NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION
NEW DELHI

FIRST APPEAL NO. 458 OF 2015

(Against the Order dated 04/02/2015 in Complaint No. 155/1997 of the State Commission Maharashtra)

1. TATE HOSPITAL & ANR.
SUKHANGAN, OPP. S.T. DEPOT, NALLASOPARA (W)
DISTRICT-PALGHAR-401203
MAHARASHTRA
2. DR. RAJESH L/ TATE
SUKHANGAN, OPP. S.T. DEPOT, NALLASOPARA (W)
DISTRICT PALGHAR-401203 .....Appellant(s)

Versus

1. SUSHRUT BRAHMABHATT & 2 ORS.
ALL RESIDING AT 108, CHANDRAMAULI, ABHINAV NAGAR, NATIONAL PARK,
BORIVALI (E),
MUMBAI-400066
2. MS. KRUPALI BRAHMABHATT
R/O. AT 108, CHANDRAMAULI, ABHINAV NAGAR, NATIONAL PARK,
BORIVALI (E), MUMBAI-400066
3. MS. HETAL BRAHMABHATT
R/O. AT 108, CHANDRAMAULI, ABHINAV NAGAR, NATIONAL PARK,
BORIVALI (E), MUMBAI-400066 .....Respondent(s)

BEFORE:
HON'BLE MR. JUSTICE R.K. AGRAWAL,PRESIDENT
HON'BLE DR. S.M. KANTIKAR,MEMBER

For the Appellant :
For the Respondent :

Dated : 11 Nov 2021

ORDER

Appeared at the time of arguments through Video Conferencing
For the Appellants : Mr. Anand Patwardhan, Advocate

For the Respondents : Mr. Shirish V. Deshpande, Advocate
Dr. Archana Sabnis, AR

Pronounced on: 11th November 2021

ORDER
PER DR. S. M. KANTIKAR, MEMBER

"There is something about losing a mother that is permanent and inexpressible – a wound that will never quite heal." – Susan Wiggs
We understand how challenging and painful a Mother's day without mom.

1. The instant Appeal has been filed by Dr. Rajesh L. Tate (hereinafter referred to as the 'Appellant/Opposite Party No. 2') and the Tate Hospital (hereinafter referred to as the 'Hospital/ Opposite Party No. 1') against the Order dated 04.02.2015 passed by the Maharashtra State Consumer Disputes Redressal Commission (hereinafter referred to as the 'State Commission'), wherein the Appellants were held liable for medical negligence.

2. Facts in brief are that Smt. Mayuri S. Brahmabhatt (hereinafter referred to as the 'Patient') during her 2nd pregnancy was visiting the Opposite Party No. 1 Hospital for regular check-up. On 19.09.1995, Dr. Tate, the Opposite Party No. 2 examined her and informed the couple that the baby was full term, matured and the delivery could occur at any time. He further advised to bring the patient immediately on noticing pain, signs of bleeding or fluid. At home, on 20.09.1995 at about 5.30 am, the patient started bleeding and immediately she was admitted to the Tate Hospital at 6.30 am. At 6.45 am she was examined by Opposite Party No. 2 and decided to perform Lower segment Caesarean Section (LSCS). The consent was obtained from her husband Mr. Sushrut Brahmabhatt (hereinafter referred to as the 'Complainant No. 1'). The Anaesthetist Dr. (Mrs.) Kelkar (hereinafter referred to as the 'Opposite Party No. 3') arrived at 8.00 am and the patient was taken to the operation theatre for LSCS under spinal Anaesthesia. It was alleged that at 8.45 am, the Opposite Party No. 2 asked the patient's husband to get a bottle of Haemaccel which was immediately purchased from local Pharmacist along with other medicines. At 9.30 am, the patient delivered a female baby. It was alleged that the Opposite Party No. 2 told his assistant to call urgently another Gynaecologist and also told the relatives of patient to arrange 'A-Negative' blood. A note on a piece of paper was given for Amit Biological Blood Bank, Vasai for supply of blood. It was further alleged that the person who went to the Blood Bank returned because the blood samples were contaminated, therefore pure sample were redrawn and given with a proper requisition slip to the Blood Bank and thereafter at about 10.30 am, 4 bottles of blood were arranged. In the meantime, due to anxiety, the co-brother of the Complainant, Dr. Ram Barot, contacted one Gynaecologist, Dr. Asha Sharik at Mallad, who performed 1st LSCS of the patient. She telephonically gave instructions to Dr. Tate to shift the patient to Bhagwati Hospital at Borivali where she could perform emergency hysterectomy to save the life of patient. The Complainant submitted that Dr. Ram Barot arranged 18 bottles of A Negative blood at Bhagwati Hospital and requested few doctors to remain present there. It was further alleged that the relatives requested the Opposite Party No. 2 to shift the patient to Bhagwati Hospital, however because of heated arguments between the Opposite Party No. 2 and the relatives, the request was refused. It was further alleged that at 3 pm, when the things were beyond control of the Opposite Party No. 2 and he realised the patient could not be saved, then decided to shift the patient to Bhagwati Hospital. While shifting the Opposite Parties Nos. 2 and 3 accompanied the patient in the ambulance which reached at Bhagwati Hospital at 4.30pm, but the patient was declared dead before admission. The Post-Mortem (PM) was performed and the cause of death was stated as "haemorrhagic shock following surgery".

Being aggrieved by the alleged deficiency and negligence during the treatment (LSCS) causing death of the patient, the husband of the patient Sushrut Brahmabhatt and two minor children Ms. Krupali and Ms. Hetal filed a Consumer Complaint before the State Commission.

3. The Opposite Parties filed their reply and denied all the allegations of the negligence and deficiency during LSCS. The Opposite Party No. 2 admitted that it was 2nd LSCS and a female child delivered at 9.30am. He further submitted that because of patient previous delivery and her rare blood group (A negative); he specifically advised the couple to go for delivery, where Blood Bank facility is available; however the couple expressed their inconvenience go to other place and decided for delivery at the Opposite Party No. 1 Hospital. The patient's husband assured to arrange required blood but he failed to arrange blood in time, therefore, the Opposite Party No. 2 arranged the blood from the Amit Blood Bank. After LSCS, the patient suffered profuse bleeding, therefore another Gynaecologist was called for help and make every possible efforts to treat the complications. Lastly, the decision was taken to shift the patient to Bhagwati Hospital at Borivali(W). The Opposite Parties No. 2 and 3 accompanied the patient in the ambulance, but unfortunately the patient died on reaching the Hospital. Therefore, there was neither negligence nor deficiency on the part of the Opposite Parties and the Complaint being frivolous, prayed for dismissal of the Complaint.

4. Upon hearing the parties the State Commission partly allowed the Complaint and directed the Parties to pay Rs. 16 lakh as compensation and Rs. 15,000/- towards the cost of the litigation to the Complainant.

5. Being aggrieved, the Opposite Parties Nos. 1 and 2 have filed the instant Appeal before this Commission.

6. We have heard the arguments at length from the learned Counsel on both sides and perused the material on record inter alia the Original record and the Order passed by the State Commission.

7. The learned Counsel on both the sides vehemently argued and reiterated their evidence filed before the State Commission. They have filed relevant medical literature and few decisions on medical negligence.

8. After our thoughtful consideration; in the instant appeal two questions which arose for consideration are whether the Opposite Party No. 2 Dr. Tate failed in his duty of care and secondly whether it was reasonable care during treatment of the patient.

9. It is an admitted fact that on 20.9.1995 Dr. Tate performed LSCS and a female baby delivered at 9.30 am. After the delivery, the patient developed profuse vaginal bleeding. The doctors did not succeed to stop the bleeding till 2.30 pm and then, the patient was taken by ambulance to Bhagwati Hospital at Borivali. However, unfortunately, the patient died at around 4.30 pm when the ambulance reached the hospital. The Post-Mortem report stated the cause of death was "haemorrhagic shock following surgery".

10. The Complainant in his support filed an opinion and affidavit of Dr. (Mrs.) Jennifer Sheth, a qualified Obstetrician and Gynaecologist, having 27 years of experience. The opinion was sought by complainant through the Association for Consumers Action on Safety and Health (ACASH). We have perused the opinion and note that the patient was 'A' Rh- Negative and had 1st LSCS delivery; therefore for 2nd delivery there were chances of unexpected uncontrolled haemorrhage. The treating doctor should keep sufficient "A negative" blood ready or make necessary arrangement to handle such complication. She further opined that the "emergency hysterectomy" or "vessel ligation" was necessary. The operative notes revealed that- there was difficulty in separating bladder and 1 inch lateral tear on both the sides of the uterus. It was one of the causes of bleeding. It is apparent from the record that the bleeding was not controlled for 1 ½ hour after the birth of the child. As per medical text under such circumstances, the "emergency hysterectomy" or "internal Iliac Ligation" was to be performed and then the patient could be shifted to the higher centre. Moreover, if we consider because of atonic uterus and adhesions caused primary haemorrhage which led to DIC; the patient could be saved if the blood and blood

components were given in time and later on the patient to be shifted the higher centre. Because cross-matched blood is not always available, maternity units should have immediate access (within 5 min) to O-negative blood. Consequently, in our view all maternity units should have their own reserve of blood products if there is no blood bank on-site.
11. In the instant case the witness Dr. Pawar on behalf of Opposite Party No. 2 stated that blood donors were available before surgery. We don't agree because, there is nothing on record to prove that the Opposite Party No. 2 took sufficient steps to keep A Negative blood ready. Beforehand the patient's blood was not sent to the blood bank for Grouping & Cross matching.
12. It is pertinent to note that the Opposite Party No. 2 failed to control / arrest the bleeding till 12.30 PM. It is evident from the clinical notes that he failed to take immediate surgical intervention or failed to refer the patient to any higher centre. The clinical notes are reproduced as below:
6.30 am Mrs. Mayuri was admitted with a sign of Show on
8.00 am Anaesthetist came to appellants' hospital
8.30 am Mrs. Mayuri was given Spinal Anaesthesia
9.30 am Baby delivered and the patient went in to atonic PPH
10.30 am Mrs. Sujata went to the blood Bank to donate blood
11.30 am Blood transfused
2.30 pm Decision taken to transfer Mrs. Mayuri to Bhagwati Hospital
3.00 pm Mrs. Mayuri was transferred to Bhagwati Hospital

13. Thus the notes (supra) show, the patient developed Atonic PPH at 9.30 am, but crucial period of 5 to 5 ½ hours was lost before transferring the patient to Bhagwati Hospital. The opinion of Dr. Jennifer Sheth cann't be faulted. The treating doctor (Opposite Party No. 2) failed to exercise reasonable skill and care. In our considered view, the delay in referral was fatal; it was Negligence per se.
14. Adverting to the cause of death of patient; it is relevant to note the PM findings, drop in Hb% level and opinion of Dr. Jeniffer. In our considered view the death was due to Haemorrhagic Shock and not due to Amniotic Fluid Embolism (AFE) . It could be explained as:
i) There was drastic fall in patient's Haemoglobin %. At the time of admission it was 12.2 g% but after LSCS it was 8.2 g% (lab report Ex…)
ii) The PM report revealed the cause of death as "Hemorrhagic shock following surgery". The PM findings correlate with that "300 ml blood & clots in vagina with 6 sanitary pads from cut side. The broad ligament sutured with peritoneum and internal abdominal wall.
ii) Affidavit filed by Complainant's Expert witness Dr. Jenifferr Sheth. It was stated that para 5, "I say that in the view of PM findings the cause of hemorrhage could be due to damage to branches of uterine vessel, as from the operation notes, mention has been made of lateral tare of 1 inch on both right and left side and difficulty in separating the bladder, which caused bleeding".
"I say that, since bleeding not controlled for almost 1 and half hours after the birth of child, emergency hysterectomy or internal iliac ligation and subsequent transfer to a major institute should have been done."
We note, even the Appellant's expert witness Dr. Prakash Pawar, in his Cross examination stated that:
"if, in spite of this, I don't succeed in controlling the bleeding then, I will not go for internal iliac ligation but I will go for an obstetric hysterectomy.

15. We do not agree the submission of opposite parties that the cause death was AFE. Such defense was raised at the first time before this Commission. It is pertinent to note that, the

Physician Dr. Deshpande was present at the relevant time who could have easily diagnosed AFE from the ECG monitor. We further note that an affidavit of senior Gynecologist Dr. Prakash Pawar stated that patient suffered PPH, but he was silent on AFE.

16. We further note that the State Commission allowed the complainant for the cross-examination of the witnesses of the Opposite Parties through Mr. R.J. Purandare, ex-President of South Mumbai, District. He cross examined Dr. Rajesh Tate, Dr. (Mrs.) Raksha Tate and Smt. Sujata Pawar, Dr. R.R. Deshpande (Physician), Dr. Prakash Pawar and Dr. S. R. Yadav. The learned Counsel for the Opposite Parties argued that the State Commission had denied the cross-examination of the Complainant's witnesses Dr. Jennifer Sheth, Dr. B. S. Shinde and Dr. R. N. Marathe (PM Doctor). We don't accept this submission, as there is nothing on record to prove the same. It is unbelievable that the State Commission, which allowed the Complainant's application for cross-examination, how it would disallow the Opposite Party's application to cross-examine Complainant's Expert witness.

17. We took reference from few medical text books on Obstetrics & Gynecology viz Munro Kerr's Operative Obstetrics - 13th edition, Williams Obstetrics- 20th edition. Postpartum haemorrhage (PPH) is the leading cause of maternal death. In developing countries, approximately 8% of maternal death is caused by PPH. The diagnosis of PPH begins with recognition of excessive bleeding and targeted examination to determine its cause. Cumulative blood loss should be monitored throughout labor and delivery and postpartum with quantitative measurement, if possible. Although some important sources of blood loss may occur intrapartum (e.g., episiotomy, uterine rupture), Healthy pregnant women can typically tolerate 500 to 1,000 mL of blood loss without having signs or symptoms. Tachycardia may be the earliest sign of postpartum hemorrhage. Orthostasis, hypotension, nausea, dyspnea, oliguria, and chest pain may indicate hypovolemia from significant hemorrhage. The causes of PPH can be simplified under the acronym "4T": tone (atony), trauma (trauma of the birth canal), tissue (retention of remains), and thrombin (clotting disorders).Regardless of the cause of bleeding, physicians should immediately summon additional personnel and begin appropriate emergency hemorrhage protocols. Protocols should provide a standardized approach to evaluate and monitor the patients. The Uterine atony is the most common cause of postpartum hemorrhage. Brisk blood flow after delivery of the placenta unresponsive to trans-abdominal massage should prompt immediate action including bimanual compression of the uterus and use of uterotonic medications.

18. Lacerations and hematomas due to birth trauma can cause significant blood loss that can be lessened by hemostasis and timely repair. Episiotomy increases the risk of blood loss and anal sphincter tears; this procedure should be avoided unless urgent delivery is necessary and the perineum is thought to be a limiting factor.

19. Patients with persistent signs of volume loss despite fluid replacement, as well as those with large (greater than 3 to 4 cm) or enlarging hematomas, require incision and evacuation of the clot. The involved area should be irrigated and hemostasis achieved by ligating bleeding vessels, placing figure-of-eight sutures, and creating a layered closure, or by using any of these methods alone.

20. Monitoring hemostasis is important during PPH. Routine coagulation tests are the most common methods for monitoring hemostasis during PPH, with the advantage of well-regulated quality control Their main drawback is that they are too slow to be clinically useful in an acute and evolving situation. In addition, PT/aPTT ratios have limited sensitivity to a developing coagulopathy associated with PPH, and are often normal, despite very large volumes of blood loss. A Clauss fibrinogen must be measured rather than a PT-derived fibrinogen level.

21. The surgical interventions should be initiated sooner than later if the medical management fails to control hemorrhage, The most appropriate choice of treatment will depend, in part, on the team experience.

(i) Intra Uterine balloon tamponade has been suggested as an effective, easily administered minimally invasive treatment option to control uterine bleeding while preserving the mother's ability to bear additional children.
(ii) Sutures are allocated around the uterus with thick absorbable material causing contact and compression of the uterine anterior and posterior walls.
(iii) B-Lynch suture requires hysterotomy for its realization and in Hayman suture is not necessary. Its overall efficacy ranged from 81 to 91.7% and gestations after its application have been described.
(iv) Artery ligation Uterine artery ligation depends on expertise. It may include the terminal part of the uterine branch, a second lower suture involving cervical branches or mass ligation of the uterine arteries and veins, including part of the myometrium (O'Leary's suture). It can preserve the uterus and subsequent fertility. Internal iliac artery ligation is technically more complicated.
(v) Hysterectomy is the most radical therapeutic option and definitively compromises fertility. The decision and procedure must be carried out by an experienced clinician and surgeon. It is considered in case of failure of conservative techniques, but an excessive delay has to be avoided.
22. Plethora of judgments have discussed about the Bolam's test with regard to the negligence of a doctor. It was held that a doctor is not guilty of negligence if he acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art.
23. The duties of the doctors to the patient are elaborated by the Hon'ble Supreme Court in the case of Dr. Laxman Balkrishan Joshi Vs. Dr. Trimbak Bapu Godbole and Anr (AIR 1969 SC 128) observed as follows:
"The duties which a doctor owes to his patient are clear. A person who holds himself out ready to give medical advice and treatment impliedly undertakes that he is possessed of skill and knowledge for the purpose. Such a person when consulted by a patient owes him certain duties, viz., a duty of care in deciding whether to undertake the case, a duty of care in deciding whether treatment to give or a duty of care in the administration of that treatment. A breach of any of those duties gives a right of action for negligence to the patient. The practitioner must bring to his task a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. Neither the very highest nor a very low degree of care and competence judged. In the light of the particular circumstances of each case is what the law requires. The above principle was again applied by this court in the case of A.S. Mittal and Ors. vs. State of U.P. and Ors. (AIR 1989 SC 1570). It observed "A mistake by a medical practitioner which no reasonably competent and a careful practitioner would have committed is a negligent one."

24. In the opinion of Lord Denning, as expressed in Hucks vs. Cole, 1968 118 New LJ 469, a medical practitioner was 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 of another. A medical practitioner would be liable only where his conduct fell below that of the standards of a reasonably competent practitioner in his field. Thus in cases where the doctors act carelessly and in a manner which is not expected of a medical practitioner, then in such a case an action in torts would be maintainable.
25. The cases discussed above would not come for the rescue of the Opposite Parties. In the instant case even if, we assume that the efforts were made by Dr.Tate to procure 'A Negative' blood, the fact still remains that but for he was knowing that it was rare blood group and chance of unexpected bleeding during 2nd LSCS, it was duty to keep standby blood bags and/or A or O Negative live blood donors before proceeding LSCS. It was lack of adequate care after the LSCS which led the patient into hemorrhagic shock. Under these circumstances, and in the absence of any valid explanation by the Opposite Parties which would satisfy us that there was no negligence

on their part, we have no hesitation in holding that Mayuri died due to negligence of Opposite Party No 2. It was an act of Omission from the Opposite Party No. 2 wherein it fell below that of the standards of a reasonably competent practitioner in his field.

26. The State Commission allowed the Complaint and vide Order dated 04.02.2015; awarded compensation of Rs. 16,00,000/- and Rs. 15,000/- towards the cost of litigation. Now at this stage we cannot ignore that the incident occurred in the year 1995 and we are in 2021, (more than 2 ½ decades). In the interest of justice, we deem it appropriate to enhance the quantum of award to Rs. 20,00,000/- as a just and proper compensation.

27. We direct the Opposite Parties Nos. 1 and 2 to pay compensation of Rs. 20,00,000/- and Rs. 1,00,000/- towards the cost of litigation to the Complainants. It is made clear that at present, if the Complainant No.1 got remarried, then the entire amount shall be paid in equal proportions to the both the daughters of deceased namely Ms. Krupali and Ms. Hetal. The Opposite parties shall pay entire amount within six weeks from today, failing which the entire amount shall carry simple interest of 6 % per annum till its realization.

The First Appeal is dismissed.

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R.K. AGRAWAL

PRESIDENT

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DR. S.M. KANTIKAR

MEMBER