THE HON'BLE SRI JUSTICE M.SATYANARAYANA MURTHY

APPEAL SUIT Nos.650 & 750 of 1997

COMMON JUDGMENT:-

Both these appeals are arising out of the decree and judgment in O.S.No.17 of 1991, passed by the Subordinate Judge's Court at Nalgonda, dated 30.12.1996, wherein the trial Court passed a decree for Rs.40,000/- towards compensation for the medical negligence attributed to the defendants.

In A.S.No.750 of 1997, the appellants are defendant Nos.2 to 4, respondents 1 to 3 are the plaintiffs and the 4th respondent is the Government of A.P./1st defendant in the suit.

In A.S.No.650 of 1997, the plaintiffs in O.S.No.17 of 1991 are the appellants and defendants are the respondents.

To avoid confusion, the ranks given to the parties in O.S.No.17 of 1991 before the trial Court will be adopted through out the judgment.

The plaintiffs filed the suit claiming damages/compensation of Rs.1,50,000/- for the untimely death of Smt.Premalatha, who was aged about 22 years at the time of her death, which occurred due to negligence in treating her by the defendants, alleging that during second pregnancy of Premalatha she was advised by the second defendant to be admitted into hospital for delivery. Accordingly, she got admitted in the Government District Headquarters Hospital, Nalgonda, on 22.07.1989 at 01.00 A.M. The 3rd plaintiff is the second issue born to Premalatha after Caesarean operation. After Premalatha was admitted into the hospital on 22.7.1989, she was

operated by the second defendant, who was assisted by third defendant as anesthetist, and the fourth defendant performed Tubectomy operation. During the process of the said operation, at about 3.30 a.m., the second defendant informed the attendants of Premalatha that a male child was born and Tubectomy operation was in progress. During Tubectomy operation, again the second defendant came out and enquired with the attendants of Premalatha as to whether Premalatha had previously suffered from epilepsy (fits). The attendants of Premlatha informed that she never suffered from such disorder.

At about 06:00 A.M., i.e., on the next day, Premalatha was brought out from the operation theatre and the Doctors informed that Tubectomy operation was also performed on her but Premalatha was found by her relatives in an unconscious state and continuous oxygen apparatus was running and at about 12:00 noon, the relatives of the plaintiffs were informed by the hospital authorities that she expired.

The 1st plaintiff, on receipt of information with regard to admission of his wife in the Government Headquarters Hospital, Nalgonda, reached Nalgonda at about 02.00 p.m. on 22.07.1989 and came to know about the death of his wife Premalatha. At the request of the hospital authorities, the 1st plaintiff and his relatives shifted the dead body and cremated on the next day at about 12:00 noon.

Premalatha was hale and healthy by the time of her death but the cause of death was only negligence in performing Tubectomy and Caesarean operations by defendants 2 to 4. It is further contended that Tubectomy operation was performed on her without the consent of the 1st plaintiff or Premalatha. It is further contended

that some upper and lower teeth of Premalatha were not present and basing on the medical case sheet maintained by the hospital authorities, the 1st plaintiff came to know that defendants 2 to 4 are careless and negligent in performing operations and caused death of Premalatha while she was being treated in the hospital.

The 1st plaintiff gave a complaint to the Superintendent of Headquarters Hospital on 25.07.1989 and on the basis of the said complaint, an enquiry was conducted at the District level under G.O.Rt.No.27, dated 07.01.1989, issued by the Government of A.P., and the said committee, after enquiry, awarded ex-gratia of Rs.10,000/- to the 1st plaintiff. Later the 1st plaintiff obtained Xerox copy of the case-sheet and on careful scrutiny, it came to his notice that defendant Nos.2 and 3 were negligent in performing Caesarean and Tubectomy operations and the cause of death of Premalatha was only due to the negligence of defendant Nos.2 and 3.

Premalatha was hale and healthy on the date of her death and on account of her death, the plaintiffs lost her services which were estimated at Rs.500/- p.m. The 2nd plaintiff, who is minor, requires services of attendant on account of the death of Premalatha and attendant services estimated at Rs.20,000/- besides the other heads of compensation including mental agony suffered by the 1st plaintiff and loss of consortium, and in total claimed Rs.1,50,000/- under various heads.

Claiming Rs.1,50,000/- for the medical negligence of defendant Nos.2 and 3, the 1st plaintiff got issued a legal notice under Section 80 C.P.C., to the 1st defendant, but no purpose was served and not even reply was issued. Hence the suit.

Defendants 2 to 4 filed written statement denying the material

allegations of the plaint, *inter alia,* contending that the suit is frivolous and vexatious. While denying the consultation of the second defendant, before Premalatha was admitted into hospital and the advice of the second defendant to admit Premalatha in hospital, it was contended that Premalatha was brought to the hospital by one person claiming to be the husband of Premalatha. Dr. Ram Mohan examined her and noted her blood pressure, pulse rate and heart and lungs condition and found to be normal. After subjecting her to preliminary investigations as routine, she was prepared for emergency Caesarean section.

Later she was shifted to operation theatre to perform Caesarean operation. At about 02.00 A.M., the Civil Surgeon Gynaecologist received a phone call for emergency Caesarean operation and he attended the hospital at 2.15 a.m., by which time the anesthetist was present. As per clinical observations regarding general conditions of the patient, inclusive of pulse rate, blood pressure, auscultation of heart and lungs were in accordance with the observations noted by Dr. Ram Mohan, Duty Medical Officer, and opined that no further investigations are required.

Before commencing operation, consent for caesarean as well as Tubectomy operations was obtained from a person, who claimed to be the husband of the patient, and he was informed that third pregnancy may be dangerous to her life and obtained signature on the consent in the case sheet. Later, Caesarean operation was performed from 02:45 a.m. to 3:45 a.m., under spinal anesthesia (local anesthesia). The particulars of anesthesia were noted in the register and it discloses administering of 5% xylocaine 1 c.c. Injection into subarachoid space between lumber No.3 & 4 and the “Effect was satisfactory”. As a result of caesarean, a male vigorous boy was born, alive. Normal saline was started. Injection

Metheregine was given after the delivery of the baby to facilitate the retraction of the uterus. It is further pleaded that during the operation, the fourth defendant was assisting the second defendant. The uterus was repaired in layers. In the said operation, the patient was also enquired and she gave consent for Tubectomy operation.

While the fourth defendant was performing Tubectomy operation, the second defendant stood by the side of the table observing the operation throughout and the third defendant was monitoring the patient's radial pulse and preasuricular pulse. Approximately at the end of the peritoneal closure about 20 to 30 minutes after commencement of the Tubectomy operation, the pulse was not felt. The site of the operation was found dry and chest movements and respiratory sounds were found absent. The third defendant gave a thumb with closed fist hand, started the external cardio message with the help of the second defendant and also gave intra cardiac adreline. 100% oxygen was given through facemask with IPPV. Heart sounds and pulse reappeared in less than one minute. Bright red blood appeared at the site of the operation. Endotracheal intubation was done. Spontaneous respiration was noted within three minutes. Closure of the abdomen was performed. Thereafter, the patient was trying to throw away the pharyngenal airway and was resisting the endotracheal tube. The endotracheal tube was therefore removed and the throat suction was done with the help of laryngoscope. At the said stage, carpal spasms were noted. Uncontrollable clenching of the teeth biting into metallic blade of the laryngoscope resulted in loosing of teeth and accordingly they were removed. The dental surgeon was also subsequently called and he assessed the loss of teeth after physical verification.

Later Dr. Bhavani Krishnaiah, Civil Surgeon was called and on his advice endotracheal intubation was done again. Subsequently, treatment as per the advice of Dr. Bhavani Krishnaiah, was continued. The patient was shifted to Gyneacology ward at about 05.55 a.m. along with the Boyles Apparatus. The second and the third defendant were with the patient till 09.00 a.m. and the third defendant was monitoring the patient. Post-operative investigations were also done to assess and to review the patient's metabolic changes. Dr. Bhavani Krishnaiah periodically reviewed the patient from 9.00 a.m. in the maternity ward. The patient suffered second cardiac arrest at 12.15 p.m. which resulted in death of Premalatha.

It is further contended that when the patient was brought to hospital, caesarean operation was to be conducted without any unreasonable delay due to her condition. There was neither carelessness nor negligence in conducting operation on Premalatha by defendants 2 to 4 and the death was only due to cardiac arrest while performing Tubectomy operation, which might be due to the result of some pre-existing cardiac disease of the patient. Thus there was no slightest carelessness or negligence in performing caesarean and Tubectomy operations thereby the death of Premalatha is not due to medical negligence of either of the Doctors, i.e., defendants 2 to 4 and prayed to dismiss the suit.

On trial, the trial Court framed as many as 11 issues, which read as under:

1. Whether the deceased K. Premalatha health was good before she was admitted in the Government Headquarters Hospital, Nalgonda for delivery?

2. Whether the second defendant was consulted during the first and second pregnancies of the

deceased K. Premalatha in relation to her pregnancies and deliveries by the deceased her parents and by the 1st plaintiff?

3. Whether tubectormy operation was performed on the deceased K. Premalatha without her or her husband's consent?

4. Whether the teeth of the deceased K. Premalatha were lost due to her teeth biting into metallic blades of the laryogoscope as pleaded by the Defendants No.2 to 4 in para-4 of their written statement?

5. Whether the defendant No.3 failed to mention in the case sheet of the deceased K. Premalatha regarding what method of anaesthesia was adopted and the quantity of anaesthetic material used?

6. Whether the deceased K. Premalatha suffered with symptoms of cardiac arrest approximately at the end of the peritoneal closure about 20-30 minutes of the starting of the operation and she suffered second cardiac arrest at 12.15 p.m. and died as pleaded in para-4 of the written statement by the defendant Nos.2 to 4?

7. Whether the defendants hospital authorities failed to perform post-mortem examination of the dead body of the deceased K. Premalatha to suppress the real cause of her death?

8. Whether the defendant Nos.2 to 4 were negligent in extending their professional skills while conducting caesarean and tubectomy operation of the deceased K. Premalatha?

9. Whether the deceased K. Premalatha died due to the negligence and want of professional skills of the defendant Nos.2 to 4 in conducting operations on her?

10. Whether the defendants are liable to pay compensation to the plaintiffs, if so to what quantum of compensation they are entitled?

11. To what reliefs the plaintiffs are entitled?

During the course of trial, on behalf of the plaintiffs, PWs.1 to 4 were examined and Exs.A.1 to A.4 were marked. On behalf of defendants, DWs.1 to 4 were examined and Exs.X.1 to X.15 were marked.

Upon hearing argument of both the counsel and considering oral and documentary evidence on record, the trial Court found that the death of the Premalatha (deceased) was due to failure in exhibiting required care and caution by defendants 2 to 4 in performing operation procedures, both Caesarean and Tubectomy. Thus the death was occasioned to negligence of defendants 2 to 4 and awarded compensation of Rs.40,000/- under all heads of compensation.

Aggrieved by the decree and judgment and having dissatisfied with the quantum of compensation, the plaintiffs preferred A.S.No.650 of 1997, whereas defendants 2 to 4 filed A.S.No.750 of 1997 raising various contentions.

The plaintiffs specifically contended that the quantum of damages/compensation awarded by the trial Court is very meager and the trial Court did not consider the loss under various heads of compensation/damages in proper perspective and mechanically awarded very low rate of compensation/damages for the untimely death of Premalatha due to medical negligence of
defendants 2 to 4.

Whereas the defendants mainly urged before this Court that the death was not due to the negligent act of any of the defendants and the finding of the trial Court that the death was due to failure of the defendants 2 to 4 to exhibit required care and caution while

performing operations is erroneous in view of the observations of the trial Court in various paragraphs. The trial Court having come to the conclusion that the death was not due to direct negligence of defendants 2 to 4, ought not to have recorded such finding, and committed an error, and prayed to set aside the decree and judgment passed by the trial Court against them and in favour of the plaintiffs by allowing the appeal.

During the course of arguments Sri T. Muralidhar Rao, appearing for the defendants/appellants in A.S.No.750 of 1997 vehemently contended that direct cause for the death of Premalatha was not negligence attributed to any of the Doctors since they took each and every precaution required to be taken while performing caesarean and Tubectomy operations. Therefore they cannot be saddled with any liability to pay compensation and prayed to allow the appeal by setting aside the decree and judgment in the suit making them personally liable to pay the said compensation.

Whereas Sri M Venkatarami Reddy, learned counsel for the plaintiffs/appellants in A.S.No.650 of 1997 argued in support of the findings, while challenging the quantum of compensation as it is too low and prayed to award just and reasonable compensation/damages while confirming the decree and judgment passed by the trial Court to the extent of negligence.

Considering rival contentions and perusing the decree and judgment under challenge, including the oral and documentary evidence, the points that arise for consideration are as follows:

1. *Whether D.2 to D.4 are negligent in performing caesarean procedure and Tubectomy operation after obtaining consent form the competent person if not are they liable for payment of damages/compensation for the untimely death of Premalatha?*

2. *Whether the plaintiffs are entitled to damages/compensation for untimely death of Premalatha, if so, to what relief?*

Point No.1:

Undisputedly Premalatha, who is the wife of the 1st plaintiff, was admitted in hospital on 22.07.1989 when she was suffering from labour pains for the second delivery and she was taken to operation theatre for Caesarean procedure. Similarly, performing of Tubectomy operation is also not in dispute, so also death of Premalatha while undergoing post operation treatment in the Government Headquarters Hospital, Nalgonda.

According to the defendants they have taken care and caution while treating the patient while conducting caesarean and Tubectomy operations, but the death was due to cardiac arrest on account of her suffering from pre-existing diseases as pleaded in the written statement. No post-mortem examination was conducted by the hospital authorities, but they handed over the dead body of Premalatha to her relatives and advised them to cremate the dead body.

In a case of medical negligence the initial onus of proof would be on the plaintiffs to prove that the patient was admitted and treated in the hospital and died during treatment, for the reason that the plaintiffs are not supposed to be present while conducting operation in the hospital theatre, it is impossible for any of the plaintiffs' to explain the reasons for death of patient. When the plaintiffs are able to establish admission of the patient in the hospital and death of the patient during treatment, the burden of proof would shift on to the defendants to disprove that the death was not due to the negligence of the Doctors, who treated her.

In the present case admission of Premalatha is undisputed fact but the cause of death, according to the Doctors, i.e., defendants 2 to 4, was due to cardiac arrest, which is pre-existing.

The word "negligence" is not denied anywhere. But in a catena of decisions reported time and again, the Apex Court defined the word "negligence" by the medical practitioners. Before deciding the alleged negligence of the duty Doctors i.e., defendants 2 to 4, who performed Caesarean and Tubectomy operations, I feel that it is appropriate to discuss as to what acts or omissions would amount to medical negligence.

In ***Martin F.D'Souza Vs. Mohd. Ishfaq***[1] the Apex Court defined the medical negligence as follows:

> "A medical practitioner is not liable to be held negligent simply because things went wrong from mischance or misadventure or through an error of judgment in choosing one reasonable course of treatment in preference to another. He would be liable only where his conduct fell below that of the standards of a reasonably competent practitioner in his field. For instance, he would be liable if he leaves a surgical gauze inside the patient after an operation vide Achutrao Haribhau Khodwa & others vs. State of Maharashtra & others, AIR 1996 SC 2377 or operates on the wrong part of the body, and he would be also criminally liable if he operates on someone for removing an organ for illegitimate trade.
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> The professional is one who professes to have some special skill. A professional impliedly assures the person dealing with him (i) that he has the skill which he professes to possess, (ii) that skill shall be exercised with reasonable care and caution.
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> Judged by this standard, the professional may be held liable for negligence on the ground that he was not possessed of the requisite skill which he professes to have. Thus a doctor who has a qualification in Ayurvedic or Homeopathic medicine will be liable if he prescribes Allopathic treatment

which causes some harm.

In ***State of Haryana Vs. Smt. Santra***[2], the same question came up for consideration before the Apex Court, wherein it was held that when the respondent therein gave birth to a child, in spite of sterilization, and when she was under considerable monetary burden, unwarranted child born to her has created additional burden for her on account of negligence of doctor, who performed sterilization operation upon her, such respondent is entitled to claim full damages from the State Government to enable her to bring up the child at least till she attains puberty.

In ***Jacob Mathew Vs. State of Punjab***[3] a Full Bench of Apex Court arrived at the following conclusions while defining the word 'negligence'.

> "1) Negligence is the breach of a duty caused by the omission to do something which a reasonable man, guided by those considerations which ordinarily regulate the conduct of human affairs would do, or doing something which a prudent and reasonable man would not do. The definition of negligence as given in Law of Torts, Ratanlal & Dhirajlal (edited by Justice G.P. Singh), referred to hereinabove, holds good. Negligence becomes actionable on account of injury resulting from the act or omission amounting to negligence attributable to the person sued. The essential components of negligence are three: 'duty', 'breach' and 'resulting damage'.
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> (2) Negligence in the context of medical profession necessarily calls for a treatment with a difference. To infer rashness or negligence on the part of a professional, in particular a doctor, additional considerations apply. A case of occupational negligence is different from one of professional negligence. A simple lack of care, an error of judgment or an accident, is not proof of negligence on the part of a medical professional. So long as a doctor follows a practice acceptable to the medical profession of that day, he cannot be held

liable for negligence merely because a better alternative course or method of treatment was also available or simply because a more skilled doctor would not have chosen to follow or resort to that practice or procedure which the accused followed. When it comes to the failure of taking precautions what has to be seen is whether those precautions were taken which the ordinary experience of men has found to be sufficient; a failure to use special or extraordinary precautions which might have prevented the particular happening cannot be the standard for judging the alleged negligence. So also, the standard of care, while assessing the practice as adopted, is judged in the light of knowledge available at the time of the incident, and not at the date of trial. Similarly, when the charge of negligence arises out of failure to use some particular equipment, the charge would fail if the equipment was not generally available at that particular time (that is, the time of the incident) at which it is suggested it should have been used.

(3) A professional may be held liable for negligence on one of the two findings: either he was not possessed of the requisite skill which he professed to have possessed, or, he did not exercise, with reasonable competence in the given case, the skill which he did possess. The standard to be applied for judging, whether the person charged has been negligent or not, would be that of an ordinary competent person exercising ordinary skill in that profession. It is not possible for every professional to possess the highest level of expertise or skills in that branch which he practices. A highly skilled professional may be possessed of better qualities, but that cannot be made the basis or the yardstick for judging the performance of the professional proceeded against on indictment of negligence.

(4) The test for determining medical negligence as laid down in Bolam's case [1957] 1 W.L.R. 582, 586 holds good in its applicability in India.

(5) The jurisprudential concept of negligence differs in civil and criminal law. What may be negligence in civil law may not necessarily be negligence in criminal law. For negligence to amount to an offence, the element of *mens rea* must be shown to exist. For an act to amount to criminal negligence, the degree of negligence should be

much higher i.e. gross or of a very high degree. Negligence which is neither gross nor of a higher degree may provide a ground for action in civil law but cannot form the basis for prosecution.

(6) The word 'gross' has not been used in Section 304A of IPC, yet it is settled that in criminal law negligence or recklessness, to be so held, must be of such a high degree as to be 'gross'. The expression 'rash or negligent act' as occurring in Section 304A of the IPC has to be read as qualified by the word 'grossly'.

(7) To prosecute a medical professional for negligence under criminal law it must be shown that the accused did something or failed to do something which in the given facts and circumstances no medical professional in his ordinary senses and prudence would have done or failed to do. The hazard taken by the accused doctor should be of such a nature that the injury which resulted was most likely imminent.

(8) *Res ipsa loquitur* is only a rule of evidence and operates in the domain of civil law specially in cases of torts and helps in determining the onus of proof in actions relating to negligence. It cannot be pressed in service for determining per se the liability for negligence within the domain of criminal law. *Res ipsa loquitur* has, if at all, a limited application in trial on a charge of criminal negligence.

In a recent judgment reported in ***Dr. P.B. Desai Vs. State of Maharashtra***[4] the Apex Court defined the concept of 'medical negligence', which is as follows:

"It could have been only if doctors would have faltered and acted in rash and gross negligent manner in performing necessary procedure. At the same time his act of omission afterwards, in not doing surgery himself and remaining absent from scene and neglecting patient even thereafter when she was suffering consequences of fistula was an act of negligence and was definitely blameworthy. Therefore, omission was not of a kind which had given rise to criminal liability under given circumstances. When appellant decided to operate on patient against U.S. doctor's advice, level of attention expected towards patient was immense and undivided kind. Operating surgeon along with fellow junior doctors was absent and appellant's omission in

> not rendering complete and undivided legally owed duty to patient and not performing procedure himself had not made any difference. It was not cause of patient's death which was undoubtedly because of acute chronic cancer condition. Negligent conduct in nature of omission of appellant was not so gross as to entail criminal liability on appellant under Section 338 of IPC but it would amount to negligence on his part and also amount to actionable wrong in tort."

From a reading of principles laid down by the Apex Court, in the decisions referred supra, it is clear that failure to record Blood Pressure, Pulse etc., and shifting to General Ward when Premalatha suffered heart-stroke while completing the procedure or omission to do an act or commission, which is not supposed to do while treating a patient, amounts to negligence. Therefore, keeping in mind the principles laid down in the judgments referred supra, I must necessarily advert to the evidence on record to decide whether the defendants were negligent in discharging their duties with due care and caution as ordinary prudent doctors.

In ***Savita Garg (Smt.) Vs. Director, National Heart Institute***[5], the Apex Court, while discussing onus of proof, ruled as follows:-

> "Once an allegation is made that the patient was admitted in a particular hospital and evidence is produced to satisfy that he died because of lack of proper care and negligence, then the burden lies on the hospital to justify that there was no negligence on the part of treating doctor or hospital. Therefore, in any case, the hospital is in a better position to disclose what care was taken or what medicine was administered to the patient. It is the duty of the hospital to satisfy that there was no lack of care and diligence. The hospitals are institutions, people expect better and efficient service, if the hospitals fails to discharge their duties through their doctors, being employed on job basis or employed on contract basis, it is the hospital which has to justify and not impleading a particular doctor will not absolve the hospital of its responsibilities."

Therefore, by applying the principles laid down in the above judgment, it is my duty to decide whether the death of Premalatha was due to medical negligence of defendants 2 to 4 or not. If the plaintiffs discharged their initial burden producing *prima facie* evidence, the burden will shift to hospital.

On behalf of the plaintiffs PWs.1 to 4 were examined and Exs.A.1 to A.4 were marked. PW.1 is the husband, who claims to be not present when Premalatha was admitted in the hospital, but Premalatha was accompanied by her father, sister and sister's husband to the hospital. When Premalatha was admitted and she was required to undergo a Caesarean operation, the Doctors are under obligation to obtain consent of a competent person. But here, under Ex.X.6, they allegedly obtained the consent of a person who is claiming to be the husband of Premalatha. There are certain corrections in Ex.X.6 and it is in the handwriting of the second defendant. When the 1st plaintiff was not available at the hospital, more particularly when he was available at his village, which is away to the hospital, he is not expected to sign on the consent. Therefore, obtaining consent of PW.1 – the husband of deceased Premalatha, before performing Caesarean and Tubectomy operations, does not arise. Mere obtaining the consent of somebody else is not sufficient, since the consent was for Caesarean and Tubectomy operations which would lead to serious future complications and unless consent of competent person was given, the same cannot be treated as consent, as required. The trial Court compared the signatures in Ex.X.6 with the admitted signatures on the vakalat, plaint and other documents of plaint and found that the 1st plaintiff was in the habit of signing in Telugu but not in English. But the signature on Ex.X.6 was appearing in English.

In ***Nizam's Institute of Medical Sciences Vs. Prasanth S. Dhananka and others***[6], the Apex Court, while dealing with consent required to undergo surgical procedures, ruled as follows:-

> "We see from the cross examination of the complainant that no consent for the operation had been taken. Moreover, it is significant that even though the record of the case had been produced before the Commission, it was with some reluctance and after several specific orders, but the written consent which had allegedly been taken is not a part of the record. It is equally significant that in the written submissions which had been filed, a copy of the consent form of NIMS has been appended but not the actual consent taken from the complainant. It must, therefore, be held that the withholding of the aforesaid document raises a presumption against the 30 NIMS and the attending Doctors. We find that the consent given by the complainant for the excision biopsy cannot, by inference, be taken as an implied consent for a surgery (save in exceptional cases), as held by this Court in *Samira Kohli Vs. Dr. Prabha Manchanda & another* (2008) 2 SCC 1. The two issues which are relevant for our purpose and raised before the Bench were:
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> (i) Whether informed consent of a patient is necessary for surgical procedure involving removal of reproductive organs? If so, what is the nature of such consent?
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> (ii) When a patient consults a medical practitioner, whether consent given for diagnostic surgery can be construed as consent for performing additional or further surgical procedure – either as conservative treatment or as radical treatment – without the specific consent for such additional or further surgery?
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> These two questions were answered in the following terms:
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> "Consent in the context of a doctor patient relationship, means the grant of permission by the patient for an act to be carried out by the doctor, such as a diagnostic, surgical or therapeutic procedure. Consent can be implied in some circumstances from the action of the patient. For example, when a patient enters a dentist's clinic and sits in the dental chair, his consent is implied for examination, diagnosis and

consultation. Except where consent can be clearly and obviously implied, there should be express consent. There is, however, a significant difference in the nature of express consent of the patient, known as "real consent" in UK and as "informed consent" in America. In UK, the elements of consent are defined with reference to the patient and a consent is considered to be valid and "real" when (i) the patient gives it voluntarily without any coercion; (ii) the patient has the capacity and competence to give consent; and (iii) the patient has the minimum of adequate level of information about the nature of the procedure to which he is consenting to. On the other hand, the concept of "informed consent" developed by American courts, while retaining the basic requirements of consent, shifts the emphasis on the doctor's duty to disclose the necessary information to the patient to secure his consent. "Informed consent" is defined in *Taber's Cyclopedic Medical Dictionary* thus:

"Consent that is given by a person after receipt of the following information: the nature and purpose of the proposed procedure or treatment; the expected outcome and the likelihood of success; the risks; the alternatives to the procedure and supporting information regarding those alternatives; and the effect of no treatment or procedure, including the effect on the prognosis and the material risks associated with no treatment. Also included are instructions concerning what should be done if the procedure turns out to be harmful or unsuccessful."."

Therefore, the consent allegedly given by the first plaintiff is not a valid consent. On this ground alone the defendants can be said to be negligent and careless in performing operations.

From the beginning, it is the consistent case of the defendants that the third defendant is an Anesthetist, who gave local anesthesia to Premalatha while performing Caesarean procedure and noted the details of anesthesia in the anesthesia book, which was marked as Ex.X.2. But the major mistake he committed was that while he was attending on the patient throughout the procedure, it is his duty to record pulse rate and B.P.,

from time to time on a sheet maintained by the hospital authorities. The explanation he offered for his failure to note down the pulse rate, B.P., etc., was that he had no access to record, but that is not a reasonable explanation for his failure to record the pulse rate, B.P., etc. The requirement to record pulse rate, B.P., etc., are only to take further steps to administer necessary drugs while treating the patient depending upon the pulse rate and B.P. For the failure on the part of the third defendant in recording pulse rate and B.P., the second and the fourth defendant could not take appropriate steps while treating Premalatha.

The trial Court, at paragraph 49 of the impugned judgment, made a clear observation that as per the synopsis of anesthesia by Alfred Lee at page 431, a chart should be maintained and on the said chart B.P and other details are to be disclosed. In the same paragraph it was observed that as per page 757 by W.D. Vylie on "practice of Anaesthesia" it is the duty of the anesthetist for proper monitoring of B.P. and pulse rate of the patient, but the second defendant did not record the pulse rate and B.P as mandated or required. Even according to the "Principles and Practice of medicine" by Davidson at page 272, if there is cardiac arrest this is not resuscitated within one minute the heart would fail to function.

The corrections in Ex.X.9 clearly disclose that the defendants made a dishonest attempt to change the entries in case sheet. Initially, it was recorded that restoration of pulse rate took place within five minutes from failure of pulse rate. But it was corrected as one minute conveniently to avoid their liability to pay compensation due to negligence, they exhibited.

Similarly, the evidence of DWs.1 to 3 discloses that after conducting Caesarean operation, they obtained consent while Premalatha was under the influence of local anesthesia and the

said fact was not noted in the case sheet. Further, obtaining of consent while Premalatha was suffering from pain due to Caesarean and under the influence of local anesthesia, the said oral consent cannot be said to be a valid consent to perform Tubectomy operation. On this ground also i.e., performance of Tubectomy operation without consent of competent person, it can be said to be carelessness or negligence in performing Tubectomy operation.

The admission of P.W.1 that he did not record the particulars of blood pressure, heart beat etc., would go to show that he was negligent in performing or discharging his duty as an ordinary prudent doctor. The commentary of J.Alfred Lee, R.S.Atkinson, 7th Edition, 1973 at page No.431, it was observed that blood pressure and pulse rates should be charted on record at frequent intervals during the operation. According to D.W.1, at the fag end of closure of peritoneum, the pulse beating was not felt by D.W.1 and on auscultation heart sounds were absent and the respiration stopped. Though the respiration stopped, blue blood was found on the womb and D.W.1 alerted the Surgeon about the condition of the heart. According to her, blue blood comes due to lack of oxygen to the heart. None of the doctors noticed about the abnormal condition of the patient. The admitted facts regarding the finding that in the absence of respiration and heart sounds etc., are only due to failure on the part of the doctor to take necessary care recording the pulse rate, heart beat, blood pressure etc., are not in dispute. This is a direct negligence attributable to D.W.1 for the reason that he did not record the pulse rate and it is sufficient to hold that D.W.1 is guilty of negligence in discharging his duties. Negligence may be either due to omission or commission. Here, not recording the details in the chart amounts to negligence.

Further, in the evidence of D.W.2, it was stated that blue blood was present when Tubectomy was being performed and the cause for presence of blue blood is lack of oxygen. Had D.W.1 recorded the pulse rate, blood pressure etc., the doctors would have observed lack of oxygen and prevented such blue blood due to lack of oxygen to the heart. According to D.W.4, the cause of cardiac arrest was due to brain-stem paralysis and not due to any pre-existing cardiac disease of the (deceased) Premalatha. But in the written statement, the defendant specifically pleaded that cardiac arrest was due to pre-existing cardiac disease of Premalatha and the same was disproved in view of the findings recorded by the duty doctor Mohan Rao in the case-sheet and pleadings and evidence of the defendants. They themselves satisfied about the general condition of the patient including the functioning of heart, lungs, brain etc. Therefore, the contention that the cardiac arrest was due to pre-existing heart disease of Premalatha is untenable.

D.Ws.1, 2 and 3 did not state anything about the reason for cardiac arrest of Premalatha, but D.W.4 specifically testified that the cause for cardiac arrest was due to brain-stem paralysis, which may be caused due to brain tumor or lack of oxygen. Here, due to failure on the part of D.W.1 to record the pulse rate, blood pressure etc., the doctors did not supply oxygen to the patient Premalatha while conducting operation, which resulted in Brain-stem paralysis and led to cardiac arrest. None of the doctors recorded the root-cause for cardiac arrest in the case-sheet. It appears from the evidence on record that the doctors did not even diagnose the decease from which she was suffering or the cause of cardiac arrest during the treatment.

There is yet another aspect, shifting of patient to general

maternity ward while she suffered severe heart-attack when she underwent Tubectomy operation is nothing but carelessness in treating the patient. When the (deceased) Premalatha suffered heart stroke in the operation theatre while performing Tubectomy operation, utmost care and caution ought to have been taken by the doctors considering the abnormality of the patient rather than treating the patient ordinarily and negligently shifting her to the general maternity ward. Therefore, I am constrained to hold that such negligent treatment of the patient by the doctors has resulted in death of Premalatha.

One of the contentions of the learned counsel for the defendants is that no staff was provided to assist the anesthetist for recording the readings. But that is not the ground to disown the responsibility of the doctors in treating the patient. In the recent judgment rendered in the case between ***Rajmal Vs. State of Rajasthan***[7], the High Court of Rajasthan made certain observations in respect of medical negligence. At point No.2 in the said judgment it was observed as follows:-

> "While cardiac arrest due to pneumo peritoneal needle insertion is rare but not unknown, we feel that the life of the patient could have been saved if adequate resuscitative facilities e.g. Endotracheal anaesthesic, defibrillator and cardiac monitoring equipment had been available. Since every human life is equal, we feel that whenever laproscopic tubectomy is being done whether in a major hospital or in smaller hospitals or in a laproscopic tubectomy Camp, a trained anesthetist with M. S. degree in anesthesiology, and the above mentioned equipment should be available. This should be mandatory for every laproscopic tubectomy operation, in view of the sensitive nature of the operation and the fact that the patient is young, disease free and healthy. Other than the lack of above mentioned resuscitative equipment and trained anesthetist, we find no evidence to doubt the competence or integrity or efforts made by Dr.C.P.Gupta."

In the light of the above judgment of the Rajasthan High Court, it is obligatory on the part of the doctors and the hospitals to keep the necessary equipment in the hospitals. In the instant case, for the reasons best known to the doctors and the hospital, no such equipments were made available for Tubectomy operation which was conducted on the Premalatha. This is also a clear omission on the part of the defendants to conclude that the doctors were negligent in treating the patient Premalatha.

The trial Court referred to various books including the Davidson's Principles and Practice of Medicine edited by Christopher R.W.Edwards and Ian A.D. Bouchier, 16th Edition at Page No.272, which reads as under:-

> "Cardiac arrest is the sudden and complete loss of cardiac function. It may be due to ventricular fibrillation, a systole, or electromechanical dissociation. Ventricular Fibrillation: this is the commonest cause and the most easily treatable cause of sudden death. It may be due to myocardial ischaemia or inappropriate electrical stimulation such as electrocution.
>
> It may be due to a localized failure of impulse conducting tissue with delay in the emergence of a ventricular escape rhythm or massive ventricular damage complicating myocardial infarction. With the former, cardiac massage or a blow to the chest will often restore cardiac activity, although an artificial pacemaker may be needed to prevent recurrent attacks"

Even according to the observations of the trial Court, the evidence of D.W.2 clearly discloses that if there was supply of oxygen to the patient, the blue blood would not have appeared. According to D.W.1, no blue blood appeared but D.W.2 had categorically deposed that blue blood appeared. Thus, in view of the inconsistent versions of D.W.2 and D.W.1, it is clear that the Brain-Stem Paralysis, suffered by the (deceased) Premalatha, is

only due to lack of oxygen, due to which, the blue blood appeared. If necessary care and caution were taken while conducting operation, Premalatha would have survived. Failure to take such precautions, viz., to provide oxygen in the operation theatre while conducting Tubectomy operation, is a clear negligence attributable to the doctors who conducted operation on Premalatha.

A similar case came up before this Court in the case between ***Mahaveer Hospital and Research Centre Vs. Alladi Suvarnamma and another***[8], wherein, this Court, after referring to several judgments of both Indian and foreign Courts, held that the defendant was under the duty to take reasonable care towards the patient to avoid damage complained of or not to cause damage to the patient by failure to use reasonable care; and, that there was a breach of duty on the part of the defendant; and, that breach of duty was the legal cause of the damage complained of and such damage was reasonably foreseeable and, therefore, the doctors are liable for payment of compensation.

In the case between ***Dr. Laxman Balkrishna Joshi Vs. Dr. Trimbak Bapu Godbole and another***[9], the Apex court held that real cause of death, namely, shock resulting from his treatment, he had hit upon theory of cerebral embolism and tried to bolster it up by stating that it must have set in right from time die accident occurred – Apologetic letter furnishes a clear indication that he was not definite even at that stage that death was result of embolism or that even if it was so, it was due to reason which he later put forward. Thus, there was no reason to think that High Court was wrong in its conclusion that death was due to shock resulting from reduction of fracture attempted by appellant without taking elementary caution of giving anesthesia to patient. Thus, the trial Court and High Court were right in holding that the appellant was guilty of negligence and

wrongful acts towards patient and was liable for damages.

In the instant case, by the date of conducting of both Tubectomy and Cesarean operations, no guidelines were issued by the Government of India concerning the same. However, in the month of November, 2009, the Government of India issued certain guidelines in the name of "Reference Manual for Minilap Tubectomy". According to Chapter – III of the said manual, counseling is an ongoing process that is integrated into all aspects of family planning service provision, enabling clients to make a voluntary, informed choice. Clients are likely to adjust well and be satisfied with their decision after surgery, if service providers have told them, what to expect and if they take responsibility for the decision to end their fertility. Satisfied clients also spread positive message regarding the contraceptive method, they are happy with. Every person working in a healthy facility contributes to the counseling process. Therefore, it is important that all of them are oriented to family planning counseling, in order to provide quality family planning services. The first method in counseling is general conselling, second method is method-specific counseling which enables pre-procedure counseling and post-procedure counseling and the third stage is follow-up counseling. In the same manual, the topic of 'Informed Consent' is included. It reads that informed consent means that a client understands the proposed medical procedure and the order of options and then agrees to receive the proposed care. However, informed consent alone does not constitute choice. The purpose of informed choice is to ensure that all clients choose the best option/s for their health care needs after getting full information about all available options. The informed consent must be documentary and the client's signature or putting her thumb mark on an informed consent form is the legal

authorization for the Tubectomy procedure to be performed. The client must always sign or put her thumb mark on the informed consent form in Annexure – 1. Similarly, the informed consent for Tubectomy should not be obtained when physical or emotional factors may compromise a client's ability to make a carefully considered decision about contraception.

In the instant case, the defendants 1 to 3 obtained consent after Cesarean operation while she was under the influence of local anesthesia and suffering from pain due to cesarean and as such, the consent obtained by the doctors from the patient who is in sub-conscious state of mind and under the influence of local anesthesia, cannot be said to be informed consent and the said act of the doctors is not in accordance with law and it cannot be said to be a valid consent. In fact, it is not the case of the defendants that they have obtained the consent by documentation. Therefore, performing Tubectomy operation without the consent of the patient Premalatha or her husband, who is competent to give consent which disables them to procreate children in future, is an invalid consent and conducting Tubectomy operation without any authority and consent of any competent person is invalid. In such a case, the death of Premalatha due to conducting Tubectomy operation and failure to provide necessary oxygen which resulted in Brain-Stem paralysis, which was not even diagnosed by any of the doctors during the treatment, and keeping Premalatha in the general maternity ward without proper attendance by competent doctors clearly amounts to failure on the part of the doctors to take proper care and caution while treating the patient who had suffered heart-stroke which is before 12 years prior to her death and thus, it amounts to negligence.

The trial court, after minute analysis of entire evidence

available on record including the references in various books on medical procedures etc., rightly concluded that the proximate cause for the death of (deceased) Premalatha was due to negligent act of the doctors D.W.1 to D.W.3. Failure to supply oxygen in the operation theatre while conducting Tubectomy operation, which led to Brain-Stem Peralysis resulting in the death due to cardiac arrest is certainly said to be negligence on the part of the doctors D.Ws.2 to 4. The findings of the trial Court on this point are well-considered and do not call for interference of this Court and I find no illegality in the findings of the trial court warranting interference. Accordingly, the findings of the trial Court on this point are hereby confirmed, holding this point against the defendants and in favour of the plaintiffs.

Point No.2:-

One of the contentions of the plaintiff before this Court is that the compensation awarded by the trial Court is too low as against the claim of Rs.1,50,000/- under various heads. By the date of death of Premalatha, she was aged 23 years and was hale and healthy, even according to the admissions made in the written statement by the defendants. There are no specific guidelines for assessment of damages in case of medical negligence, but the ordinary principles laid down in Motor Vehicles Act, 1988, can be adopted even to the cases of medical negligence, since the compensation or damages, though termed differently, is one and the same. Here the trial Court awarded damages of Rs.40,000/-. The loss sustained by the plaintiffs who suffered loss of company, guidance to the minors and loss of services to the family by the deceased Premalatha during her life and also entitled to damages under the head of loss of consortium. If the principles for assessment of compensation in cases under M.V. Act are applied to the instant case of medical negligence, certainly the

damages awarded by the trial Court is too low. In a recent judgment reported in ***Arun Kumar Agarwal and another Vs. National Insurance Company Limited and others***[10], on account of death of a housewife, the Apex Court awarded an amount of Rs.6,00,000/-.

In ***Dr. Balram Prasad Vs. Dr. Kunal Saha and others***[11], the Apex Court had an occasion to decide the question of amount of compensation and held that as the right to health of a citizen is a fundamental right, as guaranteed under Article 21 of the Constitution of India, Doctors, Hospitals, Nursing Homes and Poly-Clinics are liable to provide the same to the patients. It was further held therein that, it is the duty of the Tribunals, Commissions and the Courts to consider relevant facts and evidence and circumstances of each and every case to award just and reasonable compensation. Courts while adjudging compensation should also take into account factors like inflation of money as per cost of Inflation Index (C.I.I.), which is determined by the Union Finance Ministry every year to appreciate level of devaluation of money. There cannot be a straitjacket multiplier method in medical negligence claims and the Courts are expected to arrive at just, fair and reasonable compensation on the basis of income that was being earned by the deceased at the time of death and other related claims on account of death. While awarding just compensation, the order can be passed irrespective of the fact whether any plea in that behalf was raised by the claimant or not as the claimant, once held entitled, should receive sum of money which would put him in the same position as he would have been if he had not sustained the wrong.

Therefore, by applying the principles laid down by the Apex Court in ***Dr. Balram Prasad***'s case *supra*, the amount awarded

towards damages for the untimely death of Premalatha due to the medical negligence of D.Ws.2 to 4 is not just and the same is too low. Of course, Premalatha was only aged 23 years by the time of her death. By the date of her death, she would have sent her children to school during her lifetime besides guidance to the minors, giving company to her husband. Therefore, the plaintiff, being the husband of the deceased Premalatha, lost his company and is thereby entitled to a minimum amount of Rs.40,000/- under the head of loss of consortium, whereas the children of the deceased Premlatha, who suffered the loss of guidance due to death, are entitled to reasonable compensation. Therefore, taking into consideration the age of the claimant/plaintiff, I of the considered view that awarding of Rs.1,00,000/- under various heads of compensation is just and reasonable to meet the ends of justice. Accordingly, the compensation awarded by the trial Court is enhanced from Rs.40,000/- to Rs.1,00,000/-. This point is answered accordingly.

In view of the above discussion and for the foregoing reasons, I find that there are no merits in the appeal preferred by the defendants and is liable to be dismissed. At the same time, I hold that the appeal preferred by the plaintiffs deserves to be allowed in part by enhancing the compensation.

In the result, A.S.No.750 of 1997 preferred by the defendants is dismissed without costs. A.S.No.650 of 1997, preferred by the plaintiff, is allowed in part enhancing the amount of compensation awarded by the trial Court from Rs.40,000/- to Rs.1,00,000/- for the untimely death of Premalatha due to medical negligence with costs, through out.

Miscellaneous petitions, if any, pending in both these

appeals, shall stand dismissed.

M. SATYANARAYANA MURTHY, J

03rd August, 2015
Js / Bvv

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[1] AIR 2009 SC 2049

[2] AIR 2000 SC 1888

[3] AIR 2005 SC 3180

[4] AIR 2014 SC 795

[5] (2004) 8 SCC 56

[6] 2009 (6) SCC 1

[7] AIR 1996 Rajasthan 80

[8] 2006 (4) ALT 498

[9] AIR 1969 SC 128

[10] 2010 ACJ 2161

[11] 2014 (1) SCC 384