high.

10. Learned counsel for the plaintiffs Sr. M.V. Mathew submitted that the patient came for delivery at 2 P.M. and delivery took place at 8.20 P.M. It is the duty of the duty Doctor to find out whether there was any complication. Instead, the first defendant left for her house. According to the counsel, even though PW2 called the Doctor, the Doctor came only after two hours. According to him, it was not proper on the part of the first defendant to have gone back from the decision to operate the patient in the Women and Children Hospital. In fact, PWs. 2 and 3 were prepared for the operation. Counsel contended that Dr. Mallan was not attached to the Medical College Hospital and hence, there was no necessity to call him. He further highlighted the fact that there is no record to show that Dr. Mallan opined that without Anaesthetist, operation cannot be done. Sri. Mathew

then contended that if the Women & Children Hospital Doctors conducted the operation immediately, but for the fact that there was continuous bleeding, the patient's life could have been saved. Hence, he prayed for confirming the judgment and decree of the Court below.

11. In paragraph 25 of the judgment, the lower court correctly addressed the question as follows: "To enter a finding against the defendants, it is not sufficient to prove that there was negligence; it should be proved that the death was due to that negligence". According to the lower court, PW8 Dr. Ajithakumari, Assistant Professor in the Gynaecology Department of the Medical College Hospital, who operated on Elsamma was asked whether the delay was fatal. She answered that it depends on the condition of the patient. Then the court went on to examine the condition of the patient. It held as follows: "Bleeding started at 9.30 p.m. it was not serious. PW7 Dr. Girija Leela also has the same opinion. PW2 could control bleeding. But at 10.30 P.M. again there was complaint of bleeding. This stands proved by Ext. X1 case sheet. The correctness of these facts has not been called into question. The Court has believed the version of PW7 Dr. Girija Leela who is also an Assistant Professor in Gynaecology Department in the Medical College Hospital that hysterectomy is the only remedy when bleeding cannot be controlled. It is done only when it is impossible to stop bleeding by any other method. The first defendant has admitted that at 10.45 P.M. the condition of the patient was serious. In the witness box she stated that if she did not respond to the medicines, hysterectomy was the only remedy. The condition of Elsamma when she was brought to the Medical College Hospital has been proved by PW8 Dr. Ajithakumari. Elsamma was in the stage of collapse and was in shock. PW8 is of the opinion that even at the W & C Hospital Elsamma was serious. Her testimony has not been controverted. When the pleadings of the defendants and the evidence of PW7, PW8 and DW1 are put together it is crystal clear that at 10.45 P.M. the condition of Elsamma was very serious. By 11.15 P.M. her condition became worse". The court then went on to examine the evidence of PW7 and held that if Elsamma had not lost much of her blood, her life could have been saved. What caused to lose her blood? It was nothing but time. From 11.15 P.M. to 1.20 A.M. which is the period she spent in the W & C Hospital after the first defendant understood that hysterectomy was the only remedy, the patient lost much of her blood; she was dying by inches. This is the circumstance which took into consideration by the lower court in coming to the conclusion that there was negligence. But this, the lower court assumed that it is because of the delay that the death had occurred. When we examine the evidence of the parties, it is clear that it is never stated by anybody that it is due to the delay that the death had occurred.

12. Ext. B3 only shows that the patient did not recover from anaesthesia. The question is whether the first defendant was negligent or not. The facts are clear. The delivery of the patient was at 9.00 P.M. and the bleeding was started at 9.30 P.M. PW2 was called and it was controlled. The condition was reported normal at 10.00 P.M. Again bleeding started. It was noticed by PW2 that the bleeding was

uncontrollable. The blood pressure was 100/60. It was about 10.30 P.M. The first defendant was informed by 10.45 p.m. It has come in evidence that immediately on call the first defendant instructed the Doctors for treatment of rising the blood pressure from 60 to 100, medication for better uterus contracting and medication for improving plasma. She also made arrangements to reach the hospital picking PW3. PW3 is the R.M.O. She also came to the hospital along with the first defendant. From the evidence, the following facts are disclosed. The first defendant examined the patient and instructed for securing blood. She consulted with PW.2 and 3. Then Dr. Saiffudin was called. Dr. Saiffudin came and examined the patient. Then he noted the patient and found that the patient was medically fit for the operation. Then it was decided that hysterectomy was necessary and the patient was prepared for surgery. The pre-surgery procedures were also taken by the Doctors. She called the blood bank and other sources for the blood for the patient and they waited for blood. The Anaesthetist was called. The patient's blood was O-, which was not available. Instead, one bottle O+ was made available. It was given on the advice of Dr. Mallan and Dr. Saiffudin. Since Anaesthetist was not available, Dr. Mallan was called by PW1. Dr. Mallan examined the patient and noted that the patient was asthmatic and lack of required O- blood and also the complications for open drop ether anaesthesia. There was absence of alternative method of anaesthesia and difficulty in the management of complications of open drop (ether) method and also risk of failure at the Women and Children Hospital. The Doctors discussed this and then the first defendant decided to refer the patient to the Medical College Hospital. According to the first defendant, the patient was taken by 12"O Clock to the Medical College Hospital. But the reference report says that the patient was referred by 1"O Clock. After referring to the Medical College Hospital, the first defendant made arrangements for taxi to carry the patient and called Dr. Ajithakumari at the Medical College Hospital and discussed the case of the patient and left only the confirmation of the patient reaching the Medical College Hospital. From the evidence of PW7, it is seen that the patient was brought to the Hospital at about 12.50 A.M. and the patient was examined by 1"O Clock by PW7 and gave one bottle of blood and was ready for surgery at 2.30 A.M. and the surgery was done at 3.00 A.M. The patient declared dead at 7 A.M.

13. The above facts show that the first defendant was active from at least 11"O Clock in the night to 1"O Clock till the patient was referred to the Medical College Hospital. Now, the main complaint attributed against the first defendant is that after getting the advice that the patient was medically fit for the operation, she need not have referred the patient. According to the plaintiffs, both PWs. 2 and 3 have stated that they were prepared for operation and do the anaesthesia respectively. The first defendant has an answer to this. According to her, PW2 may do the operation, but there was no qualified Anaesthetist. Since the Anaesthetist was not available, she called Dr. Mallan, who was attached to the District Hospital. There is nothing wrong in calling Dr. Mallan, because he is also a Doctor attached to the District Hospital, which is under the control of

Government of Kerala. We don't find anything wrong in the Doctor consulting with an expert, when Doctor wants to do so. The only thing that was stated against Dr. Mallan is that Dr. Mallan has not written down his opinion. We don't think, the non-noting of the opinion of Dr. Mallan is fatal. In a case of emergency, oral opinion can be taken and there is nothing in this case to show that the first defendant and Dr. Mallan had anything against the patient or her relatives. The lower court has stated that there is variation between pleading and proof. We don't think, that approach made by the Court below is correct. It may not be always necessary to give every details and the steps taken to control the bleeding. The court says that earlier Dr. Mallan had only stated that he wanted the patient to be referred, because blood was not available. But in his deposition, he has stated that he took that view because there was no qualified Anaesthetist.

14. The question is whether the first defendant was negligent or not. Here is a case where the first defendant called Dr. Mallan and Dr. Mallan advised that without a qualified Anaesthetist, the operation cannot be carried on. Can we say, in such circumstances, the first defendant was negligent? According to us, the first defendant cannot be said to be negligent. The first defendant took a decision to refer the patient to the Medical College Hospital, where all the conveniences were available. Can we blame the person because latter took a decision that the patient can be operated more safely in a hospital having better convenience. One cannot say that this decision was wrong.

15. Then the other question is regarding the delay. As we have already stated, nothing has been stated to show that the death was due to the delay. It is true that there was bleeding. But evidence shows that at the time when the patient was discharged from the Women & Children Hospital, her condition was not bad. Whatever that may be, we are of the view that unless there is definite evidence to show that the death was due to the delay of the first defendant cannot be mulcted with the negligence. Hence, we differ from the court below and hold that the negligence on the first defendant has not been proved.

16. Learned counsel for the plaintiffs then submitted that even if the first defendant cannot be said to be negligent, the conditions that existed in Women & Children Hospital and the non-explanation of the cause of death by the Medical College Hospital Authorities show that there was negligence on the part of the second defendant - State of Kerala. Learned counsel submitted that it has now come out in evidence that there was a permanent Anaesthetist in the Women & Children Hospital. It has also come out in evidence that at the relevant time no other Anaesthetist was available. The evidence discloses that there is a rule that Anaesthetist should be available within a particular radius. It seems that on that particular day, e was in Cherthala. This is in violation of the Rules. It is the duty of the Authorities under the second defendant to see that its employees are available in time in the hospital. If for any reason, a Doctor or an expert is not available, the Hospital Authorities would have known it before hand and some other persons should be posted. Here is a case where absence of an Anaesthetist

prevented the surgeon in the Women & Children Hospital to conduct operation on the patient. But if there is every possibility that the Anaesthetist was available and the operation had been conducted early, probably, the patient would have been saved. So also the Medical College Hospital Doctors have not disclosed the cause of death. The patient died within hours and after the operation the patient did not regain consciousness. Inside the operation theatre, admission is restricted to the Doctors, nurses and hospital staff. It is their duty to disclose the cause of death of the patient. Learned Government Pleader submitted that the hospital is only vicariously liable and if the plaintiffs cannot prove that any particular Doctor was negligent, then the liability cannot be mulcted on the State. There are two answers to it. First, the burden is on the second defendant to prove that there was no negligence on the part of the Doctors after the operation in the Medical Hospital. This has not been discharged. It is true that the plaintiff proceeded on the basis that the first defendant was negligent. But that does not mean the second defendant can keep quiet and not disclose to the Court the true cause for the death. The other aspect is, in many of the cases, there has been a tendency to treat the question of a hospital authority's liability not as one of vicarious liability only but also as one of the primary liability of the authority for breach of its own duty to the patient - see *Gold v. Essex County Council* - (1942) 2 K.B. 293 and *Cassidy v. Ministry of Health*, (1951) 2 KB 343. In many cases, a patient who approaches the hospital does not know the Doctors. He/she approaches that hospital because of the reputation of the hospital. Here, the primary responsibility of the Hospital Authorities is to see that there is no negligence on its part or on the part of its officers. The non-praying of a Doctor or Anaesthetist or an assistant is essentially a lapse on the part of the Hospital Authorities and hence, the hospital is negligent. Hence, we are of the view that the second defendant is liable.

17. The next question is with regard to the compensation. The below has awarded a total compensation of Rs. 1,37,750/-. After going through the compensation awarded under each head, we are satisfied that the amount awarded is proper. But, according to us, the entire compensation cannot be given to the father. The father need be given the amount awarded under the head "special damages" Rs. 2,750/-, compensation for loss of consortium Rs. 25,000/- and 1/3rd compensation for future income amounting to Rs. 24,000/- and also Rs. 18,000/- towards compensation for engaging a person to bring up the second plaintiff. Thus, the father is entitled to get Rs. 69,750/-. So far the daughter is concerned, she will be entitled to the compensation of Rs. 20,000/- towards loss of love and affection and 2/3rd of the loss of future income of Rs. 72,000/-. Thus, from the total amount of Rs. 1,37,750/-, the first plaintiff is entitled to get Rs. 69,750/- with interest 6% per annum from the date of decree of the trial court, ie., 22.12.1993 till date of realisation and the second plaintiff is entitled to get a compensation of Rs. 68,000/- with interest at 6% per annum from the date of decree, ie., 22.12.1993 till the date of realisation. The second defendant is made liable for the above amount. The amount due to the second plaintiff is to

be deposited by the second defendant in the Court below, which shall deposit it in a Nationalised Bank as fixed deposit initially for a period of one year and then it can be extended till the second plaintiff attains the age of 20. The interest accrued on the fixed deposit can be withdrawn by the guardian on behalf of the second plaintiff, till she attains majority and after the second plaintiff attains the majority, the interest can be withdrawn by her. After the second plaintiff attains the age of 20, the entire amount can be withdrawn by her by making necessary applications to the Sub Court, Alappuzha. We further make it clear that in case any amount is necessary for the second plaintiff, viz., for her marriage, education or any other necessity, she can apply to the Sub Court for withdrawal of the amount and the Court is free to grant the amount to the second plaintiff, it is satisfied with the necessity. The second defendant-State is directed to deposit the amount within a period of two months from today.

The judgment and decree of the court below are modified to the above extent. Appeals are disposed of.