NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION
NEW DELHI

FIRST APPEAL NO. 358 OF 2013

(Against the Order dated 04/02/2013 in Complaint No. 2/2008 of the State Commission Kerala)

1. PHILIPS THOMAS & ORS.
S/o Y. Thomas, Thaddathivila Veedu,Managamankala,
Vilakkudi Village, Punalur P.O. Pathanapuram Taluk,
KOLLAM-691 305
KERELA
2. MR. AJU PHILIPS THOMAS
Represented by his father Philips Thomas,
KERELA
3. MS. ANJU THANKAM PHILIPS
Represented by her father Philips Thomas,
KERELA ....Appellant(s)

Versus

1. DEEN HOSPITAL & ORS.
Punalur,
KERELA
2. DR. R.V. ASHOKAN
Proprietor, Deen Hospital,
PUNALUR,
KERELA
3. DR. A. BALACHANDRAN
Deen Hospital,
PUNALUR,
KERELA
4. DR. VINU BALAKRISHNAN
Deen Hospital,
PUNALUR,
KERELA
5. DR. LAILA ASHOKAN
Deen Hospital,
PUNALUR,
KERELA ....Respondent(s)

FIRST APPEAL NO. 662 OF 2013

(Against the Order dated 04/02/2013 in Complaint No. 2/2008 of the State Commission Kerala)

1. DEEN HOSPITAL & 2 ORS. ....Appellant(s)
REPRESENTED BY ITS PROPRIETOR DR. R.V.
ASHOKAN,
KOLLAM DISTRICT
2. DR. R.V. ASHOKAN
PROPRIETOR, DEEN HOSPITAL, PUNALUR

3. DR. A. BALACHANDRAN , DEEN HOSPITAL,
PUNALUR

Versus

1. PHILIPS THOMAS & 4 ORS.
S/O Y. THOMAS, THADATHIVILLA VEEDU,
MANGAMANKALA, VILAKKUDI VILLAGE, PUNALUR
P.O.-691305
PATHANAPURAM TALUK,
KOLLAM DISTRICT
2. AJU PHILIPS THOMAS,
REPRESENTED BY HIS FATHER PHILIPS THOMAS,
THADATHIVILLA VEEDU, MANGAMANKALA,
VILAKKUDI VILLAGE, PUNALUR P.O.-691305
PATHANAPURAM TALUK, KOLLAM DISTRICT
3. ANJU THANKAM PHILIPS,
REPRESENTED BY HER FATHER PHILIPS THOMAS,
THADATHIVILLA VEEDU, MANGAMANKALA,
VILAKKUDI VILLAGE, PUNALUR P.O.-691305
PATHANAPURAM TALUK,
KOLLAM DISTRICT ....Respondent(s)

BEFORE:

HON'BLE DR. S.M. KANTIKAR,PRESIDING MEMBER

FOR THE APPELLANT :

Dated : 06 June 2023

ORDER

Philips Thomas & Ors. : Mr. Saju Jakob, Advocate with

Mr. Arush Gangal, Advocate

Mr. Tessy Varghese, Advocate

Deen Hospital & Ors. : Mr. Raghenth Basant, Advocate

with Mr. Ajay Krishna, Advocate

Pronounced on: 06th June 2023

ORDER

1. This Order shall decide both the First Appeals arising from the impugned Order dated 04.02.2013 passed by the State Consumer Disputes Redressal Commission, Kerala (hereinafter referred to as the "State Commission") in Consumer Complaint No. 2/2008,

wherein the State Commission allowed the Complaint and held the Opposite Parties Nos. 1 to 3 negligent and awarded the total compensation sum of Rs.7,00,000/- out of which Rs.3,00,000/- should be deposited in the name of minor children of Complainant No. 1 along with a cost of Rs.10,000/-.

2. For the convenience, the parties are referred to be as in the Complaint before the State Commission. Deen Hospital, Punalur (OP-1), Dr. R.V. Ashokan, the proprietor (OP-2), Dr. A. Balachandran (OP-3), Dr. Vinu Balakrishnan (OP-4) and Dr. Laila Ashokan (OP-5). OP-3 to 5 were working at OP-1.

3. The issue involves an alleged case of medical negligence concerning Mini Philip (since deceased) a 37 years old patient who underwent laparoscopic sterilization at Deen Hospital, Punalur (OP-1) on 25.09.2006. The surgery was expected to be completed within half an hour, but it took longer than scheduled due to respiratory problems. The patient was later transferred to Poyanil Hospital and then to Ananthapuri Hospital, Thiruvananthapuram. Unfortunately, she was pronounced dead at around 5-5:30 pm the following day.

4. Heard the leaned Counsel on both the sides. The learned Counsel for the Complainant submitted that the cause of death showed that General Anaesthesia and Spinal Anaesthesia were administered on the patient simultaneously. The injection marked on the back of trunk shown in the post mortem was characteristic feature of anesthesia. It was due to negligence of OP-3 & 4 who did laparoscopic sterilization in causal manner. The operation was done casually under supervision of OP-5. The patient was in sound health. He submitted that the brain hypoxia and ARDS because of injuries to the spinal canal where by dura was punctured. The OP-3 administered anesthesia. The OP-3 was not qualified to administer anesthesia as he was not anesthetist. The OP-1 hospital had no accreditation from the Health Department to conduct laparoscopic sterilization on females. Therefore, OP-1 was not competent to conduct laparoscopic surgery. The surgery was not warranted when the patient was ailing from respiratory distress.

5. The OPs filed their joint written version. The patient was managed with care and shifted to higher centre without delay. Everything necessary was done with best of interest of the patient. The OP-5 the gynaecologist was working in OP-2. She explained the patient and her husband about the modality of sterilization. The OP-5 further explained in details about the pros and cons of tubal sterilization and chances of failure. The choice and risks of anesthesia were informed. The patient was taken for operation at 5.30 p.m. under general anesthesia. It was administered with thiopentone and thereafter OP-4 performed laparoscopic surgery. At the end of surgery patient was stable, oxygen saturation was satisfactory on spontaneous respiration. Thereafter, extubation was done. After few minutes patient developed breathlessness and again she was intubated immediately and positive pressure ventilating was done with 100% oxygen. The patient showed signs of pulmonary edema, immediately Lasix inj was administered. The OP-4 & 5 was assisting for OP-3 for resuscitation. The other anaesthetist was called and Bronchodilators and corticosteroids were given in repeated intervals. The endotracheal suction was done throughout, but the oxygen levels remained to 75% to 80%. The pulmonary edema persisted and therefore, the conscious decision was taken to Poyanil Hospital for ventilator support. Thereafter, on 26.09.2006 the patient was shifted to Ananthapuri Hospital the higher center at Trivendrum but on the same evening she expired.

6. The State Commission upon hearing the parties partly allowed the Complaint and directed the OPs 1 to 3 to pay jointly and severally Rs.7 lakh as compensation to the Complainant and Rs. 10,000/- as a cost. The OP-4 & 5 were exonerated from the liability.

7. Being aggrieved, the Complainant filed FA/358/2013 for enhancement of compensation whereas the OP-1, 2 & 3 filed FA/662/2013.

8. I have heard the learned Counsel for the parties. The proprietor of Deen Hospital, Dr. R.V. Asokan was present along with his Counsel. They have reiterated their respective evidence filed before the State Commission.

9. Adverting to the qualification of OP-3 the anesthetist, it is transpired from the evidence that the OP-3 completed one year exclusive senior house residency in anesthesia in the Govt. hospital. She had experience in the field of anesthesia over 25 years. The Travancore Kochi Medical Council allows doctor with MBBS to administer anesthesia. In my view, she was competent to administer anesthesia for minor procedures.

10. The crux of the matter is whether the patient was administered a general anesthesia and/or spinal anesthesia and whether the death was due to spinal anesthesia.

11. It is evident that the patient was taken to OT at 5.30 p.m. The IV line was started using Ringer lactate. On completion of tubectomy surgery the OP-3 slowly performed reversal of anesthesia. However, noticed gradual fall in oxygen saturation. Therefore, the patient was immediately re-intubated and put on 100% oxygen and ventilated. Thereafter the patient was quite satisfactory on spontaneous respiration for some time. The patient became steady and extubation was done. Within few minutes the patient developed breathlessness and again patient was intubated and started IPPV with 100% oxygen. It was suspected the patient developing signs of pulmonary edema. Resuscitation was started, inj bronchodilators and corticosteroids were given in repeated intervals.

12. It is pertinent to note that the PM was performed by Dr. K. Sasikala and she mentioned that "injection mark with infiltration of blood over an area of 2.5 X 1.5 X1 cms, just to the left of midline and 12 cms above natal cleft. The track of the injection mark was found entering the spinal canal, dura was punctured. Infiltration dark red in colour was seen in the extra dural space of the spinal canal. However, the evidence shows the OP-3 had not given spinal anesthesia to the patient. The injection mark itself is not conclusive whether it was done for diagnostic or therapeutic purpose. Moreover, during post-mortem CSF was not collected for analysis to know about the injection administered to the patient. The chemical analysis did not reveal any drug or poison. Thus, the possibility of spinal anesthesia was ruled out.

13. The PM report states that the death was due to the combined effect of brain hypoxia and ARDS. Brain hypoxia means reduction oxygen supply to the brain tissue below physiological levels. On the other hand, ARDS (Adult Respiratory Distress syndrome) is a clinical syndrome of severe dyspnea of rapid onset, hypoxemia (Low oxygen level in blood and diffuse pulmonary infiltrates, leading to respiratory failure. The negative pressure pulmonary edema, causing brain hypoxia and ARDS are rare complications, but serious complications known to occur, after General anesthesia. Once patient was under GA, there

was no necessity to administer spinal anesthesia. The cause of death cannot be due to combined administration of General Anesthesia and Spinal anesthesia.

14. Robbins Textbook "Pathologic Basis of Disease", also enumerates many conditions which lead to the development of ARDS but lumbar puncture or spinal anesthesia was not the cause. As per literature, the known complications of spinal anesthesia are Failed spinal anesthesia, Hypotension and Spinal headache. Moreover, if the alleged spinal anesthesia caused respiratory distress, in that case the surgery could not have been completed. Admittedly the surgery was completed and then the patient suffered respiratory distress which followed extubation, after completion of surgery.

15. I have gone through the ‘Postmortem technique hand book’ to know about the PM findings of spinal canal. In the instant case the in the PM report the doctor has mentioned 12 cm above the natal cleft. Natal cleft is not a bony landmark to be mentioned in the postmortem report. The doctor should have mentioned the vertebral disc number at the level of puncture (like – a pin prick needle mark is noted over the back bone line ----- cm below the top of head and ----cm to the right of posterior tip of iliac crest (hip bone) (at the level of L2 – L3 Lumbar vertebrae).

16. It is surprising that during PM the track of the puncture mark cannot be detected on dissection of the skin and muscles over the back of the body. The findings were due to the extravasation of blood into the tissue spaces. Moreover, upon withdrawal of the needle in a living patient the puncture mark will collapse and cannot be detected on dissection of the body.

17. The puncture over the Dura also cannot be commented because the spinal cord is retrieved for examination by anterior / posterior approach by cutting the vertebral column by using saw. In such a scenario it is not possible to appreciate the pin point puncture mark. The deceased in the said case survived for around 24 hours after the spinal anesthesia. Therefore, in my view, the PM finding are not convincing to prove that spinal anesthesia was given in the instant case.

18. It is known that every death of a patient cannot, on the face of it, be considered as death due to medical negligence, unless there is material on record to suggest to that effect. In the **Jacob Mathew v. State of Punjab[1]** case, the Hon’ble Supreme Court laid down the ‘test’ for establishing medical negligence that ‘[It] is clear that in every case where the treatment is not successful or the patient dies during surgery, it cannot be automatically assumed that the medical professional was negligent’.

The Hon’ble Supreme Court in the case of **Bombay Hospital and Research Medical Centre vs. Asha Jaiswal & Ors [2]** observed that:

“if the patient was in a critical condition and he could not survive even after surgery, keeping that in mind the blame cannot be passed on to the Hospital and the Doctor who had provided all possible treatment within their means and capacity to diagnose the patient of this illness. The family may not have coped with the loss of their loved one, but the Hospital and the Doctor cannot be blamed as they had provided the requisite care at all given times.”

19. It is pertinent to note that in the instant case after the surgery the doctors in the operation theatre have effectively managed the complications and done resuscitation. The patient was referred at appropriate time to Poyanil Hospital for ventilator support. In my view, negligence cannot be attributed to OPs 1 to 3. The post mortem findings of spinal anesthesia are erroneous. Therefore, whole approach of State Commission, holding the OPs guilty of medical negligence is not sustainable in law. The First Appeal No.662/2013 filed by the OPs is allowed and the First Appeal No.358/2013 filed by the Complainant is dismissed. Consequently, the Complaint filed before the State Commission stand dismissed.

20. The learned Counsel for OPs on instructions from OP-1 made submissions that, on humanitarian grounds, the OP-1 on his own volition wishes to pay the amount of Rs. 7 lakhs which has already been deposited in the State Commission. Therefore, the Registrar of the State Commission is directed to release Rs.7 lakhs along with the accrued interest to the Complainants within six weeks from today. It is made clear that, in any manner this shall not be construed as a precedent.

The Registry is requested to send the copy of this Order immediately to the State Commission.

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[1] (2005) 6 SCC 1

[2] 2021 SCC OnLine SC 1149

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DR. S.M. KANTIKAR
PRESIDING MEMBER