NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION
NEW DELHI

CONSUMER CASE NO. 428 OF 2015

1. SOMRAJ SEN & ANR.
94/A, Old Calcutta Road,Anandapuri Barrackpore,
Kolkata- 700 122,
West Bengal
2. .
.
3. DR. MRINAL KANGI DAS (VISITING CONSULTANT
REGISTRATION NO. 34263, ADD: SUORO, 1ST FLOOR, 43-
JYOTISH ROY ROAD, NEW ALIPORE,
KOLKATA-700053. ....Complainant(s)

Versus

1. KOTHARI MEDICAL CENTRE & 7 ORS.
(Through its M.D.) 8/3, Alipore Road
Kolkata-700 027
2. Dr. Samir Roy(Surgeon)
Flat 1/A,!4, Gopal Banerjee Lane, P.S.-Tollygunge,
Kolkata-700026
3. DR. JYOTSNA BASU(ANAESTHETIST)
90, Ballygunge Place,
Kolkata-700019
4. DR. PRITHA DATTA(SENIOR REGISTRAR)
Flat No. 3D, Block-NI, Sherwood Estate,169, NSC Bose Road,
Kolkata-700103
5. DR. NIRMALA JAISWAL(RESIDENT REGISTRAR)
P-64, Block-A, Bangur Avenue,
Kolkata-700055
6. BARUN DAS GUPTA (OPERATION THEATRE
TECHNICIAN)
MAHATAPUR, JUGNITALA, PO: MIDNAPORE(WEST) PS:
MIDNAPORE(WEST)
WEST BENGAL-721101
7. ILA SARDAR (STAFF NURSE)
ARABINDA NAGAR, R.C. THAKURANI, P.O- THAKURPUR,
24 PGNS (S), WEST BENGAL-743512
8. DR. MRINAL KANTI DAS GUPTA (VISITING
CONSULTANT)
SOURO, 1ST FLOOR, 43- JYOTISH ROY RAOD,NEW
ALIPORE,
KOLKATA-700053 ....Opp.Party(s)

BEFORE:

HON'BLE DR. S.M. KANTIKAR,PRESIDING MEMBER
HON'BLE MR. DINESH SINGH,MEMBER

For the Complainant :
For the Opp.Party :

Dated : 13 Jan 2023

ORDER

Appeared at the time of Arguments:

For Complainant	:	Mr. Shiv Shankar Banerjee, Advocate with Ms. Arijita Ghosh, Advocate
For OP-1 :	:	Mr. N. R. Mukherjee, Advocate with Mr. Partha Sil, Advocate and Mr. Sourya Mukherjee, Advocate (in physical hearing)
For OPs -2 & 8	:	Mr. Partha Sil, Advocate with Mr. Tavish Bhushan Prasad, Advocate Ms. Binota Roy, Advocate (in physical hearing)
For OP-3	:	Mr. Anshuman Ashok, Advocate with Dr. Jyotsna Basu, OP-3 in person
For OP-4	:	Mr. Ghanshyam, Advocate (in physical hearing)
For OP-5	:	Ex-parte
For OP -6	:	Ex-parte
For OP-7	:	NEMO

Pronounced on: 13th January 2023

ORDER

DR. S. M. KANTIKAR, PRESIDING MEMBER

Facts:

1. On 04.02.2012, Dr. Arunima Sen, a young practicing physician (since deceased –hereinafter referred to as the 'patient') consulted the Gynaecologist - Dr. Samir Roy (hereinafter referred to as the 'OP-2') for her pelvic pain during menses. As prescribed, she took Oral Contraceptive Pills from July, 2012 to March, 2013, got relief for that period and then the medicines were stopped. Again on 19.03.2013, she developed pain and consulted the OP- 2, who advised 'D & C' laparoscopic Dye Test. As it was an invasive procedure, the patient did not agree for the test. However, during subsequent visits on 30.04.2013, 31.10.2013 and 22.02.2014, the OP-2 insisted for the test. Therefore, the patient agreed and the test was fixed to be done on 05.03.2014 in Kothari Medical Centre (OP- 1). It was alleged that on 05.03.2014, the procedure commenced at about 9.50 am, however within 15 minutes of its commencement, Dr. Samir Roy informed the patient's husband Dr. Somraj Sen (Complainant No. 1) that the patient suffered a massive Cardiac Arrest and no hope of survival. At 11.15 am, the patient was shifted to ICU, but while shifting, the patient's attendants did not notice any signs of life. It was alleged that the patient was pretentiously taken to ICU to give false impression of continuing treatment. The patient was declared dead at about 1.30 p.m. The Complainants alleged that the death was due to gross medical negligence of the Hospital and the OP- 2. The Complainant lodged an FIR before Alipore Police Station registered U/S 304A/34 of IPC. The post mortem examination was done at the Katapukur Morgue, which prima facie revealed cause of death being surgical procedure. According to the Complainants, it was a case of *res-ipsa loquitur*. The patient's husband, after the incident, took opinion of few expert doctors, which revealed gross negligence of the OP- 2. He was lacking skill to perform D & C Laparoscopic Dye Test and performed the procedure even though the patient was not willing.

2. It was further alleged that the OP- 2 failed in his duty of care and caused bowel injury to the patient, which went unnoticed. The video recording of the procedure was not done. The Complainant further alleged that it was negligence per se of Anaesthetist – Dr. Jyotsana Basu - OP- 3, who failed to do pre-aesthetic check-up (PAC). The Complainant further alleged that as per anaesthesia prescription, no pre-operative medicines (sedatives) were given and anaesthesia chart shows interpolation, it was not maintained properly. The OP- 3 administered anaesthesia without safety measures like multi-channel monitors and the procedure was done without Capnograph machine. The OPs- 2 to 8 were also negligent, who failed to detect the deteriorating condition of the patient and failed to revive her during cardiac arrest due to lack of emergency equipment in the operation theatre. The endometrial tissue was not sent for histopathology and the hospital stated that it was misplaced.

3. Thus, being aggrieved by the gross medical negligence on the part of OPs, the Complainants have filed this complaint under Section 21(a)(i) of the Consumer Protection Act, 1986 and prayed for compensation to the tune of Rs. 50,47,59,167/- against OPs - 1 to 8 jointly and/or severally along with 18% interest.

Defense:

4. The OPs filed their respective written versions and denied the allegations of medical negligence. They all have taken preliminary objection of the maintainability of the complaint that the Complainants have no locus standi to file the instant complaint as under the provisions of 'The Indian Succession Act, 1925'. The right to sue does not survive in the instant case. The proceedings before this Commission being summary in nature and the issue involved being complicated and highly technical, needs elaborate evidence and cross-examination. Another similar complaint was pending before the West Bengal Medical Council (WBMC) and the police authorities. The claim made by the Complainant was highly inflated for Rs. 50,00,00,000/- (Rs. Fifty crores), it was based on surmises and conjectures and claim against OP- 1 - Kothari Medical Centre for Rs. 10,00,00,000/- (Rs. Ten crores) was not justified. The law does not allow the Complainant to earn a bounty out of unfortunate event.

5. The **OP- 1- Kothari Medical Centre** submitted that before the procedure, Dr. Asma Prabeen Samuel, the medical officer, examined the patient. As per the past history of the patient, in 2006, she underwent appendectomy under General Anaesthesia, therefore, she was deemed to have a good tolerance for the anaesthetic drugs. During the procedure, the patient was connected to multi-channel monitors. The patient was attended by three doctors, anaesthetists and nurses/paramedics. The OP- 1 further submitted that the D & C + Lap Dye Test was conducted successfully within about 15 minutes, but, subsequently the patient suffered sudden cardiac arrest. Immediately, blue code was alerted and resuscitative measures as per the standard protocol were performed, the patient was shifted to ICCU, but she could not survive.

6. The **OP- 2 - Dr. Samir Roy (Gynaecologist)** submitted that initially the patient was diagnosed as repeated secondary dysmenorrhea. After investigations, she was prescribed oral contraceptive pills (OCP) and other medicines for the relief from her repeated pain. The patient responded well to the OCPs. Clinically, the OP- 2 suspected 'Mittleschmerz', but it was ruled out. The Ultrasonography (USG) revealed multiple myomas – i.e. benign tumors (fibroids) of uterus, adenomyosis and poly cystic ovarian syndrome (PCOD). Thereafter, in March 2013, the OP- 2 advised 'Dilation & Curettage with Laparoscopic Dye Test' to visualise the pelvic organs. On 03.03.2014 in morning, the laparoscopic procedure was started. After induction of anaesthesia, the pneumo-peritoneum was created smoothly with carbon-dioxide (CO_2) by using verse needle via infra umbilical port. The Laparoscopic findings were seen as below:

- Presence of two fibroid at fundus of the bulky uterus (confirming with previous U.S.G. reports);
- Both tubes were congested and ovaries appeared normal;
- P.O.D. (pouch of Douglas) was free with 5-10 ml of fluid;
- Evidence of pelvic endometriosis was absent.

Subsequently, dye test was performed using vaginal cannula by injecting 20ml of distilled water coloured with approximately 3-4 drops of methylene blue. The procedure was completed with curettage of one strip of endometrium obtained. After 15 minutes of the completion of the procedure, the RMO informed about sudden deterioration of the condition of the patient. Immediately, the OP- 2 rushed to the O.T. The external cardiac massage and IV medications were started. The CPR team immediately rushed to O.T. and the CPR was continued. The senior Cardiologist, Dr. Mrinal Kanti Dass (OP- 8) was also called by the OP- 2. The patient was immediately transferred to the ICCU for ventilatory support with cardiac pacing. Despite all efforts from the entire medical team, the patient could not be revived and declared dead at around 01.25 p.m.

7. The **OP- 3 - Dr. Jyotsna Basu, an Anesthetist** submitted that during the pre-anaesthetic check-up, the patient revealed that she was treated for childhood asthma, it weaned off as she grew older and now, no treatment was required. In 2006, she underwent appendectomy operation under general anaesthesia without any complications. The patient was allergic to SULPHA drugs and TINDAZOLE. The OP- 3 examined the patient, who was healthy and in good general condition. Her systemic parameters were under normal limits. Keeping in mind her allergic propensity, pre-operatively all intravenous medications were administered under multi-monitoring system. After routine preparation, at 9.30 a.m., the patient was taken inside the operation theatre (OT). Inj. Midazolam (1 mg) was administered slowly under continuous monitoring of vital parameters, followed by inj Fortwin (25 mg). Injection of Propofol (10ml 1% solution) was then infused followed by a calculated intubating dose of Suxamethonium (Scoline) (75mg). It was given for safe, quick induction and for ultra-short duration of action (3min -5 min). Also, Glycopyrrolate 0.5 ml (100mcg) was given to avoid any adverse response to vagal stimulation during induction. The patient was then placed in lithotomy position with the head-end of table "down" for the operation. As abdominal insufflation for laparoscopy started, an additional total calculated dose of Suxamethonium (total 75mg) with glycopyrrolate (total 0.5ml having 100 mcg) infusion was given slowly. Last dose of Inj. Suxamethonium was given before introducing dye vaginally. As the patient showed signs of respiratory efforts while recovering, the OP- 3 continued assisted ventilation manually using 100% Oxygen via the ET Tube.

8. The OP- 3 also submitted that the D & C procedure was near to complete, the patient's vitals deteriorated drastically. It was noticed by a change in the tone of the pulse-oximeter sound with multi-monitor alarm. There was rapid and continued fall of oxygen saturation (SaO_2), acute fall in systolic pressure from 130mm of Hg to

80mm of Hg and further with failure on the part of multi-monitor to record NIBP was noticed. It was followed by ECG monitor showing flat line, pulse oximeter and NIBP showed “no readings”. The oxygen supply line from anaesthesia machine to the patient was intact and working at the time. A provisional diagnosis of acute cardio-vascular collapse due to severe Anaphylactic shock was made. External cardiac massage was started by the surgical team. Simultaneously, alarm for Code Blue was sounded. Injection hydrocortisone, atropine, adrenaline, noradrenaline infusion, volume expender, sodium-bicarbonate and calcium gluconate were given. Senior Cardiologist - Dr. M. K. Das also arrived. He continued the CPR along with cardiac electrical stimulation in the OT. The patient was then transferred to the I.C.C.U, but all hopes of her revival ended and at 1.25pm patient was declared dead.

9. The **OP- 4- Dr. Prisha Datta** submitted that, her duties were for admission and discharge of the patient and their pre-operative and post-operative management in consultation with their surgeons or consultants. The OP- 4 was never consulted or involved in the decision-making for the laparoscopic dye test of the patient. Her role was only to assist the OP- 2 during the procedure to paint and drape the patient, empty the bladder with a catheter and perform a pelvic examination. Since the OP- 4 was on the pelvic side of the patient, she had no role during the laparoscopic procedure. She has introduced the Hysterosalpingography (HSG) cannula into the cervical OS and as per the instruction of the OP- 2, she pushed 10 ml of diluted Methylene blue solution into the uterine cavity of the patient. Since there was no spillage from either fallopian tube as observed on the monitor, then as instructed, the OP- 4 pushed in 10ml of methylene blue solution. Thereafter, the OP-2 continued the rest of laparoscopic procedure himself. Further, the OP- 4 held the vaginal speculum while the OP- 2 withdrew the cannula and reintroduced it into the cervix to ensure the proper positioning of the cannula. Thereafter, the OP- 2 again pushed 10ml of the dye twice more but again no spillage was noted from the fallopian tube. The OP- 2 performed D & C. At the end of the procedure, the OP- 4 cleaned up the vagina with betadine lotion and the tissue obtained from D & C was put in a vial which was to be sent for histopathology examination (HPE).

10. **The OP-5 - Dr. Nirmala Jaiswal (Resident)** did not file the written statement, therefore, vide Order dated 27.07.2016, her right to file the written statement was forfeited under Section 13(2) of the Act, 1986. **The OPs-6 & 7** were OT technician and Staff Nurse respectively. They were proceeded ex-parte.

11. **The OP- 8 - Dr. Mrinal Kanti Das (Visiting Cardiologist)** submitted that she was visiting cardiologist and the deceased was not her patient. She, on entering the OT, found that the patient was intubated and presence of entire Code Blue team. The patient was fully under the control of CCU resuscitation team and anesthetist, who were giving CPR. Thereafter, the patient became pulseless, cold upper extremities with bluish tinge and ECG showed flat curve. However, despite every attempt of doctors, the patient expired.

Arguments:

On behalf of Complainants:

12. The learned Counsel for the Complainant vehemently argued that the OP- 2 made vacillating diagnosis. The OCPs which gave relief to the patient were stopped further. The diagnosis as Mittleshmerz suggests for chronic pelvic pain, which could be treated by only medicines, but even though the OP- 2 suggested D&C Laparoscopic Dye Test. Thus, either diagnosis of Mittleshmerz was wrong or D&C Laparoscopic Dye Test was not needed. He further submitted that if the chronic and non-cyclic pain does not respond to NSAIDs or OCPs, then the laparoscopy was indicated. He further argued that even the last prescription of the OP- 2 did not mention about pre-anaesthetic check-up.

13. The pre-anaesthetic check-up was vaguely done by the OP- 3. The learned counsel for Complainant relied upon the book Lee’s synopsis of anaesthesia. The anaesthesia chart not maintained as per norms which shows at several places blanks, interpolations, incorrect noting of age and weight. The relevant investigations like HB, X-ray Chest, ECG, blood urea were left blank, same was admitted by the OP- 3 that the incorrect noting were due to slip of her hand. The learned Counsel for the Complainants argued that the Anaesthetist (OP- 3) failed to do pre-anaesthetic check-up as per the standards prescribed by American Society of Anaesthesiologist followed worldwide including India. The Anaesthetist did not physically examine the patient

and did not review investigations like lab reports, ECG and X-rays. During the laparoscopic D & C procedure the Anaesthetist failed to monitor vital parameters, therefore cardiac arrest was lately detected.

14. Regarding the Consent, the counsel submitted that no reliance could be placed on the consent form. It was blank for dates and taken up for laparoscopic cholestectomy, however the contention of the OP- 1 was that it was the duty of the patient, who herself was a doctor to indicate or fill the form. The age was also incorrectly mentioned as 31 years. It was the duty of hospital to obtain valid consent before any procedure.

15. The learned Counsel further argued that the Capnograph was not available during the laparoscopic procedure. The license of the instant medical college was not renewed because of absence of Capnograph in the Operation Theatre .The CO_2 used to inflate the abdomen, possesses a risk of gas embolism. Therefore, CO_2 saturation during laparoscopic procedure was important, but the OP- 3 was silent on monitoring CO_2 and Capnography. Even the treatment record, does not show any steps taken towards managing gas embolism. He also submitted that Capnograph was used to confirm proper intubation either in trachea or esophagus. The OP- 3 admitted before the WBMC that CO_2 was not monitored and gas embolism does not occur due to CO_2. Thus such act of the OP- 3 proves her lack skill as a Specialist in Anaesthesia. The counsel further submitted that none of the Opposite Parties Nos. 4, 6 and 7 attended after the alarm from multichannel monitor. The possibility cannot be ruled out that the multichannel monitor was either not properly set or it was defective[1]

16. The learned Counsel further argued that the Opposite Parties failed to do bowel preparation, before the laparoscopic procedure. Only advice for Nothing By Mouth (NBM) on the day of procedure was not sufficient. The Anaesthetist Dr. Jyotsna Basu did not take care of the allergies of the patient and no test dose was given. The repeated use of Scoline by the Anaesthetist was contrary to the established protocol. She used very high doses of Scoline, it was fatal to the patient. As per the medical literature, scoline was not the drug of choice and it should be administered under careful monitoring. Admittedly, there was no monitoring as well as CO_2 saturation. The Scoline was administered (injected) in Bolus dose , but it was not mentioned in the Anaesthesia chart. Further, the OP- 3 failed to treat cardiac arrest within the golden time. Adrenaline administered and blue code arrived at 10:20 am as per records i.e. 10 minutes after cardiac arrest that is beyond the golden time to reverse a cardiac arrest. In fact it is the case of the complainant that Scoline was administered in bolus dosages. Admittedly no skin test of drugs administered was done.

17. The counsel further submitted that there was doubt about the available members of blue code and no signatures of any member were put in the progress sheet. The OP- 3 administered Sodium Bicarbonate which clearly indicates that it was used to treat over dose of drugs and hyperkalaemia which are known side-effect of Scoline. He further argued that the OP- 5 was a fake doctor, did not possess medical degree. There was no documentation or deposition of the OP- 5 before WBMC. The role of the OP- 5 was evident by the evidence of the OP- 4, accordingly the OP- 5 was the first assistant and was not a mere observer. She initiated CPR, which shows the cardiac arrest was not monitored on war footing. She was responsible for the loss of an endometrial tissue. There was a perforation as evident from the PM report proves that the bowel injury occurred due to negligence during procedure. The learned Counsel further argued that it was incomplete procedure like endometrial tissue which was admittedly missing, no video recording of laparoscopic procedure, no record of the vitals from the multichannel monitor. There was discrepancy in the views of OP- 2 and the Autopsy Surgeon about the presence of Dye.

18. Though the WBMC knew that the OP- 5 was not registered with it, but gave biased opinion in favour of the Opposite Parties. The police record also shows that the OP- 1 failed to produce her qualification and her employment with the hospital, but the WBMC ignored it. The Complainant challenged the Order of WBMC before the MCI, which is still pending. One FIR registered at Alipore P.S. Case No. 46 of 2014, the police initially gave clean chit to the OP- 2. The case was reopened on judicial intervention and the police found that one of the doctors was not a doctor at all and the OP- 2 along with others, were guilty of gross negligence.

19. The learned Counsel for the Complainants relied upon one expert opinion of Dr. K. D. Ghosh, the consultant Gynaecologist and Obstetrician (OBG), who opined that there was no indication or necessity for laparoscopic Dye Test. He further relied upon decision of Hon'ble Supreme Court in **Malay Kumar Ganguly**

vs. Dr. Sukumar Mukherjee[2], wherein it was held that *"(x) At AMRI records of vital parameters like temperature, pulse, blood pressure, etc. were not maintained which itself is an act of gross negligence".*

20. The learned Counsel summed up his arguments on the following points:

a. At each stage, from diagnosis, to pre-operative assessment, pre anaesthesia check up, ensuring the presence of required equipments, testing drugs for allergy given a history of allergic propensity, rash manner of administering heavy dosage of a dangerous drug.
b. Presence of a fake doctor performing incorrectly important tasks.
c. No evidence of the procedure having been completed, non-preservation of important records.
d. No proper steps for reversing cardiac arrest.
e. Inability of OPs to explain the cause of death in a admittedly minor procedure, with a young and healthy patient with no cardiac problems and the post mortem reason pointing out – death due to the effects of surgical procedure puts the burden on the OPs to explain the cause of cardiac arrest and resultant death.

Arguments from the Opposite Parties

21. **Arguments from OP-1 (Kothari Medical Centre)**

The learned Counsel for the OP- 1 argued that during procedure, the patient was receiving oxygen and she was attached to multichannel monitor which, *inter-alia*, continuously monitored the heart rate, oxygen concentration, blood pressure etc. The monitor gives visual indication as well as audio alarm. The patient was under continuous observation of qualified experienced doctors, anesthetist, paramedics, and nurses. The crisis – emergency the Code Blue was issued and the crisis management team immediately attended the patient and shifted her to ICCU wherein the patient suffered massive cardiac arrest, but in spite of all efforts from the doctors, she could not survive. The Patient expired due to sudden cardiac arrest/cardio respiratory failure, therefore such mishap was not a medical negligence. Thus, the Complainant failed to prove the *"facta probanda" as also "facta probantia*".

22. **Arguments from the Opposite Parties Nos. 2 & 8 (Dr. Samir Roy & Dr. Mrinal Kanti Das)**

The learned Counsel for the Opposite Parties Nos. 2 & 8 argued that the decision of the OP- 2 to stop the OCPs was not wrong. The decision to discontinue OCPs was taken considering the marital status of the patient. The said allegation was solely on the ground that there is no mention of "chronic pelvic region" or "chronic pelvic pain" in the prescriptions issued by the OP- 2. Any pelvic pain persisting for more than 6 months with or without temporary relief of symptoms with medication is termed as "chronic pelvic pain". Moreover, the patient was herself a doctor by profession, possesses the basic knowledge of gynecology and she had duly consented for the D & C Laparoscopic Test procedure in October 2013 and even after during her last visit to the OP- 2. Though Mittelschmerz was one of the diagnosis but suggested D & C laparoscopic Dye Test for chronic pelvic pain only. The Complainants' allegation was just misrepresentation in order to seek the sympathy of this Commission. He further submitted that the Complainant No. 2 was father of the patient, he being a doctor and a medical classmate of the OP- 2 had verbally confirmed over telephone on enquiry that X-ray and ECG as required had already been done on the patient and such reports did not reveal any abnormality that would prohibit such procedure. Therefore, again no x-ray and ECG were advised to the patient. The Counsel further argued that allegations of not providing the Capnograph record and HPE report of the endometrium were entirely concerned with Kothari Medical Centre and it was no way, concerned with the OP- 2. The complainants made vague allegations from PM report that the D & C Laparoscopic Dye Test procedure was not completed by the OP- 2. Moreover, the OPs rendered emergency medical assistance to the patient during the 'Golden Period' and treated the cardiac arrest, thus the allegation of the Complainants was totally false.

23. The OP- 8 was a visiting Cardiologist in the OP- 1 Hospital. He was neither aware nor associated with the treatment of deceased patient. He was on his routine rounds on 5th & 6th floor of the Hospital and was called

on to manage the crisis situation in the O.T. Thus there was no privity of contract either between the deceased patient / the Complainants with the OP- 8.

24. **Argument from OP-3 (Dr. Jyotsna Basu-Consultant Anaesthesiologist)**

The learned Counsel for the OP- 3 reiterated the evidence. He argued that the West Bengal Medical Council and the Penal & Ethical Committee passed an order dated 23.09.2015 concluded that there was no negligence from the treating doctor at OP-1. The Medical Council of India Ethics Committee Order dated 30.06.2016 unanimously decided to exonerate all three doctors namely Dr. Samir Roy, the operating surgeon, Dr. Jyotsna Basu, Anesthetist and Dr. Mrinal Kanti Das, Cardiologist.

25. The Counsel for the Opposite Parties further brought our attention to three expert opinions on record. The 1st Expert Committee Report dated 05.07.2014 from the R. G. Kar Medical College which held that “All the drugs used during that period was adequate in proper dose and manner and all resuscitation management by the Anesthetist was adequate and proper. The experts have finally opined that “Cause of death or any deficiency in the management by the Anesthetist and Gynecologist could not be fixed.”

26. The 2nd Expert Committee Report dated 16.02.2015 of R. G. Kar Medical College issued to the Deputy Director of Health Services (Admn), West Bengal Government upheld the dated 05.07.2014 which exonerates the OP- 3.

27. The 3rd Expert Committee Report of R. G. Kar Medical College vide order dated 16.02.2018 having the same panel of experts, gone through the documents have given a different opinion. However, despite contradictory findings, the committee did not question the medical team. Therefore, 3rd report may not be treated as an expert opinion.

28. Similarly Enquiry Report of Bankura Sammillani Medical College dated 07.06.2016 was a personal enquiry made by the Investigating Officer of the Criminal Case in Kolkata filed by the complainants. It was based on conjectures and inconclusive. Thus, the said report may not be treated as an expert opinion.

29. The learned counsel for the OP- 3 argued that the Expert opinion of Dr. R K Sharma has no evidentiary value, since he was not an Anesthesiologist and not competent to opine on anesthetic drugs and procedures. As per MCI Guidelines on Expert Medical Opinion should be credible opinion from a competent doctor qualified in that branch of medical practice on the facts mentioned in the documents supplied by the concerned doctor/hospital. However, the Expert Opinion on behalf of the OP- 3 from Prof. H. L. Kaul, Retired Prof & HOD Dept. Of Anesthesiology, AIIMS, New Delhi was after in depth analysis of the case which has completely exonerated the Anesthesiologist (OP- 3).

30. The Counsel further argued that a professional may be held liable for negligence if he or she does not possess the requisite skill which he or she claims or if a doctor fails to exercise reasonable competence. Dr. Jyotsna Basu (OP- 3) was a senior consultant Anesthesiologist, having over 40 years of experience. This was the only unfortunate incident she had to face and even in the facts of the case in hand, the OP- 3 tried every possible method to revive the patient but unfortunately the patient could not be revived. The Counsel for the OP- 3 relied upon following few authorities.

a. *Bijoy Sinha Roy v. Biswanath Das, (2018) 13 SCC 224*
b. *Maharaja Agrasen Hospital v. Rishabh Sharma, (2020) 6 SCC 501*
c. *Ins. Malhotra v. Dr. A. Kriplani, (2009) 4 SCC 705*
d. *Achutrao Haribhau Khodwa v St of Maharashtra, (1996) 2 SCC 634,*
e. *Jacob Mathew v. State of Punjab, (2005) 6 SCC*
f. *J.N Shori Multi Speciality Hospital & Anr. vs. Krishan Lal & Anr. Judgement dated 23.07.2021 in Revision Petition No. 2988 of 2012.*

31. **Arguments from OP- 4 (Dr. Pritha Dutta)**

The learned Counsel for the OP- 4 argued that the OP- 4 rendered assistance to the Consultants as and when required during her working hours. Her duties in the said hospital *inter-alia* comprised of ward duties, admission, discharges of the patients as well as their Pre-Operative and Post- Operative management in consultation with various Consultants. She could neither grant sanction nor cancel surgeries nor make any decision regarding the same. Her role was restricted to assisting during the surgery. The learned Counsel for the Opposite Parties vehemently denied that at the end of the procedure, the patient was left alone with the OP- 5 Nirmala Jaiswal for long time. The patient was being monitored by the OP- 3, who was being assisted by the Opposite Parties Nos. 6 & 7 (OT technician and the OT sister). When Dr. Ayan Mukherjee reported back to the OT at around 11.30 a.m., he was briefed about the case. Thereafter, the OP- 5 was allowed to go back to the ward and never called back to the OT regarding the instant case on that day.

32. Furthermore, it is to be noted that the State Medical Council did not find any Medical Negligence on part of the OP- 4. The two expert committees from Bankura Medical College and RG Kar Medical College also did not find any wrongdoing or lapses on the part of the OP- 4. The Medical Council of India order is still awaited. Even the OP- 4 had been summoned by the Alipore PS in 2018 to assist the investigation in criminal proceedings in the case filed against the Opposite Parties Nos. 1,2,3 and 5. There was no evidence of medical negligence found against her (OP- 4). However, subsequently about a year later in 2019, her name was added in a supplementary charge sheet despite the fact that no new evidence had emerged implicating her. There was however no specific charge against her even in the supplementary charge sheet. The stay order had been passed in the criminal proceedings against OP- 2 in 2018 by the Hon’ble High Court of Kolkata and the Complainants are using the criminal case to gain benefit from this Commission.

Observations & Discussion:

33. We have perused the entire medical record and the expert opinions filed on behalf of both the sides. The Complainants relied upon two expert opinions of **Dr. K. D. Ghosh**, the consultant Gynaecologist and Obstetrician (OBG) and **Prof Dr. R. K. Sharma**, medico-legal expert.

Dr. K. D. Ghosh opined that there was no indication or necessity for laparoscopic Dye Test. The relevant paragraphs are reproduced as below:

> “Late Dr. Arunima Sen Nee Ghosh, was known to me. On going through the medical records and treatment papers of Late Dr. Arunima Sen Nee Ghosh, I have noted the following:
>
> She went to Dr. Samir Roy complaining of pain in abdomen during and after her periods, particularly during mid-cycle. The pain was severe in nature and she had to take analgesics during that period. It appears to me that she was suffering from “mid-cycle ovulatory pain” and nothing else. That was sufficiently proved when she was given oral contraceptives for three months which relived her of her pain completely. To pin-point the diagnosis, an invasive test like – Laparoscopic Dye Test was not at all necessary in her case. Any other concerns that the doctor might have had, could have been revealed through a simple diagnostic tests like Ultrasonography examination of pelvic organs. In her case, it was done twice and it did not reveal anything out of the ordinary. I really could not find a justification for going for an invasive test in her case.

34. The Complainant filed an opinion of medico-legal expert **Prof. Dr. R. K. Sharma.** He examined the medical records, PM report and pointed out following points:

a. Pre-anaesthetic check up of patient was not done even though OT was booked on 26.02.2014. There was ample time to schedule a pre anaesthetic check-up.
b. Weight of the patient was 53 kg while it has been mentioned as 65 (+/-). She was 5’1" and of average built.
c. No record of operation has been kept, recording of pulse oxymeter which Is very essential Is missing. Video recording of whole procedure is missing.
d. It is mentioned that endometrium was sent for histo-pathology examination but Its report Is not there. The hospital authorities have later admitted In writing that the sample was lost and hence not sent for histo-

pathology examination,

e. In anaesthesia chart, age has been wrongly mentioned as 20 years while she was 31 years old.
f. Dosages of Scoline are very high showing incompetence on behalf of anaesthetist who has not taken consideration of correct weight
g. Drugs like Atropine should be administered along with Scoline Instead Pyrolate was given which does not have the same effect as Atropine.
h. In anaesthetic chart, heart rate and BP during Investigations are not mentioned at all,
i. In notes It Is mentioned that at 10:15 am , patient was pulseless, how can patient become pulseless at once? It means that there was no monitoring; of vitals.
j. Patient could not be revived as detection of cardiac arrest was quite late and a lot of time had passed when patient was In cardiac arrest.
k. Provisional diagnosis has been written as anaphylactic shock or embolism. The treatment line showed that they were managing anaphylactic shock.

35. Dr. R. K. Sharma further opined that as PM revealed perforation of small Intestine and the final opinion that death was due to effect of surgical procedure. Thus it was obvious that patient has died due to surgical procedure. Surgeon was negligent in causing perforation. He further commented that the cardiac arrest may occur due to faulty placement of needle in the vessels or abdominal organ resulting in embolism. Thus timely detection of such event can save life of person, it emphasize role of monitoring of vitals and timely action by anaesthetist. Also if insufflation was done rapidly, it can cause cardiac arrest, therefore close monitoring was essential for prevention of cardiovascular collapse. He concluded the following deficiencies:

1. Surgeon has committed an error as it has caused perforation in small Intestine.
2. Anaesthetist has not-done any pre-anaesthetic check-up.
3. Dosages of Scoline were higher than recommended,
4. No monitoring of vitals "like pulse and BP was done during anaesthesia.
5. Patient's Age and weight wrongly recorded.
6. No video record of procedure was done.
7. No recording of pulse oxymeter and Capnography.
8. Endometrium sample was lost by hospital showing gross negligence,
9. Timely detection of cardiac arrest was not done in proper time and hence caused death of patient.

According to Dr. R. K. Sharma, it was gross negligence on behalf of Surgeon, Anaesthetist and Kothari Hospital in death of Dr. Arunima Sen @ Ghosh.

36. In reference to the allegations raised in the complaint, the WBMC made the following observations:

1. This procedure was justified in the instant case.
2. Employing the services of Dr. Jyotsna Basu (not a regular member of that team) was not wrong as she was adequately qualified and vastly experienced.
3. Apart from the pre-operative examinations done, no other investigations were mandatory as the patient's condition did not call for any such investigations.
4. Lack of video recording of the operation could not be taken as a deficiency on the part of the medical practitioners since most Operation Theatres in the world do not have video monitoring. Besides this, it was not a mandatory provision.
5. Lack of video recording of the laparoscopy was also not a deficiency in the instant case as this was not a standard procedure.
6. Death on table could not be declared in the instant case since standard procedure demands at least 45 minutes of CPR to revive a patient. On that ground, temporary pacing was justified. The efforts on this ground by team involved in the management of the patient be appreciated since the patient was only 31 years old.
7. The surgeon was not in his regular cloths (he had taken off his gown and was in his 'theatre green' –as deposed by the witness) and he did enquire from anaesthetist if everything was OK before leaving the

room when he opened his gown in front of the scrub basin and washed his hands. He was next to move the Surgeons' lounge to write his notes when he was informed of the cardiac arrest.

8. The autopsy report indicated a small bowel perforation but that could not lead to such an extraordinarily rapid and sudden death. The patient, the committee feels was in profound hypotension for maybe 2 or 3 minutes, in between or after the last NIBP recording, in which period the tachycardia compensation did not occur or, sudden stimulus lead initially to an almost inexplicable brady and almost immediate cardiac arrest.
9. The Blue Code Team arrived as soon as possible and took over the patient but there was no loss of time as external massage was started instantaneously by the surgical team as per recommended CPR protocols. However, no single etiology could be attributed to this death and there might be several reasons leading to the failure of her revival.
10. Presence of a cardiologist in such type of surgical procedure was not mandatory and therefore, it was no fault on the part of the Operation Team to call for the assistance of the cardiologist when situation demanded.
11. The dosage of drugs administered was rational and no significant dosage error was evident. The patient was not given any drug, which was contra-indicated in her case.
12. The resuscitation procedure was initiated immediately by the Members of the surgical team, which was taken over by the Code Blue Team within reasonable time.

The WBMC concluded that the doctors involved in the instant case were not negligent. However, it pointed out deficiencies in the infrastructure of a Tertiary Care Hospital. The Council decided to write to the Director of Health Services, Government of West Bengal to advise the concerned hospital authority to install recording facilities in the OT monitors so that retrieval of data for future examination could be made possible.

37. It is pertinent to note that the ethics committee of MCI unanimously decided to exonerate the operating surgeon, Dr. Samir Roy (OP- 2), the Anesthetist, Dr. Jyotsna Basu (OP- 3) and the Cardiologist, Dr. Mrinal Kanti Dass (OP- 8). Those recommendations of the Ethics Committee have been approved by the Executive Committee at its meeting held on 30.06.2016.

38. It is pertinent to note that the WBMC took an opinion from **Prof. H. L. Kaul**, the retired Prof. & Head of the department of Anaesthesiology, at AIIMS, New Delhi. His opinion was based on the documents. He, after going through the records, and opinion given by the Forensic expert, opined that:

1. (i) Pre anaesthetic check/ general check-up was performed by Dr. Asma Parveen at 9am of the day of the procedure. Past history, allergies, blood pressure pulse general and cardiovascular examination results are entered. she also concluded that all are within normal limits under heading investigations done.(Annexure H) Exact weight record is a must in paediatric patients while in adults it is not so crucial.

(ii) Premedication was given on the operation table as Inj. Medazolam and fortwin. Inj. Propofol, scoline and pyrrolate was given prior to intubation. Anaesthesia was maintained with oxygen and nitrous Oxide mixture. Repeat doses of scoline were used thrice to maintain muscle relaxation.This is accepted practice for general anaesthesia for patients undergoing short procedures. To say that failure and neglected to administer general anaesthesia in lieu thereof administered the muscle relaxant is incorrect. The muscle relaxant is used to facilitate passage of endotracheal tube for ventilation and administration of anaesthetic gasses prior to start of general anaesthesia.

2. Scoline is not obsolete not it has been banned and is still used in many hospitals. Pyrrolate is equally effective as atropine in reducing secretion and are universally used. Glycoppyrrolate and atropine have similar action and more and more anaesthesiologist now use glycopyrrolate instead of atropine. In the instant case Intubation dose was 75 mg. of Suxamethonium as standard practice for patients weighing around 65 Kg. Although this patient weighed less, the doses should not matter in outcome.

(i) For the procedure lasting less than an hour, many anesthesiologists avoid longer acting non-depolarizing relaxants. Therefore, supplementary doses of Suxaméthonium are acceptable. In the instant case the technique of intermittent scoline and IPPV is used for short lasting procedures as reversal in such case with this technique is quick. The vital signs such BP, Pulse have been monitored during anaesthesia as depicted in anaesthesia chart. According to Dr. H.L. Kaul Suxamethonium (Scoline) has not been banned as an anaesthetic drug. So its use is not forbidden.

(ii) He further stated that sudden fall in blood pressure and bradycardia generally associated with

a. Insufflation gas embolization. There is no record of maximum intra-peritoneal pressure generated during the procedure.
b. Anaphylaxis : Whether Methylene blue can cause anaphylaxis is not clear. There are cases on record about anaphylaxis after instillation of Methylene blue[3].The course of events after injection of Methylene blue and fall in BP and HR is not clear.

3. About the **use of Capnograph**, he opined that it is not mandatory and not listed as a mandatory monitoring device. However, sudden fall in ETCo2 would indicate gas embolism which leads to refractory cardiac arrest. It does not respond well to resuscitation the right side of the heart is filled with gas which prevents flow of blood during resuscitation. It may not be detected on autopsy unless cardiac chambers and Pulmonary Artery are opened specifically to look for the gas embolism. Safe limit of intra-peritoneal pressure during gas insufflations is 10-12 mm Hg. And is normally set on the insufflator.

Finally, Dr. H.L.Kaul opined the possibilities for cause of cardiac arrest as:

1. Anaphylactic shock to Methylene blue instillation (patient has history of allergy to certain drugs as elicited in history).

2. Gas embolism due to uncontrolled gas insufflations or direct injection of gas into an organ (small intestine perforation)or a blood vessel. (no mention made of insufflating pressure or use of an gas insufflator).

39. **Report of the Expert Committee**

According to the Expert Committee, in this case, **anaphylaxis or embolism** was possible by any drug (including dye or gas) used during the entire procedure. But anaphylaxis management was done properly. Multichannel monitor record (trend) along with capnography record was urgently required to assess the vital parameters of the patient particularly from 9.50 a.m. to 10.15 a.m. All resuscitation done by Anesthetist was proper between 10.15a.m to 10.20 a.m. The PM report has not mentioned about the size of small Intestine loop. It was blood less perforation and unlikely to cause death. In the surgical note, uterine cavity was found to be smooth and 10 cms, it was obliterated. The Committee opined that the cause of death or any deficiency in the management by the anaesthetist and gynaecologist could not be fixed. The final opinion will be given after receipt of (i) Multichannel monitor record (including capnography record) and (ii) Histopathology report of the endometrium.

40. **Whether D & C- Laparoscopic dye test was necessary in the instant case?**

(i) As per the history and symptoms of the patient, it was "Secondary Dysmenorrhoea" which is a cyclic menstrual pain that occurs in association with underlying pelvic pathology. From the standard text book Derek Novak's Gynaecology there are several underlying causes which include Endometriosis, Adenomyosis, Subacute Endometritis, and pelvic inflammatory diseases, copper containing intrauterine devices (IUDs), ovarian cyst, congenital pelvic malformation and cervical stenosis. Whereas the diagnosis of primary Dysmenorrhoea is based on history and presence of normal pelvic examination and ultrasound.

(ii) The diagnosis of secondary Dysmenorrhoea may require review of repeated pain to confirm cyclic appearance investigations with transvaginal ultrasound examination and further need of laparoscopy and / or hysteroscopy. Laparoscopy is essential in diagnosing some causes of chronic pelvic pain such as endometriosis and chronic pelvic inflammatory disease. Diagnostic laparoscopy is the only test capable of reliably diagnosing peritoneal endometriosis and adhesions. Findings on physical examination are not reliable predictors of laparoscopic findings. Up to 50% of patients with negative results of physical examination have abnormal laparoscopic findings

Therefore, decision of OP-2 to perform laparoscopic dye test was neither wrong decision nor it was a therapeutic misadventure in the instant case. He treated the patient as per the accepted standard of practice.

41. We further note the OP-3 administered doses of Scoline within the recommended pharmaceutical doses with slow manual infusion. There was no bradycardia or arrhythmia after the administration. From the anesthesia chart, the intubation dose of Scoline was 75 mg IV and then the infusion dose of 75 mg (25+25+25) given over period of 20 minutes. The last dose of 25 mg was given before introduction of dye vaginally. It is pertinent to note that Scoline acts on voluntary muscles, but not on the cardiac muscles which are involuntary. Thus, it affected the heart is not acceptable. The Scoline is fast acting with short duration, it does not require reversal[4]. Therefore, it was the medicine of choice in this short diagnostic procedure like the instant laparoscopic dye test. In the instant case, the sodium bicarbonate was used to correct metabolic acidosis during resuscitation. The patient went into sudden hypertension and cardiac arrest, the recordings from multi-monitor were recorded in the anesthesia chart manually by OP-3. The patients vitals deteriorated drastically in spite of she being ventilated without any difficulty by ETT (No. 7 cuffed) using a bains circuit. The patient was receiving 100% oxygen with manual intermittent positive pressure ventilation (IPPV) by OP-3. There was no intra-abdominal or external hemorrhage.

42. The next question is whether it was a gas embolism. It should be borne in mind that during laparoscopic procedure, CO_2 is administered in controlled manner, the insufflator is fixed such that the pressure cannot be more than 10-12 mm Hg. The machine will turn off itself on reaching the pressure up to 10 mm Hg. However, the increase in CO_2 level in blood was due to rise in BP, pulse rate and sweating. Capnograph was not available, the signs were monitored by the Anesthesiologist as was usually done before the advent of Capnography / in the absence of Capnography. It is the fact that CO_2 is highly soluble in blood, therefore, the air embolism was unlikely. The post-mortem also ruled out it was air embolism. Even there was no clinical evidence to show that there was hypercarbia during surgical procedure. From the several literatures, per operative refractory cardiac arrest, the cause could not be determined.

43. Regarding pre-anesthetic checkup (PAC), admittedly chest x-ray and ECG were not advised. It is known that the father of the patient (Complainant No. 2) himself was a doctor and classmate of the OP-2 and had verbally confirmed over telephone on enquiry that X-ray and ECG as required had already been done on the patient and such reports did not reveal any abnormality that would prohibit such procedure.

44. About perforation, mentioned in the PM report, the Complainant relied heavily the term rupture in small intestine is used twice in the PM report. It should be borne in mind that the terms 'rupture' and 'perforation' have separate implication. The perforation refers to pinhole to larger size resulting into release of intestinal fluid in the peritoneal cavity, but the rupture may be referred to the acute explosive disruption of the organ by pressure from within or without. The PM report did not show the exact size and site of the intestinal perforation. We do not accept that the OPs failed to treat the emergency during the golden period, by which cardiac arrest could have been reversed. It is pertinent to note that the OP-2 finished washing off his hands and while he was still in his OT dress outside the OT room, the OP-5 informed him that the patient's condition suddenly deteriorated. Immediately, the OP-2 rushed inside the OT and found that external cardiac massaging and CPR was started. The grave situation of the patient was informed to the Complainant No. 1 and the patient was shifted to ICU on ventilator support with cardiac pacing. The doctrine of *res ipsa loquitur* is not applicable in the instant case.

Conclusion:

45. The WBMC and the opinion of experts affirmed that pre-operative anaesthetic check-up was duly conducted and nothing was abnormal. The D&C-Laparoscopic procedure was also uneventful but after the procedure, the patient had a cardiac arrest on the operation table. All the resuscitative measures were taken but unfortunately could not save the life. The PM was performed, but the Autopsy Surgeon could not confirm the cause of death. The WBMC noted that both the Gynaecologist and the Anaesthetist had long experience in their respective field of practice and there was no deficiency in the services rendered by them in the instant case. As regards the findings of the Autopsy Surgeon about the presence of a perforation in the small bowel, the WBMC observed that such perforation could definitely not be the cause of a sudden cardiac arrest and resultant death. The WBMC also noted that the / committee had, through interrogation of various staff and doctors present in the OT, confirmed that the Anaesthetist had never diverted her attention from the patient and she was all along present at the bed side.

46. In our view, no overdose of Scoline administered by OP-3. It is evident from the anaesthesia record (chart) that Scoline was injected as per the recommended standard dose and the patient was under monitoring. The Post-Mortem report revealed the small intestine was extremely congested and there was perforation at *** *illegible* ***(? ileoceacle area). Even the PM findings did not indicate there was fatal intra-abdominal haemorrhage.

47. However, we can't turn a blind eye to the grave lapses on the part of the hospital administration. With respect to consent, we find though it was a day care procedure and the consent was signed by the patient, but few blank spaces were also there.

48. In so far as the Operation Theatre (OT) facilities, the WBMC noted that Capnography was not available in the OT. Though it was not a mandatory requirement, but in our view, the tertiary care hospital should provide Capnograph machine in the OT especially laparoscopy where CO_2 gas is used for insufflation. We have gone through the standard textbook - Morgan and Mikhail's Clinical Anesthesiology (5th Ed.) to know about monitoring during anesthesia. The Capnography is a valuable monitor of the pulmonary cardiovascular, and anesthetic breathing systems. Both types of capnographs in common use rely on the absorption of infrared light by CO_2. The Capnography is used for determination of determination of end-tidal CO_2 ($ETCO_2$) concentration to confirm adequate ventilation is useful during all anesthetic procedures, but particularly so for general anesthesia. A rapid fall of $ETCO_2$ is a sensitive indicator of air embolism, a major complication of surgical procedures. However, in the instant case, it is an admitted fact that Capnography machine was not available during the procedure.

49. We further note the hospital failed to convince us about the availability of multichannel monitor. The hospital failed to produce the monitoring record prior to cardiac arrest, but as stated by the Anesthetist (OP-3), the parameters were recorded manually.

50. The further lapse on the part of hospital is that the OP-5 doctor Ms. Nirmala Jaiswal was not registered with WBMC and her presence in the OT was not as an observer but she assisted the OP-2 doctor during the procedure. The WBMC is silent on her qualifications and registration. Also the OP-1 hospital administration failed to produce her qualifications and registration.

51. We may sum-up some of the patent lapses on the part of the Hospital Administration (OP-1). A few blank spaces were apparent in the Consent Form. Age and Weight of the patient were erroneously recorded. Pre-anesthetic check-up was not done. The specimen of endometrium was not sent for Histo-Pathology Examination (HPE), which was admitted by the hospital, as it was "lost" and hence not sent for HPE. More importantly, Capnograph, as also proper Multi Channel Monitoring System of acceptable standard, were not available in the OT even though it was a Tertiary Care Hospital. In fact, the West Bengal Medical Council in its Order dated 28.09.2015 has also concluded that the Council decided to write to the Director of Health Services of the Government of West Bengal citing deficiencies in the infrastructure of a Tertiary Care Hospital and to request him to advise the concerned hospital authority to install recording facilities in all the monitors installed in every OT so that retrieval of data for future examination can be made possible. A most serious lapse was the association of the OP- 5 "Doctor" (Ms. Nirmala Jaiswal) with the operation, who, it is an admitted and proved

fact, was not qualified as a Doctor at all and had no medical degree whatsoever but was yet an integral part of the operating team of doctors. In fact she was employed with the OP-1 as "Resident Registrar". The very fact that a person masquerading as a Doctor was inside the OT with the approval and knowledge of the Hospital Administration speaks (most adversely) for itself and is *per se* an unfair and deceptive act within the meaning of 'unfair trade practice' under the Act 1986.

52. In respect of alleged medical negligence on the part of the doctors *per se* (and not in respect of the hospital) we would like to refer to few judgments of the Hon'ble Supreme Court which laid down the law what constitutes medical negligence. In **Jacob Mathew's case**[5], it was held as under:

"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."

53. The allegations need to be proved with cogent evidence, it was held by Hon'ble Supreme Court in **Bombay Hospital & Medical Research Centre vs. Asha Jaiswal & Ors.**[6], whereby it was held in paragraphs 32 and 34 of judgment as below:-

32. In **C.P. Sreekumar (Dr.), MS (Ortho) v. S. Ramanujam[7]**, this Court held that the Commission ought not to presume that the allegations in the complaint are inviolable truth even though they remained unsupported by any evidence. This Court held as under:

> "37. We find from a reading of the order of the Commission that it proceeded on the basis that whatever had been alleged in the complaint by the respondent was in fact the inviolable truth even though it remained unsupported by any evidence. As already observed in Jacob Mathew case [(2005) 6 SCC 1 : 2005 SCC (Cri) 1369] the onus to prove medical negligence lies largely on the claimant and that this onus can be discharged by leading cogent evidence. A mere averment in a complaint which is denied by the other side can, by no stretch of imagination, be said to be evidence by which the case of the complainant can be said to be proved. It is the obligation of the complainant to provide the facta probanda as well as the facta probantia."

> 34. Recently, this Court in a judgment reported as **Dr. Harish Kumar Khurana v. Joginder Singh & Others[8]** held that hospital and the doctors are required to exercise sufficient care in treating the patient in all circumstances. However, in an unfortunate case, death may occur. It is necessary that sufficient material or medical evidence should be available before the adjudicating authority to arrive at the conclusion that death is due to medical negligence.

54. In the case of **S. K. Jhunjhunwala vs. Dhanwanti Kaur and Another**[9], the Hon'ble Supreme Court held that there has to be direct nexus with these two factors to sue a doctor for negligence. It was further held 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. Similarly in the recent decision on April 20, 2022, the Hon'ble Supreme Court in the case of Dr**. (Mrs.) Chanda Rani Akhouri & Ors. Vs Dr. MA Methusethupathi & Ors.**[10] has laid down in no uncertain terms that merely because doctors could not save the patient, he/she cannot be held liable for medical negligence. the Hon'ble Supreme Court held in para (27) that:

> 27. It clearly emerges from the exposition of law that a medical practitioner is 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 to another. In the practice of medicine, there could be varying approaches of treatment. There could be a genuine difference of opinion. However, while adopting a course of treatment, the duty cast upon the medical practitioner is that he must ensure that the medical protocol being followed by him is to the best of his skill and with competence at his command. At the given time, medical practitioner would be liable only where his conduct fell below that of the standards of a reasonably competent practitioner in his field.

55. Sequel to the above discussion, we conclusively determine 'deficiency' as well as 'unfair trade practice' on the part of the hospital - OP-1, a tertiary care hospital of which the highest standard of essential infrastructure and patient's care and management was expected and required but which it failed to provide.

However, we are unable to conclusively determine medical negligence on the part of the doctors – OPs- 2, 3 and 4.

56. It is unfortunate that the deceased was a young doctor, a physician, aged just 31 years, who lost her precious life. This necessitates just and adequate compensation. There is no straight jacketed formula for award of compensation, it is difficult to quantify the value of human life in monetary terms, but considering the facts and circumstances, to attempt to meet the ends of justice, lumpsum compensation of Rs. 1.25 crore appears to be just and adequate in the present case. As such, we deem it appropriate that the OP-1 hospital shall pay Rs. 1.25 crore to the Complainants within 6 weeks from today, failing which the amount shall carry interest at the rate of 9% per annum till its realisation. Additionally, the OP- 1 hospital shall pay Rs. 2 lakh towards cost of litigation to the Complainants. We would also like to request the State Government of West Bengal through its Chief Secretary to get the OP-1 hospital inspected in order to ensure that it is compliant with the statutory requirements and licencing protocols.

The Complaint stands partly allowed against the OP-1 hospital.

57. The Registrar is requested to send a copy each of this Order to the parties in the case as well as to the Chief Secretary to the Government of West Bengal.

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1. Lee's synopsis of Anaesthesia

[2] (2009) 9 SCC 221

[3] Anesth.Analg. 2005;101, 149-150

[4] Morgan and Mikhail's Clinical Anesthesiology, 5th Edition & Oxford Handbook of Anesthesiology.

[5] (2005) SSC (Crl) 1369

[6] 2021 SCC OnLine SC 1149

[7] (2009) 7 SCC 130

[8] (2021) SCC Online SC 673

[9] (2019) 2 SCC 282

[10] 2022 LiveLaw (SC) 391

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DR. S.M. KANTIKAR
PRESIDING MEMBER

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DINESH SINGH
MEMBER