(2012) 04 NCDRC CK 0027

In the National Consumer Disputes Redressal Commission

Narayan Murty — APPELLANT

Vs

Christian Hospital For Women And Children — RESPONDENT

Date of Decision : 26-04-2012

Acts Referred:

Citation : 2012 0 NCDRC 250 : 2012 3 CPJ 579

Hon'ble Judges : ASHOK BHAN , VINEETA RAI J.

Advocate : K.N.TRIPATHI , MANOJ V.GEORGE , B.D.DAS

Judgement

1. THIS revision petition has been filed by Ch.Narayan Murty and another (hereinafter referred to as ''Petitioners '') who were the original complainants before the District Forum being aggrieved by the order of the State Consumer Disputes Redressal Commission, Orissa (hereinafter referred to as the ''State Commission '') in Appeal No.706/2004. The Christian Hospital for Women & Children and Dr.Sangeeta Padhy are Respondents herein.

2. BRIEFLY stated the facts of the case are that the Petitioners '' daughter (hereinafter referred to as the ''patient '') who was deserted by her husband after she became pregnant, was taken to the Respondent/Hospital in the hope of getting better treatment for which necessary fees was also deposited. After scanning and some other tests etc., her expected date of delivery was estimated to be 29.12.2000 but since she started complaining of labour pains on 04.12.2000, Petitioners got her admitted in the Respondent/Hospital at 5.30 am where she was administered a penicillin injection and given other medicines etc. At about 2.00 pm, the patient suffered severe and intolerable labour pains following which Petitioners gave a written request to Respondents for a Caesarean Operation to ensure safe delivery for the mother and baby but when no heed was paid to this request, Petitioners requested for discharge of their daughter to take her to another hospital which Respondents declined and instead gave a false assurance of this being a normal condition of delivery. At about 3.30 pm, the patient was taken to the labour room where only one doctor and some nursing staff was present and after about half an hour, it was declared that the

patient had died as also the newborn. After the funeral, Petitioners approached the Respondent/Hospital including Respondent No.2 (Dr.Sanjeeta Padhy) being the Superintendent of the Respondent/Hospital for specific information which led to their daughter ''s death but Respondents remained tightlipped or gave evasive replies. Aggrieved by this, Petitioners filed a complaint before the District Forum on grounds of medical negligence and deficiency in service and requested that Respondents be directed to pay the Petitioners, Rs.3 lakhs towards compensation, Rs.1 lakh for loss of their daughter and grandchild, Rs.20,000/- as medical expenses and Rs.20,000/- as expenses towards funeral etc.and such other relief as the Forum may deem fit. The above contentions were denied by the Respondents who stated that the Respondent/Hospital was one of the best of its kind in the country with reputed doctors/specialist and state of the art modern equipments but despite the best medical care unfortunately death of the patient suddenly occurred for which the Respondents cannot be held guilty.

3. THE District Forum after hearing both parties allowed the complaint on the ground that the patient was attended by a doctor who was not qualified or a specialist in Obstetric & Gyaenacology. The District Forum relied on the judgment of the Hon ''ble Supreme Court in Laxman Balkrishna Joshi vs Trimbak Bapu Godbole And Anr - 1969 AIR 128 wherein it has been held that the medical practitioners owes certain duties towards its patients. One such duty is "in deciding whether to undertake the case " meaning thereby that if a doctor feels that he is not qualified or experienced for treating a particular ailment or is not equipped for the same he must not undertake that case. District Forum therefore, directed the Respondents to pay Rs.1,50,000/- each to both the Petitioners towards compensation and Rs.10,000/- each for other expenses within one month of receipt of the order along with interest @ 9% per annum from the date of filing of the case till realization and further litigation cost of Rs.5,000/- failing which the entire amount will carry interest @ 12% per annum.

4. AGGRIEVED by this order, Respondents filed an appeal before the State Commission. The State Commission requested the Head of the Department of Obstetric & Gaenacology, S.C.B. Medical College Hospital, Cuttack to give his expert opinion in the case after examining all the relevant records. The expert in his report concluded that the patient was not provided with adequate services right from the time of admission till her death. However, State Commission did not accept this report by observing that it did not appear to be based on records. The State Commission also observed that a perusal of the order of the District Forum would show that no clear and specific reason was given in support of its finding that the Respondents were guilty of deficiency in service. In view of these facts, the State Commission remitted the matter to the District Forum for re-examination and fresh disposal according to the law. It directed that the Respondent/Hospital should produce the doctors for their examination as also for cross-examination. This revision petition has been filed against the above order of the State Commission remitting the case back to the District Forum. Counsel for both parties made oral submissions. Counsel for Petitioner contended that the

State Commission erred in remitting the case back to the District Forum when there was adequate evidence on record including the expert opinion of the Professor & Head of the Department of Obst. & Gynaecology, S.C.B. Medical College, Cuttack who concluded by giving detailed reasons in his three page report that there was deficiency in the treatment given to the patient which ultimately led to her death. According to the expert, the deceased patient was a high risk case in view of her short height with a big baby and high position of the fetal head which is an adverse situation for a vaginal delivery. He also observed that starting a Pitocin drip to induce labour pain by a non-specialist doctor who anticipated a vaginal delivery without proper pelvic assessment and examination by a gynaecologist to rule out cephalopelvic disproportion was a clear case of misjudgment and deficiency. The conclusive observations of the expert are as follows: "There is no doubt that the Christian Hospital for Women and Children might have specialist doctors, but there is every doubt that the victim in this case has not been provided with services of the O&G specialist from admission till death. That Dr.Sangeeta with a MBBS degree and without any specialization befitting her services for the victim, has come to rescue of the victim on pen and paper only, just one hour before death and seems innocent and is no way connected to the maltreatment of the victim. That this treatment story is ''one man show '' created from 5.30 am on 04.12.2000 till death without any documentation of treatment by doctors at different times and without any record of any specialist care at any point of time before death of the innocent victim. That there is every reason to find the Christian Hospital for Women and Children/ Hospital authority at fault in providing such imaginary treatment to the victim Rajani Pattnaik, whose death could have been prevented by judicious treatment. "

5. ON the other hand, no evidence to controvert these findings had been filed by the Respondents and therefore, the State Commission erred in not reaching a conclusive finding based on the opinion of an expert appointed by it and instead remitted the case to the District Forum. Counsel for Respondent on the other hand stated that the State Commission had given clear and cogent reasons for remitting the case back to the District Forum because from a perusal of the patient ''s history labour-chart it is clear that this was not a ''one man show '' but the patient had been examined by a number of specialist doctors including Dr.Kumudini Chaulia, Dr.D.Rohini Amma and Dr.Puspita Behera who after due examination concluded that there was no cephalopelvic disproportion and hence it was decided to go in for a vaginal delivery.

6. WE have considered the oral submissions of the learned Counsel for both parties and have carefully gone through the evidence on record. We note that the District Forum, as a first court of fact, on the basis of evidence led by both parties had concluded that there was deficiency in service on the part of the Respondents in the treatment of the patient by entrusting the case to a doctor who was not qualified to treat a high risk delivery case. The Head of the Department of Obstetrics & Gyaenacologist, S.C.B. Medical College Hospital, Cuttack who was appointed by the State Commission to give his expert opinion,

has reached a similar conclusion that the Respondent/Hospital by entrusting the case to a doctor without any specialized degree befitting the services required of the patient who because of cephalopelvic disproportion was a high risk case, was clearly at fault. It was further stated by the expert that had she been treated by specialist doctors who were available in the Respondent-Hospital, her death could have been prevented. Detailed reasons have been given by the expert in his meticulous report based on the case history and other documents. Apart from perusing this document, we have also looked at the medical literature on the subject and it is medically well established that cephalopelvic disproportion is one of the major reasons for undertaking caesarian operations in the interest of the safety of mother and her child. The American Pregnancy Association and other medical authorities have further stated that examination by a Gyaenacologist is absolutely necessary in cases of cephalopelvis disproportion and the nature of treatment would depend on the progress of labour in such high risk cases. In the instant case, as noted by the medical expert appointed by the State Commission, due care was not taken at a number of stages. It was e.g. specifically mentioned in his report that adding 3.5 units of Pitocin in the IV drip at 3.30 pm without consulting a specialist was not judicious and aggravated the situation for both the mother and the foetus. The medical expert has also pointed out that the procedure of intubation and ventilation required expert services by an anesthetist but there is no documentation as to who intubated and ventilated the patient. Further when the patient was shifted to ICU, it was not clear whether any ICU doctor attended on her. All these ommissions clearly indicate deficiency and lack of due care and responsibility in treating the case which led to a double tragedy of two deaths. The State Commission despite seeing this detailed report, decided to remit the case to District Forum on the grounds that as per the labour chart, the patient was seen by at least 4 other doctors, 2 of which had necessary specialized qualifications, and the expert failed to consider this aspect. However, we note that as per the affidavits of these doctors, they were not actively involved in the treatment and care of the patient. One of the doctors, Dr.Puspita Behera, for example, has clearly stated in her affidavit that she examined the patient at 9.45 am in a routine ward round and noted that there was no cephalopelvic disproportion. Although, the IP Card at 6.30 am records the short height of the patient with a big baby and high position of fetal head which indicate the potential for cephalopelvic disproportion. The other expert, Dr.Kumudini Chaulia, after examining the patient advised complete bed-rest which appears to be advice of a general nature and not specific to the case. Keeping in view these facts and the detailed opinion of an independent expert appointed by the State Commission, we are unable to comprehend why the State Commission still considered it necessary to remand the case back to the District Forum. It is well settled through a catena of judgments of Hon ''ble Supreme including in Laxman Balkrishna(supra) that a medical practitioner owes certain duties towards the patients and one of such duties is "in deciding whether to undertake the case " meaning thereby that if a doctor feels that he is not qualified or experience for treating a particular disease or is not equipped for the

same he must not undertake that case. In the instant case, this principle was clearly violated and as discussed in the foregoing paras, we are in agreement with the order of the District forum that there was clear deficiency in service and omission on the part of the Respondent/Hospital and its staff in the treatment of this patient which led to a double tragedy which could have been avoided. We, therefore, have no option but to set aside the order of the State Commission and restore the order of the District Forum. The revision petition is accordingly allowed. Respondents are directed to pay Rs.1,50,000/- each to both the Petitioners towards compensation and Rs.10,000/- each for other expenses within one month of receipt of the order along with interest @ 9% per annum from the date of filing of the case till realization and a further litigation cost of Rs.5,000/- failing which the entire amount will carry interest @ 12% per annum.

