NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION
NEW DELHI

CONSUMER CASE NO. 264 OF 2015

1. SALEEM AHMAD & ANR. .....Complainant(s)

Versus

1. DR. SANDHYA BANSAL
BANSAL HOSPITAL, A1, NEW FRIENDS COLONY,
NEW DELHI-110 025
2. BANSAL HOSPITAL
THROUGH ITS OWNER DR.SANJIV BANSAL, A1, NEW FRIENDS COLONY,
NEW DELHI - 110 025
3. DR. RAHUL MANCHANDA
H. NO. A-32, NEW FRIENDS COLONY,
NEW DELHI-110025
4. DR. AJAY KAPOOR,
H. NO. 146, 1ST FLOOR, POCKET-2, JASOLA,
NEW DELHI-110075
5. ORIENTAL INSURANCE COMPANY LTD.
B-328, 1ST FLOOR, SECTOR-8, DWARKA,
NEW DELHI-110075 .....Opp.Party(s)

BEFORE:

HON'BLE MR. JUSTICE RAM SURAT RAM MAURYA,PRESIDING MEMBER
HON'BLE MR. BHARATKUMAR PANDYA,MEMBER

FOR THE COMPLAINANT : MR. TARIQUE SIDDIQUE, MS. JYOTSNA BHARDWAJ,
MR. FAJALU REHMAN, WITH COMPLAINANT IN PERSON

FOR THE OPP. PARTY : MR. SALIL PAUL & MR. SAHIL PAUL, ADVOCATES FOR OP-1
MR. RAJIV K. GARG & MR. ASHISH GARG, ADVOCATES FOR OP-2
MS. DIYA KAPUR, ADVOCATE FOR OP-3
MR. PRADEEP KUMAR & MS. MONICA KUMAR, ADVOCATES FOR OP-4
MR. AJAY SINGH, ADVOCATE FOR OP-5

Dated : 24 September 2024

ORDER

PER HON'BLE BHARATKUMAR PANDYA, MEMBER

1. Heard Mr. Tarique Siddique, Advocate, Ms. Jyotsna Bhardwaj, Advocate, and Mr. Fajallu Rehman, Advocate for complainant. Mr. Salil Paul Advocates for OP-1 and Mr. Rajiv K. Garg and Mr. Ashish Garg, Advocates for OP-2 and Ms. Diya Kapur, Advocate for

OP-3 and Mr. Pradeep Kumar and Ms. Monica Kumar, Advocates for OP-4 and Mr. Ajay Singh, Advocate for OP-5.

2. The Complaint: Ms. Kaushar Jahan died due to medical misconduct & gross negligence of opposite parties (OP-1 and OP-2) on 04.10.2013. On the advice and assurances of OP-1 Dr. Sandhya Bansal, Ms. Kaushar Jahan, was admitted at OP-2 Bansal Hospital on 03.10.2013 vide registration no 13/2780 at 08:00 pm to be operated for ASHERMAN'S SYNDROME on 04.10.2013 early morning by Dr. Sandhya Bansal. Before the operation, the possibility of any complication of '*air embolism*' was neither explained to the deceased and complainant no. 1, nor it was documented. As per OP-2 hospital, the deceased had a cardiac arrest during surgery when the hysteroscope was being removed from the uterine cavity. In the operation theater itself the condition of the patient could not be managed by the doctors due to lack of expertise, proper assessment, absence of specialist doctors and required machines etc. resulting into prolonged cardiac arrest without proper resuscitation. When the patient could not be managed by OP-1 and OP-2, ambulance from Fortis Hospital was called and after a prolonged delay of more than an hour, the patient was shifted to Fortis Hospital where she breathed her last at 3.15 pm. As per OP-4 Fortis Hospital (now deleted as OP) and as per death summary prepared by it, the cause of death is not due to cardiac reasons (EF.60 percent). It was a case of suspected *air-embolism*. At the same time, OP-4 hospital admits that the X-ray of chest shows bilateral haziness quite possibly due to aspiration of secretions and that suctions was not done properly at OP-2 hospital or later during transit by Ambulance. By the time the patient reached OP-4 hospital, the endotracheal tube was full of bloody secretions which was removed by Suction at OP-4 hospital. Further the 'Arterial Blood Gas' [AGB] report suggests that the patient was brought to OP-4 hospital in nearly irreversible and dead condition. The sequence of events make it clear that there was no attempt from the doctors at OP-2 hospital to put the best foot forward from the beginning to avoid such complication which took the life of Ms. Kaushar Jahan. *It is well recognized fact that complication in Operative Hysteroscopy, occur only when contraindications are ignored at, and when proper techniques are not followed or equipments/ instruments are used in an inappropriate fashion.*

3. The medical misconduct & gross negligence leading to the death of Ms. Kaushar Jahan during the surgery/operative hysteroscopy and thereafter maneuvering and manipulation of documentation to cover up the actual cause of complications leading to her death can also be seen from the facts that OP-2 hospital kept the facts hiding relating to the complications which developed after anesthesia and during operation and further removed the details of the patient Ms. Kaushar Jahan from the record and register of the hospital which records are mandatory to be kept under the Medical Council of India Notification dated 11.03.2002 and Clinical Establishment Act, 2010. Despite several requests, OP-2 hospital refused to provide any details relating to the registration no. 13/2780 dated 03.10.2013 of Ms. Kaushar Jahan, including records of TIME OUT carried out at operation theater before starting the surgery procedure, on the pretext that after her death now nothing is available with OP-2 hospital. There is lot of maneuvering at creating false and fabricated records and also subsequent insertions in the medical record to create false evidence in an attempt to establish that (i) Dr Sandhya Bansal is not concerned with the surgery (ii) Dr. Manchanda (OP-3, added as OP at the instance of OP-1 and 2) performed the surgery and (iii) the deceased died due to complication of air-embolism and cardiac arrest, and, not due to

any lack of skill, knowledge or due to medical misconduct and negligence of OP-1 and OP-2.

4. In the month of September 2013, Ms. Kaushar Jahan consulted Dr. Sandhya Bansal [OP-1] at Bansal Hospital [OP-2] for her minor Gynecological problem. The OP-2 hospital is on the panel of Medi-assist India Pvt. Ltd. and on its website the OP-2 hospital introduces itself as under:

> *"... facility is unique in its kind with functional 50 beds and highly equipped modular Operation Theatres, Labour Rooms, Nursery and ICU. Well qualified doctors, impressive infrastructure, latest technology & excellent facilities is the specialty of Bansal hospital."*

5. On 30.09.2013, Dr. Sandhya Bansal at Bansal Hospital advised Ms. Kaushar Jahan for Diagnostic and Operative Hysteroscopy + D&C and for the said purpose, prescribed various tests/ investigations to diagnose the Hysteroscopy. Dr. Sandhya Bansal (OP-1) explained to Ms. Kaushar Jahan and her husband/ complainant no. 1 that she is having ASHERMAN'S SYNDROME and the dense adhesions/ scar tissue developed in the cavity of uterus will be removed through the procedure of 'Diagnostic & Operative Hysteroscopy'. OP-1 doctor represented and assured that she is having team of expert doctors, and, excellent medical facilities with latest technology are available in OP-2 hospital for this minor surgery. The complainant no.1 and his wife got convinced with the OP-2 doctor persuasiveness for the said procedure of surgery at OP-2 hospital. On 03.10.2013, Ms. Kaushar Jahan was admitted at OP-2 hospital at 08:00 pm to be operated for ASHERMAN'S SYNDROME. On dated 04.10.2013, in the morning at 06.45 am Ms. Kaushar Jahan was called to the operation theater (OT) for the procedure of surgery to be done by Dr. Sandhya Bansal (OP-1). At about 09:35 am, the complainant no.1 was informed by Dr. Sanjiv Bansal, (owner of OP-2 Hospital) that during operation, Ms. Kaushar Jahan has developed some complications and the doctors are trying to revive. Again within 10 minutes at about 09.45 AM Dr. Sanjiv Bansal informed complainant no.1 that the doctors in the OT are not able to handle the complications which developed during Surgery, for which they are shifting Ms. Kaushar Jahan to Fortis Escorts Hospital [OP-4]. At around 10:00 AM, the ambulance reached Fortis Escorts hospital [OP-4]. The patient was taken to the Intensive Care Unit (ICU), Heart Command-II, though she had a gynecological problem. On 04.10.2013, Ms. Kaushar Jahan expired. The 'Doctor's Progress Notes' dated 04.10.2013 at 03:15 PM states as under:

> *"Patient declared dead at 03: 15 PM*
>
> *working diagnosis :out of hospital Cardiac arrest. Acute pulmonary edema with persistent Hypoxemia with Metabolic Acidosis.*
>
> *Cause of death- Cardiorespiratory arrest"*

6. As per 'Death Summary' issued by Fortis Escorts Hospital (now deleted as OP), the patient was undergoing uterine synechiolysis under spinal anesthesia; developed cardiac arrest (CPR done for 5 min) intubated and shifted to FEHI as a case of post cardiac arrest on

mechanical ventilation with the inotropic support. Frank frothy expectoration was suctioned off from ET tube at regular intervals in copious amounts. Patient was put on ventilation but required high ventilatory parameters (PEEP-14, Fio2-100%). Chest X-ray showed bilateral diffuse opacities. ABG repeated at around 11:15 am showed persistent hypoxemia and mixed acidosis pattern. The death summary prepared by Fortis Hospital is reproduced as under:

DEATH SUMMARY

Patient's Name	*: Mrs. Kaushar Jahan*	*Age : 31*	*Sex : F*
EHIRCNO.	*: 00522612*	*IPD NO.*	*IP00299296*
Date Of Admission	*: 04/10/2013*		
Date of Expiry	*: 04/10/26l3 at 03:15 PM*		

Mrs. Kaushar .Jahan, 31 years old lady resident-of Jamia NMagar, Delhi who was undergoing uterine synechiolysis.under spinal anesthesia at outside hospital, developed cardiac arrest. (CPR done for 5.min) intubated and shifted to FEHl as a case of post cardiac arrest on Mechanical Ventilation with inotropic support. At presentation, patient was having a BP of 110/70 (on Norepi and Dopa support). pulse=l58/min and oxygen saturation of 85%. Frank frothy expectoration was suctioned off from ET tube at regular intervals in copious amounts. Patient was put on ventilation but required high ventilatory parameters (PEEP - 14, Fio2 .- .100%). Femoral art line and central line was put and inotrope support was continued. ABG initially showed, respiratory and metabolic acidosis according to which ventilatory requirements were modified. 2D echo revealed EF-60% with RA/RV being normal and no regional wall motion abnormalities & no evidence of any pulmonary embolism. On clinical examination, patient's chest had creps bilateral and GCS was poor (3-15). Chest X-ray showed bilateral diffuse opacities. ABG repeated at around 11:50am showed persistent hypoxemia and mixed acidosis pattern. At I2:00pm, in view of persistent hypoxemia and worsening respiratory parameters a decision for prone ventilation was taken but because of labile BP readings and increasing requirement of inotropes, it couldn't be done. At around 2:15pm, patient had a sudden fall in blood pressure associated with fall in pulse rate followed by asystole. CPR was initiated as per ACLS protocol Inj Atropine, Inj. Adrenaline. Inj. Sodabicarbonate was given as stat dose. Inotropes were increased and vasopressin, dopamine and norepinephrine was Initiated and continued. Chest compressions and bag and mask ventilation was also initiated with repeated suctioning from the ET tube. CTR was continued with stat doses of Inj. Atropine/Adrenaline being given according to ACL protocol. Patient also received DC shock of 200J at around 2:30 pm but the rhythm could not be reverted.

CPR was continued till about 3:15pm when the patient's pupils was found dilated with no spontaneous cardiac on respiratory activity. Inspite. of all .effective resuscitative measures, patient could not be revived and declared dead on 04.10.2013 at 3:15 pm.

7. On 07.10.2013, Complainant no.1 through the insurance agent of Medi-assist India Pvt. Ltd. received bills and Referral Summary dated 04.10.2013 of the OP-2 hospital. On 21.11.2013, Fortis Hospital on payment of Rs.1000/- supplied its own medical records pertaining to the treatment of Ms. Kaushar Jahan including patient document checklist dated 15.10.2013, admission slip dated 04.10.2013, admission & discharge record, death summery, cardiac evaluation form, progress notes of CCM team, doctors progress notes, nursing admission assignment, daily nursing care plan, test reports, critical care progress notes, ward treatment overview record, patient care form, ambulance duty slip. However Fortis hospital did not provide the records of OP-2 hospital and informed the complainant no.1 that the records of OP-2 hospital are not available with them. On 24.12.2013, Complainant no.1 filed RTI applications to the concerned authorities including, the Ministry of Health & Family Welfare (Govt. of India); Directorate of Health Services (Govt. of Delhi); Medical Council of India; Delhi Medical Council, seeking information's against OP-2 and OP-4 hospitals. On 28.02.2014, Complainant filed complaint before Delhi Medical Council against opposite parties for medical misconduct & negligence. This complaint has been filed on 13.04.2015. The complainants requested this Commission for awarding Rs. 10 crores plus interest for Ms. Kaushar Jahan's death due to medical misconduct and negligence causing death of the patient. Alongwith the complaint, the complainant filed Annexures C-1 to C-11

8. Opposite Party No. 1 and 2 jointly resisted the Complaint by filing a reply dated 28/06/2015 as further amended on 28.02.2018. It is stated that the OP-2 hospital is one of the best in 50 bedded category in Delhi and one of the few who have successfully obtained NABH certification. It is further stated that the complainant and the deceased had a long-standing patient-doctor relationship with OP-1 and 2 from 2009 onwards, during which period the first baby of the deceased and two surgeries of the complainant and two DNCs of the deceased have been successfully carried out at OP-2 hospital. Therefore, deceased and the complainant both had full acquaintance and knowledge of the facilities and skills of the doctors at OP-2 hospital and had full confidence in OP-2 hospital's doctors, services, facilities, and infrastructure. Despite being Hepatitis B positive and financially capable with Mediclaim insurance, the couple chose OP-2 hospital over others, even after being advised for operative hysteroscopy at Sir Ganga Ram Hospital for Asherman's Syndrome. On 30/09/2013, OP-1, after advising for hysteroscopy, recommended Dr. Rahul Manchanda, one of the best in the field, for the procedure, which was agreed upon on 03/10/2013 when the patient was admitted. Dr. Manchanda after examining the patient on the same day, explained the procedure, obtained consents, and scheduled it for 04/10/2013. Dr Manchanda along with his team arrived at the hospital at around 6.30 am on 4/10/2013 alongwith anesthetist Dr. Kapoor (OP-4). During the procedure, the patient suffered a cardiac arrest due to suspected air embolism, was revived, and transferred to Fortis Escorts, where she later died at 3:15 PM (Pg 318-328). Vide order dated 05.04.2018 in a complaint filed by the complainant, Delhi Medical Council (DMC) found no negligence or misconduct by Dr. Sandhya Bansal or Bansal Hospital. The complainant's appeal against the DMC's decision with the Medical

Council of India (MCI) has also since been rejected vide order dated 05.04.2018. The couple had multiple treatments at OP-2 hospital between year 2010 and 2013 (Pg 264, 328), and the complainant, who remarried and had a child from the new marriage, concealed these facts in the complaint and thereafter. The procedure was performed by Dr. Manchanda, not OP-1, who merely facilitated the process. Allegations against OP-2 hospital's infrastructure and procedures are false, making the complaint misleading and without merit, warranting dismissal. It has been categorically pleaded by the OP-1 that she is in no way concerned or responsible for what happened in OT because hysteroscopy was performed by OP-3 and anesthesia was administered by OP-4 both of whom together, if at all, were responsible for pre-surgery check up, surgery itself and for managing postoperative condition of the patient. OP-1 merely provided pre-surgery consultations and OP-2 provided the well-equipped OT and nursing staff. There is no negligence or deficiency in service on the part of OP-1 and 2. OP-1 and 2 have filed, alongwith their replies, Annexures R1-1 to R1-18.4.

9. At the instance of OP-1 and OP-2, OP-3 Dr Rahul Manchanda and OP-4 Dr. Ajay Kapur were impleaded. OP-3 Dr. Rahul Manchanda, in his written statement filed on 01/02/2016 averred that he has more than 20 years of experience of which more than 10 years has been in the filed of hysteroscopic surgeries. He has many publications, awards and workshops and conducting of training sessions to his credit and has successfully performed several thousand gynecological endoscopy and hysteroscopy surgeries. He trains obstetricians and gynecologists who are already Post Graduates in this super specialty. He is widely recognized, including by AIIMS. He has performed several thousand surgeries in the field of gynecological endoscopy and has worked with leaders in this field, the world over. Each and every surgery conducted by him has been successful and till date, there has not been a single complaint against him. His role in the present case was limited to being the specialist consultant surgeon who successfully carried out the hysteroscopic surgery as a part of Dr. Sandhya Bansal's team and that he is not answerable for any other matter beyond such role. He has not been paid any fee by the deceased. The deceased, Mrs. Kaushar Jahan, was a patient of Dr. Sandhya Bansal at Bansal Hospital. Dr. Sandhya Bansal was in charge of (a) The surgery, (b) Coordination of various specialists involved in the surgery, (c) OT management (d) OT staff (e) Facilities provided by the Bansal Hospital (f) Pre operative care and management, (g) Intra operative care and management (h) Post operative care and the management. Hospital records show that the patient was Dr. Sandhya Bansal's patient and that anesthetist Dr. Ajay Kapur was also a part of the team assembled by Dr Sandhya Bansal. In so far as his limited role of hysteroscopic surgeon is concerned, the patient received the highest standard of surgical care. He performed his function with his well-recognised skills and precision and after following all the best medical practices, completed the same satisfactorily which is recorded in the DVD of the surgery. As a matter of fact, the complainant has no specific allegation with regard to the conduct or success of the surgery but has grievance with regard to how and why the patient suffered "prolonged cardiac arrest", and why post-complication stage was poorly managed by OP-1 and OP-2. In the present case, he carried out his role and function with care and precision and following all the best medical practices and protocols. The surgery is in fact recorded and a viewing of the DVD of the surgery (which "can be produced if the Commission requires") demonstrates the fact that it was conducted in accordance with the highest medical standards. OP-3 met the patient in the evening of 03.10.2013 before the surgery, and informed her about the procedure as well as the risks involved. OP-3 then directed the resident doctor to explain the

risks to the patient once again and take her written confirmation that she has understood the risks. The hand written consent form and consultation report is already part of the record. The procedure was scheduled for 7:00 AM on 04.10.2013. OP-1 Dr. Sandhya Bansal and her team, OP-4 along with OP-3, and the OT staff and nurses were all present. OP-3 put the patient in reverse Trendelenberg's position after she was given Anaesthesia. The perineum was cleaned with betadine antiseptic solution and then draping with sterile sheets was done. A 2.9 mm thin Office Bettochi Hysteroscope of the Karl Storz Company with an operating sheath was used to do the procedure. The telescope was attached to a Karl Storz High Definition Video Camera. 5 French scissors were used in the operating channel to cut the adhesions. The scope was so thin that dilatation of the cervix was not done. A vaginoscopic technique was used. This meant that the telescope was introduced through the closed vulva lips which were held together so that at no point was the vagina opened to any air communication outside as it was filled with saline and closed to the outside by the approximated vulva. The fluid irrigation system was preloaded with normal saline and the tubing flushed with saline before starting to prevent any air from entering the system. Under direct visualization and vision the telescope was introduced into the vagina. Normal saline which is isotonic with the body fluids was used. The vagina was distended with fluid / saline and with continuous irrigation under direct vision slowly the telescope was introduced into the cervical canal. The cervical canal was completely closed and cicatrized due to adhesions. The Adhesions were seen and these were cut with mechanical instrument (5F hysteroscopic scissor). No electrosurgical / gas producing instrument was used. After cutting the cervical canal adhesions the telescope was further advanced into the uterine cavity where adhesions were seen and were dealt with systematically and expeditiously. The cavity was compromised and smaller due to the adhesions. 5 French Hysteroscopic scissors were used systematically to cut all the adhesions and release the cicatrized cavity in order to enlarge it to a normal size. This included cutting the adhesions on both lateral walls (bilateral lateral wall metroplasty).The procedure took around 10-15 minutes from start to end and at the end of the procedure the cavity was well formed and normalized and the cervical canal had been reopened as evidenced by the video recording. At no point of time during the surgery was there any air bubbles introduced into the cavity. The procedure, was completed uneventfully and to complete satisfaction and the telescope withdrawn from the uterus and cervical canal slowly. All preventive / safety measures required to be used were undertaken. The procedure was successful and was completed by 7:45 am. After completion of the procedure and while the patient was still on the operating table the patient had a cardiac arrest. The OT notes prepared reveals in brief these facts about surgery. There is no complaint that in the present case the surgery was not properly conducted. The complaint is that the patient died of cardiac arrest after the surgery and that the situation post the cardiac arrest was not properly managed. It has been stated that probable cause of the cardiac arrest of the patient was an "air embolism". There is no proof that the cause of cardiac arrest was in fact an air embolism. Indeed, cardiac arrests can be caused for a variety of other reasons, unrelated to the surgery. In so far as air embolism is concerned, an air embolism is a known and documented risk of a hysteroscopy and this risk was specifically explained to the patient and her consent for surgery taken after the risk was explained. Delhi Medical Council, after thorough examination (Pages 5-32 of IA 7517 of 2018), found no negligence by any doctor. Subsequently, an appeal to the Medical Council of India has been rejected as the Ethics Committee of the Medical Council of India upheld the DMC decision, citing the inherent risk of air embolism in hysteroscopic surgeries (Annexure-A). In a similar case (*Dr. Manisha*

Agarwal & Anr. v. Kapil Bajaj & Anr. in FA No. 1107 of 2018) DMC dismissed the complaint, recognizing the inherent risks despite the best efforts of doctors (Annexure-B). It's emphasized that OP-3 possessed the requisite skill, executed the procedure diligently (Pages 110-118), and responded appropriately to the post-surgical cardiac arrest (Pages 108-109). In conclusion, there's no evidence of negligence, and the complaint against OP-3 should be dismissed. He filed Annexures R-1 to R-8 along with reply.

10. OP-4 - Dr. Ajay Kapur resisted the complaint by filing a reply on 02/02/2016 and averred that the patient's admission for hysteroscopy due to severe Asherman's syndrome resulted in a cardiac arrest during surgery, promptly addressed through resuscitation and subsequent transfer to Fortis Escorts Hospital. His role is described as under:

"On 4-10-2013 at around 6:40 A.M., the answering OP carried out the pre- anesthetic check up (including detailed history from the patient and thorough examination). The patient was categorised as ASA GRADE 1 which is the best / healthiest grade. The type of anesthesia was discussed with the patient. She opted for spinal anesthesia. Pre medication given to her i.e. injection rantac l/v and injection perinorm was checked. Then the answering OP proceeded to start the anesthesia after performing the preliminary tasks: i)~checking the anesthesia work station, emergency drug tray and routine check of instrument (e.g.: working laryngoscope, monitor and other instruments) the necessary leads of the monitor on the patient were placed. ii)~Her Initial vitals were recorded. Thereafter, the following parameters were continuously monitored throughout the procedure till the surgery was completed:SP02 , ECG and NIBP. iii)"The patient was pre-loaded with 500 ml ringer lactate and then prepared for spinal anesthesia. The patient's back was painted with betadine solution in sitting position and cleaned with spirit. She was draped as per aseptic technique. 2.5 ml of 0.5% (H) Bupivacaine was injected with.26 G spinal needle at lumber spine after confirming free flow of CSF at around 7:00 A.M. and the effect was adequate. The surgeon started the surgery at around 7:15 A.M. At around 7:40 A.M. the operating surgeon announced that the surgery was about to finish. Till this time the patient remained stable and was in a conscious state and was talking with the people around. The surgeon was using an integrated camera and a monitor system for the surgery. Just when the surgeon was about to pull his surgical uterine scope out of the uterine cavity he asked his assistant manning the irrigating fluid to check as he noticed air bubbles in the uterine cavity. At the same time the anesthetist found that the patient was becoming irritable and disoriented. He shouted out as to whether the air had gone in. The surgeon immediately pulled the surgical scope out of the uterine cavity. The monitor was showing absent Plethysmograph, with sudden loss of pulses and ECG showing normal electrical activity soon which became irregular and the patient had a cardiac arrest. All these events happened very fast in less than a minute. CPR was immediately started. The patient was intubated. During intubation, the oropharynx was clear with no secretions. No bile or gastric contents were seen. The patient was ventilated with 100% oxygen and chest compression was started. Injection adrenaline 1ml l/v was given followed after 2 min with DC shock; with a strong suspicion of air embolism in mind, the answering OP put in a central venous catheter via subclavian route and aspirated 50 ml of blood. It is clarified that, in the ordinary course of events, had there been no occurrence of air embolism, there was no occasion or need to a central venous catheter. This was done specifically to suck out the air that might have gone in. When the blood was sucked out through the central catheter, the suspicion of air embolism was confirmed because the blood

that came out was foamy in appearance because of the presence of air bubbles. At the same time, he advised to give 1 bottle (500 ml) of fluid fast. As he aspirated blood from the CVP line, the patient got revived within about 5 minutes. She became conscious with spontaneous breathing effort, and was put on inotropic support [dopamine @ 10 meg /kg/min]. At this time the anesthetist noted that the patient was having frothy secretions in the endotracheal tube,with tachypnea and falling oxygen saturation. He decided not to extubate and paralyzed the patient with injection atracurium 40 mg + Inj. fentanyl 100 meg and put on ventilator CMV mode /100% fio2/ Tv450 ml/ RR 15. After successful resuscitation, a blood sample for ABG was taken and ECG was recorded. The ECG showed normal rhythm with no abnormality except sinus tachycardia. At this point, Dr. Anirban Biswas, the Physician of Bansal Hospital, was consulted. He advised to send sample for SOB profile. ABG report was received at around 8:20 A.M. It showed ph 7.082, Pao2 199.3, Pco2 55.4, S02 98.9 , HC03 16%, BE-14.4 and SOB Profile CKMB<1.0 mg/ml, Myo 987, TNI <.05 BMP 6.9 Pg/ml DDIM 3820 . After receiving the ABG report, metabolic acidosis was corrected by giving sodium bicarbonate and setting ventilator parameters. These reports were informed to Dr. Biswas. Inj. clexane 40 mg s/c and Inj. Lasix, 10 mg l/v were given as advised by him. Meanwhile Dr. Rahul Manchanda apprised and discussed about the condition of the patient with the complainant no. 1. After the discussion between them the answering OP was informed that a decision had been taken to shift the patient to Fortis Escorts Hospital for further management of the patient for which the complainant no. 1 had given a written consent. The patient was being continuously monitored during this time. In order to maintain blood pressure, inotropic support was maintained. Dopamine at the rate of 10 mcg/kg/min was given followed by noradrenalin at the rate of I mcg/kg/min. Intermittent gentle suctioning of the endotracheal tube was done to remove copious frothy blood tinged secretions. The patient was continuously ventilated on ventilator with 100% oxygen. At no time was the patient neglected and maximum effort was put forward to improve the condition of the patient. After obtaining the consent for shifting the patient to higher center, a call was made to a nearest tertiary center (Fortis Escorts Hospital) by the hospital authorities. Their fully equipped Ambulance along with their team of doctor and staff, arrived at Bansal Hospital O.T. at around 9:00 A.M.along with their portable ventilator. They were told about the event, its management and the present condition of the patient. They took over the management of the patient in the OT itself and advised and simultaneously prepared to shift the patient to Fortis Escort hospital. At around 10:00 A.M., the patient was shifted out of Bansal Hospital in the ambulance of the Fortis Escort hospital under the charge of the emergency team present in the ambulance. A doctor from Bansal Hospital also went along with them. At the time of shifting, the condition of the patient was: *HR : 140/min pupil B/L dilated and reacting BP : 126/76 on inotropic support. RR CHEST CVS CVP on ventilator SP02 93% : B/L crept (+) : S1S2 (N) : 16 cm H20 URINE OUTPUT : 150+150 =300.* The complaint has no specific allegation or grievance against OP-4 and the complainant did not prove medical negligence, as further confirmed by the Delhi Medical Council's exoneration of the doctors involved. It is stated that immediate and proper resuscitation was given. Central venous line was fixed without any delay to aspirate air from the blood circulation. Defibrillation was done. Inj. Adrenaline 1 ml., IV was given and other necessary steps were taken. This resulted in revival of the patient within 5 minutes of the cardiac arrest. The patient resumed normal heart beat. After receiving the ABG report, metabolic acidosis was corrected by giving sodium bicarbonate. This is clear from the hospital record. It is stated that unexpected and even fatal events can occur at any time while

a competent doctor, whether a physician or a surgeon, is treating a patient in the best possible manner. All such events, many of which might be uncommon / rare, cannot be always explained unless a post mortem is done. Mere occurrence of such events does not amount to negligence.

11. The Complainant filed Rejoinder and Affidavits of Evidence have been filed by all the parties. Parties filed interrogatories and replies thereto have been filed .

12. Heard the Learned Counsel for both the Parties and carefully perused the records. The first issue that calls for our consideration and decision is with regard to who in fact has performed the surgery and why such issue should at all arise. In the complaint originally, the complainant raised the plea of the negligent service only against OP-1 Dr. Sandhya Bansal and OP-2 Bansal Hospital (Fortis Hospital and Dr. Ashok Seth, joined initially, were given up as OPs by complainant). The averments in the complaint, as noted earlier are, in substance, that the complainant's wife Smt. Kausher Jahan was, after previous consultation with OP-1, admitted on 03.10.2013 in OP-2 hospital to be operated for Asherman's syndrome on 04.10.2013. As per the complaint, the surgery was carried out by OP-1 (and her team) and that before the surgery no explanation/consent about the likely complication of life threatening "Air Embolism" was provided or obtained. During the hysteroscopy, when after surgery, the hysteroscope was being removed from the uterine cavity, the patient suffered cardiac arrest due to suspected Air Embolism which was poorly managed by the OP-1 and OP-2 due to lack of proper skill, equipment and specialist doctors and therefore, the cardiac arrest was unreasonably prolonged without proper resuscitation. Thereafter, there was no communication from OP-1 or OP-2 to the complainant and due to inefficient management of the episode of cardiac arrest and lack of proper medical facility at OP-2 hospital, the OP-1 and OP-2 shifted the patient to Fortis Escort Hospital allegedly for better management of cardiac condition, where ultimately she died at around 3 p.m. Such loss of life of the patient is due to evident medical misconduct and negligence of OP-1 and OP-2 who together lacked the requisite foresight, skill and equipments firstly to foresee and avoid the likely complications of hysteroscopy and secondly in effectively managing the complication when it did arise. Also, contra-indications of hysteroscopy were overlooked which only led to complication, suspected air-embolism. OP-1 and OP-2 in their written version submitted that OP-1 is in no way concerned with the surgery or with the management of the complications which arose during the surgery in operation theater. According to OP-1, the advice for hysteroscopy was indeed given by the OP-1. However, at the same time, it was clearly informed to the complainant on 30/09/2013 that OP-1 herself does not undertake the hysteroscopic surgeries and that Dr. Rahul Manchanda is a highly acclaimed expert for the same and that he should be consulted for hysteroscopic surgery. Accordingly, the complainant and the patient consulted Dr. Manchanda who agreed to perform the surgery on 04.10.2013, as was suggested by OP-1. Dr. Manchanda also visited the patient after admission in the evening of 03.10.2013 and examined her. Dr. Manchanda along with his team of assistant doctors including the anesthetist Dr. Ajay Kapoor arrived at the hospital at around 6.30 a.m. on 04.10.2013 and carried out surgery where OP-1 was neither present nor had any role to play. As per the OT notes prepared by Dr. Manchanda, the surgery was successfully carried out and immediately after the surgery, the patient suffered a cardiac arrest after which the patient was resuscitated by the anesthetist Dr. Ajay Kapoor who also was part of Dr. Manchanda's team. The information was duly provided by Dr. Manchanda to

the complainant. Subsequently, after evaluation of the patient's condition, a decision was taken by Dr. Manchanda in consultation with OP-2 hospital to shift the patient to a higher center for more effective management of cardiac condition. Despite knowing all these facts, the complainant preferred not to implead Dr. Manchanda and Dr. Ajay Kapoor for reasons best known to him. Similarly, the Fortis Hospital where unfortunately the patient died, and Dr Ashok Seth, who were impleaded but against whom no allegation or relief were claimed were subsequently deleted as OPs. The complaint is, therefore, liable to be dismissed for non-joinder of necessary parties. Subsequently, OP-3 and OP-4 have been impleaded at the instance of OP-1 and 2. The critical evidence with regard to who has performed the surgery, as relied upon by the complainant are: (i) the consultation prescription of Dr. Sandhya Bansal dated 30.09.2013 prescribing the hysteroscopy (ii) the admission form dated 03.10.2013 wherein the consulting/Incharge doctor is stated to be Dr. Sandhya Bansal (iii) the referral summary dated 04.10.2013 while transferring the patient to the Fortis Hospital which is in the hand-writing of and is signed by Dr. Sandhya Bansal and (iv) the bill and referral summary as provided to medi-assist (v) Generic and High Risk Consent forms which all record Dr. Sandhya Bansal as the incharge doctor, and, (vi) the fact that the OP-2 hospital did not maintain and provide medical records as statutorily required and has also filed "manipulated" records before DMC and before this commission. In addition to this, it is the averment of the complainant that it is not clear that why a reputed surgeon like Dr. Rahul Manchanda, who was never consulted by the complainant, should have wrongly taken the responsibility for the death of Kaushar Jahan, thus implying that though the hysteroscopic surgery was done by Dr. Sandhya Bansal, the story that Dr. Manchanda and not Dr. Sandhya Bansal has carried out the surgery, was concocted by OP-1 and OP-2 with active support from OP-3 and OP-4 to come out of the responsibility of deficient and negligent medical misconduct. The bill raised by OP-2 Bansal Hospital clearly indicates that the charges for surgery and for anesthesia have been billed and collected by the OP-2 hospital and as mentioned by Dr. Rahul Manchanda in his written version, no fee has been charged by him or paid by the complainant to him implying that Dr. Manchanda has not performed the surgery. On the other hand, Dr. Sandhya Bansal OP-1 has, in the first instance in the written version, pleaded that she is in no way concerned with the surgery and with subsequent events because the surgery in fact was undertaken by Dr. Manchanda and his team of assistant doctors and technicians including Dr. Ajay Kapoor, the anesthetist. Even in reply to complaint filed by the complainant before DMC, at the instance of OP-1 and 2, OP-3 and OP-4 have not only been impleaded but both of them have also admitted their respective roles as surgeon and anesthetist, though at the same time, denying any negligence or medical misconduct and liability and also pleading that the liability, if any is that of OP-1 and 2. It is further stated that the patient had independently consulted Dr. Manchanda (though upon her advise), who also examined the patient in the evening of 30.09.2013 and has also prepared the OT notes and obtained the consent of the patient. Similarly, the anesthesia notes have been prepared by member of Dr. Manchanda's team Dr. Ajay Kapoor. After getting impleaded, both Dr. Manchanda and Dr. Ajay Kapoor have filed their written versions wherein they have clearly admitted that the surgery was carried out by Dr. Manchanda after administration of anesthesia by Dr. Ajay Kapoor. As per OPs, the episode of cardiac arrest immediately after the surgery on account of suspected Air Embolism was successfully handled by the anesthetist Dr. Ajay Kapoor. These facts are evidenced also by the respective affidavits of OP-1, OP-3 and OP-4 and the entries in the OT register as also in the consent form for high risk surgery, and hand-written consent for surgery.

13. Let us now critically survey the evidence. While doing so, we first note that there is no evidence placed by the OP-1 and 2 to establish that any or what and when medical record was provided to the complainant or to Fortis Hospital. We cannot be oblivious to the fact that even in the face of *prima facie* unusual death of the patient requiring evidence based explanation from the OPs, the complainant would still be constrained to seek from and rely only on the documents supplied by the Hospital, and the allegations can be raised only on the basis of such records under the umbrella of overall evidence of unusual death. The complainant on 13.04.2015 filed along with his complaint annexures C1 to C11 which includes copies of RTI applications made to DMC on 24.12.2013 and complaint to DMC. Annexure C2 (page 33 to 38) is the copy of the documents received by the complainant from Medi Assist which are the documents sent by OP-2 hospital to Medi-assist in connection with the cashless treatment covered by insurance. It is noteworthy that the only documents furnished by OP-2 to the insurance TPA Medi Assist are the bill for Rs.60,081/-, which includes anesthesia, OT and surgery charges totaling to Rs.43,000/- as per which the surgery and the anesthesia charges are billed and received by OP-2 hospital and not by OP-3 or OP-4. The other two documents are the referral summary and OT notes, both of which have been signed by Dr. Sandhya Bansal without any reference of Dr. Rahul Manchanda. Our attention has also been drawn to the admission form dated 03.10.2013 (page 283 and 284). While page 283 records exclusively the name of Dr. Sandhya Bansal as the Consultant doctor, the additional handwritten admission form has recorded the "Doctor Incharge" as "Dr. Rahul Manchanda/Dr. Sandhya Bansal". Complainant has pointed out that the name of Dr. Rahul Manchanda is patently inserted at a subsequent date, OP-2 Dr. Sandhya Bansal has insisted that this entry implies that Dr. Rahul Manchanda is in fact the Incharge doctor for this admission. The OP-1 has also relied on Annexure R1/10 (page 286) being an undated note allegedly prepared by Dr. Husan Ara of Bansal Hospital to contend that Dr. Rahul Manchanda had seen the patient on 03.10.2013, and had posted the surgery at 6.45 on 04.10.2013. OP-1 and OP-2 also relied on the consent form (page 288-289) to further support the contention that the patient Kaushar Jahan had provided an informed high risk consent to Dr. Rahul Manchanda and his team to perform any part of the "procedure". It is also emphasized that paragraph 3 of the consent form describe the likely risks/including air embolism in the procedure. We, while perusing this particular document, have noted that paragraph 1 which should have contained the name of the procedure has been left blank. Page no. 302 is the "Generic Informed Consent" for registration no. 299 (corresponding to indoor patient no. 13/2780). Once again, the consultant doctor's name is mentioned only as Dr. Sandhya, however, the continuation of the same form on page 305 mentions the name of "Dr. Rahul Manchanda/Dr. Sandhya Bansal". It is evident that the handwriting on the top of the page no. 302 and on the remaining portion of the form including that on page no. 305 are different. While the form begins with consultant's name as Dr. Sandhya, it is incomprehensible to us, and has remained unexplained, as to how and why the handwritings in the same form on different pages can or should be different. Page 308 is undated "Consent for hysteroscopy" which is signed by both the deceased and the complainant which has been relied upon by the OPs to contend that both the complainant and the deceased had given informed consent after having fully been explained the procedure, the risk associated therewith and also the fact that Dr. Rahul Manchanda is to perform the surgery, which inference we are unable to make. Page no. 311 is the copy of OT register filed by OP-1 and 2 to contend that Dr. Rahul Manchanda and his team's name is also appearing there as surgeon. On the contrary, it has been pointed out by the complainant that it is obvious that the name of

Dr. Rahul and team has been inserted subsequently below the name of Dr. Sandhya. Page no. 314 (Annexure R1/14) is stated by the OP-1 and 2 to be the OT notes prepared by Dr. Rahul Manchanda on the day of the surgery, irrefutably establishing that it is Dr. Manchanda who performed the surgery. Contesting the same, the complainant has pointed out that this is clearly manipulated, fabricated and subsequently inserted document for the simple reason that there is already an OT note at page no. 38 of the complaint which was signed by Dr. Sandhya Bansal which was in different handwriting and which narrated the facts differently and which was forwarded by the hospital to Medi Assist in connection with cashless insurance. Also the referral summary filed as P-12 was similarly brought to our notice. OP-3, apart from evidence already filed by OP-1, additionally filed only the evidence of his expertise and experience in his field of hysteroscopic surgeries and medical literature to argue that air-embolism is a recognised risk in hysteroscopy. While relying on OP1-2's evidence to plead that surgery was with top-class instruments with full caution and care and that the surgery itself was successful, he also tried to establish and plead that OP-1, and not he, was incharge and accountable for management of likely critical complications as and when arose and that there is no grievance to the complainant against him because surgery was successful and uneventful. OP-3 has maintained that OP-1 was the incharge surgeon who was present in the OT throughout the surgery, and he in fact joined only as her team, which stand is contrary to the Anesthesia notes. There is no explanation as to why, if no payment of fee has been received by him, he has still chosen to undertake his part even as a team-member of OP-1, or how and why exactly he has entered the scene. The question, therefore, also remained for the OP-1 and OP-2 and also for OP-3 to answer, and which has remained unanswered, as to how and why and under what circumstances the name of Dr. Sandhya prominently remained as the doctor incharge in few of the contemporary hospital papers, why Dr. Manchanda's name appears inserted at few other places, and why their stand and narration of the event contradicts. Also, if Dr. Manchanda's OT notes were available as claimed, why different notes/summaries were provided, why the three OT notes are at variance and why the note sent to the Medi Assist and to Fortis is signed by Dr. Sandhya Bansal, if originally and actually, the surgery was conducted by OP-3, and, OT notes prepared by OP-3 Dr. Rahul Manchanda were available, and OP-1 was "in no way concerned" with the surgery. Also, the fact that "apparent air-bubbles were seen by the surgeon and the hysteroscope was immediately withdrawn", is missing conveniently in subsequently prepared notes. Let's have a re-look at the notes of various doctors:

OT notes sent to Medi Assist

Patient Kaushar Jahan was taken for diagnostic operative hysteroscopy on 04.10.2013. There were dense adhesion in cervical canal, Adhesion was dense. hysteroscope was introduced gently. Dense adhesions were removed on all walls with hysteroscope scissors. Lt (left) OS... was made clean Rt (right) OS... was N (normal) While telescope was being withdrawn from the cervical canal Pt had cardiac arrest Pt was revived by all means and was shifted to Escorts hospital.

…….. sd/- Dr. Sandhya Bansal

OT notes of Dr. Manchanda:

PROGRESS SHEET

Please Document Pain Score & action taken, if any

please write all orders in order sheet

4.10.2013

Date/Time

7.15a.m.

OT NOTE

Dr. Manchanda

Diagnostic & OP Hysteroscopy with Adenolysis under S.A.

Hysterescope introduced under 2.9 mm bittorchi

1. B/L ostia opened up

2. Cervical Canal was closed (fibrosed) this was cut and opened.

3. B/L wall uteroplasty done and cavity was opened up.

4. Cavity was compromised initially and this was opened up

5. Cervical canal was normal at end of procedure

Procedure finished on the table just after that patient had cardiac arrest. CPR was done and patient intubated straight away and revived within 3-4 minutes. This happen at 7.45 a.m. All measures for resuscitation were taken. Adrenaline given. Patient was revived and spontaneous ventilation came back on the tube. She was given lasix for chest congestion and Oedema. It was died to put her on a ventilator and shift her to a higher center for further management.

BP was 120/88 mmhg.

And pulse was 120 per minute.

EGG was taken SOB profile sent.

Sd/- Rahul

14. Apart from page no. 37 and 38, the apparent OT notes/referral summary filed by the complainant along with complaint as sent to Medi Assist, the complainant with rejoinder has also filed Annexure C-12 which is the referral summary sent by the OP-2 hospital to Escorts hospital which is as under:

OT notes sent to Fortis Hospital

Refer Summary

Pt (Patient) Kausar Jahn, Age 30 Yrs/F, R/o 109/87, Ghaffar Manzil, Jamia Nagar was admitted on 03.10.2013 for Hysteroscopy GA (General Anesthesia).

She was a case of Asherman's Syndrome.

During the Procedure, Pt (Patient) has an episode of Air Embolism followed by Cardiac arrest.

Cardiac arrest was immediately revived according to ACLS guidelines.

Pt (patient) was shifted to Higher Centre for further management as Pt (Patient) went on ventilator support and isotropic support.

Condition of the patient explained to relatives.

S/d

SANDHYA BANSAL

MBBS & DGO (Gyno & Obst.)

Bansal Hospital,

New Friends Colony, New Delhi.

15. Having evaluated and appreciated the evidence on record, we agree with the complainant that indeed there is no direct and contemporary independent documentary evidence filed by any of the OPs to establish that Dr. Manchanda performed the surgery. The fees have not been charged by him. There is no prescription, pre-surgery or post-surgery medical notes provided either to Medi-assist or complainant's health-insurer or to Fortis Hospital or to the complainant evidencing that Dr. Manchanda was consulted before the surgery or has in fact performed the surgery. Any of the OPs has not come up with any explanation as to how Dr Manchanda popped up on the scene when no fee is shown to have been paid to him. Similarly, the question which arise on account of inconsistency between the OT notes sent by hospital to the Medi Assist and as filed by the OPs along with their written version has indeed remained unanswered by the OPs. Also though it is not positively established by the complainant that there are insertions in the medical papers filed by OP-1

and 2, the close examination of these documents R-1/8 to R-1/13 indeed show manipulation/interpolation which creates a reasonable suspicion that Dr Manchanda's name has been interpolated in records. For example, annexure R-1/8 filed by the OPs is a consultation slip before admission i.e. dated 30.09.2013 and it is contended that various pre-surgery tests were prescribed. This is a document dated 30.09.2013. It is not explained by the OPs as to why an outdoor patient consultation slip is available with the hospital. Moreover, it is attempted to be contended that various pre-surgery tests were prescribed therein on the same day. The reports for these tests which also equally should be available with the hospital, have not been filed. Also, the alleged pre-surgery prescription of Dr. Manchanda is a stand-alone piece, which has no sequential connection with progressive management of the patient in the hospital. Therefore, the pre-surgery prescriptions before admission and before surgery by both the doctors not only do not get established, but rather a joint attempt on the part of all the four OPs to create or manipulate records or documents gets established. Similarly, the printed admission form (R-1/9) mentions only Dr. Sandhya Bansal's name as consultant. Same Dr Sandhya's name is also mentioned on the admission form as "Doctor In Charge". These two documents, together with the fact that Dr. Rahul Manchanda's name is obviously added at a later date (because if written in normal course, there was enough space to write two names) would also throw strong doubt as to who has really been incharge of the patient and who has performed the surgery. Similarly, the alleged undated prescription by Dr. Rahul Manchanda (R-1/10), though pleaded to be dated 03.10.2013 does not at all inspire our confidence because the same has no evident contemporaneousness. Consent form Annexure R-1/1 (page 288) neither has signature of the patient Kaushar Jahan nor para 1, 2 and 4 of the consent form have been filled with requisite details of the proposed surgery, of benefits and reasons, nor of details of alternatives available. The Generic Informed Consent at page no. 302 bears the name of only Dr. Sandhya, however, surprisingly on page 305 the name of "Dr. Rahul Manchanda/Dr. Sandhya Bansal" have been recorded with obvious different handwriting. In the OT register (page 311) also the name of Dr. Rahul Manchanda and team does not appear to have been mentioned in the ordinary course of maintaining the register but appears to have been subsequently added. On the other hand, the pre-surgery consultation including advise for surgery is admittedly by OP-1. There is no indication at all in Dr. Sandhya's categorical prescription for hysteroscopy that any other surgeon would perform that surgery. Admission form, OT notes and the hospital final bill sent to Medi-assist in the ordinary course, all included exclusively and only the name of Dr. Sandhya Bansal as consultant gynecologist and nowhere had any mention of Dr. Rahul Manchanda as the Incharge Surgeon. Fee is also received by Bansal Hospital. As per the doctors, the patient suffered "Air Embolism' and consequent 'Cardiac arrest', but there are no credible blood/ECG/Echo or any other reports filed by them to establish the same. The ECG report (page 323) which is claimed by the OPs to be that of the deceased after the cardiac arrest and resuscitation is illegible and does not appear to bear the name of the patient. 'ABG report' (page 325) also does not bear patient's name but shows patient ID as "SHAKSNA". We have also further noted that no other report with date/time stamps showing the name of the patient has been filed by OP-1 and OP-2 for pre-surgery or post-surgery period. In our opinion, therefore, the active non-maintenance, apparent manipulation of records and withholding of vital evidence is a palpable factor requiring adverse inference. OP-1 and OP-2 for the first time took the plea before the DMC in their reply dated 22.04.2014 that surgery was performed by Dr. Manchanda and filed evidence discussed earlier in this behalf. We have also noted that though complainant categorically pleaded in both the complaints (before

DMC and before us) that the medical records, when demanded by the complainant, were not provided by the OP-1 and 2, apart from mere denial of the allegation, no evidence could be filed by the OP-1 and OP-2 to establish that record was maintained or ever provided. Also, questions like when did Dr. Sandhya come to hospital ? When she signed or authenticated referral summary or note sent to Medi-assist? Why her note to Medi-assist differ from Dr. Manchanda's OT notes? Why Dr. Ajay Kapoor states that air-bubbles were seen in uterine cavity and suddenly the hysteroscope was withdrawn? Who all were there in OT and who took decision to shift patient? Which hysteroscope was used for surgery? Why DVD of surgery, though stated to be available, is not placed on record by OPs? There is no answer. We therefore conclude on the basis of preponderance of probability that the cumulative evidence, including absence thereof, lead to the conclusion that Dr. Sandhya Bansal performed the surgery, and, that perhaps due to complications or consequence of inept surgery due to inexperience and lack of skill, the same could not be managed by her team, Dr. Manchanda was perhaps called in emergency as an expert. The self-serving affidavits of both Dr Sandhya and Dr. Manchada as supported by manipulated records lack credibility. In *Krishna Rao v. Nikhil Specialty Hospital* Supreme Court held that 'there cannot be a mechanical or straitjacket approach that each and every medical negligence case must be referred to experts for evidence', though only in rare and obvious cases. Also, in *Maharaja Agrasen Hospital Vs. Master Rishabh Sharma (2020) 6 SCC 501,* Supreme Court has held that the hospital is always vicariously liable for medical negligence or misconduct of the doctors and professionals and the assisting nursing, OT and other staff, either under employment or on contract:

> *"12.4.21. It is well established that a hospital is vicariously liable for the acts of negligence committed by the doctors engaged or empanelled to provide medical care. [Savita Garg v. National Heart Institute, (2004) 8 SCC 56; Balram Prasad v. Kunal Saha, (2014) 1 SCC 384 : (2014) 1 SCC (Civ) 327; Achutrao Haribhau Khodwa v. State of Maharashtra, (1996) 2 SCC 634; V. Krishnakumar v. State of T.N., (2015) 9 SCC 388 : (2015) 4 SCC (Civ) 546] It is common experience that when a patient goes to a hospital, he/she goes there on account of the reputation of the hospital, and with the hope that due and proper care will be taken by the hospital authorities. [Savita Garg v. National Heart Institute, (2004) 8 SCC 56] If the hospital 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 the acts of commission or omission on behalf of their doctors. [Savita Garg v. National Heart Institute, (2004) 8 SCC 56]"*

16. As per the complainant, Dr Sandhya and her team of specialists, were to undertake the surgery and has performed the surgery. Dr. Sandhya Bansal, in our opinion, is not at all justified in submitting that "she is in no way concerned with the surgery and subsequent events" or that she was not directly involved in the surgery and management of the episode of cardiac arrest subsequent to suspected Air Embolism post surgery, when as per the records, she herself is the primary consulting gynecologist and when the patient had followed her advise of undergoing the surgery in a hospital where she is an incharge doctor. As such, on the basis of evidence on record, not only the complainant but even OP-3 is right in submitting that Dr. Sandhya Bansal was the primary incharge and consultant doctor who advised the patient for hysteroscopy, who advised the surgery by Dr. Rahul Manchanda and consequently, the patient consented to get admitted and operated in OP-2 hospital.

Documentary evidence in the form of pre-surgery prescription for hysteroscopy, and two referral summaries both in the handwriting or under authority of Dr. Sandhya Bansal herself are available on record. At the best, the contention in the written version of OP-3 that his team (Dr. Manchanda's team consisting of himself and Dr. Sanjeev) was a part of the team assembled by Dr. Sandhya Bansal and that his role was limited to undertaking the hysteroscopic surgery as assisted by his own team and the nursing staff of OP-2 therefore appears factually more plausible. Even the anesthetist Dr. Ajay Kapoor joined in the operation theater as a part of Dr. Sandhya Bansal's team. Similarly, we are also not at all convinced with the contention of OP-3 in his written version that his role was limited to carrying out the hysteroscopic surgery and nothing more. The contradictory stands of Dr. Sandhya Bansal and Dr. Manchanda with regard to who is responsible or accountable for the condition of the patient Kaushar Jahan in the operation theater and till the time she was shifted to the Fortis Hospital via ambulance, are unethical to say the least and we have no doubt in our mind that it is a well orchestrated joint strategy on the part of the OPs to create scope for escape from liability. We are of the considered opinion that the management of each of the emergencies and each of the complications and consequences which arise in the operation theater, or which continue, is indeed a joint responsibility and accountability of the hospital where the surgery takes place who has provided the equipments and nursing and technical staff, of the surgeon who is expected to exhibit skill, caution and preparedness for foreseeing, preventing and handling the likely complications apart from skillfully carrying out the surgery, and of the anesthetist who is trained, skilled and experienced in anticipation and management of critical complications of surgery and anesthesia and who has the responsibility to bring the patient back to consciousness by anesthesia-reversal medications while constantly monitoring of patient and handling the emergencies. The OP-1 and OP-2 issued interrogatories to the complainant who has replied the same. In reply 10, it is categorically stated by the complainant that on 30.09.2013 there was no suggestion for hysteroscopy surgery to be done by Dr. Manchanda. Similarly, in reply 12 the complainant has reiterated that he or deceased never met or consulted Dr. Rahul Manchanda and never paid any fee to Dr. Manchanda. In subsequent replies upto reply 23, the complainant maintains that the name of Dr. Rahul Manchanda is being wrongly suggested as the hysteroscopic surgeon and the same is a part of covering up the actual complication which arose during the surgery by Dr. Sandhya Bansal; and is also an attempt of maneuvering and interpolation of records. Refuting the suggestion in reply 22, 23, the complainant has maintained that not Dr. Rahul Manchanda but Dr. Sanjeev Bansal (owner of Bansal Hospital and husband of Dr. Sandhya Bansal) took signature for transferring the patient to Fortis hospital by communicating that the same would be required by the Fortis Hospital, and that it was the decision of OP-1 and OP-2 to shift the patient. In reply to questions 24 and 25 suggesting that the ambulance was called "after the consent was given" and that it reached Fortis Hospital at 9.15 am accompanied by Dr. Pawan Zutshi, the complainant stated that ambulance was called at 8.48 am, reached OP-2 hospital at 9 am and left OP-2 hospital only at 9.55 am and reached Fortis Hospital at 10 am. On overall appreciation of the evidence on record, we conclude that there is a systematic attempt on the part of OPs to introduce/insert name of Dr. Manchanda as hysteroscopic surgeon who purportedly performed the surgery. All such relied upon documents are such which could unilaterally be created subsequently or which allowed for subsequent writing of name of Dr. Manchanda, or are the notes prepared by the OPs themselves. The spontaneous contemporary documents are evidencing Dr. Sandhya's name as surgeon who has attempted to simply wash her hands off with aid from

other OPs. We, therefore, conclude that the evidence on record produced by OPs to establish the alleged fact of "surgery by OP-3" is not credible, and cannot be relied upon for that conclusion. We therefore conclude that the hysteroscopy was, as per evidence, performed by Dr. Sandhya Bansal who did not possess the requisite experience or expertise in the field, and that is why, when untoward complication occurred, Dr. Manchanda's name was introduced in the records.

17. The complainant has also filed copy of the complaint 1292/2014 filed by him in DMC dated 28.02.2014 wherein allegations against OP-1 and OP-2 similar to those in the present complaint have been levelled. It is seen that the Delhi Medical Council's order dated 05.04.2018 in complaint filed by the complainant against Dr. Sandhya Bansal and Dr. Ashok Seth (subsequently Dr. Rahul Manchanda and Dr. Ajay Kapoor added as OPs) has exonerated the opposite party doctors. Delhi Medical Council in the complaint of medical misconduct and negligence filed by this complainant Saleem Ahmed against Dr. Sandhya Bansal of Bansal Hospital and Dr. Ashok Seth of Fortis Hospital (wherein Dr. Rahul Manchanda and Dr. Ajay Kapoor were subsequently impleaded/examined) has exonerated both the medical professionals, by observing as under vide their order dated 05.04.2018 which also subsequently came to be upheld by the Medical Council of India vide their order dated 20.11.2019.

> *"In view of the above, the Disciplinary Committee observes that the patient (a 31 years old female) was suspected case of Asherman Syndrome who required hysteroscopy for diagnosis and eventually lysis of adhesions is advised later or on the same sitting. The patient was explained about the risks of the surgery and written informed consent was taken at Bansal Hospital. The patient was taken up for diagnostic hysteroscopy with adhesiolysis on 4th October, 2013. During the procedure, the patient suffered (probably) venous air embolism and eventually cardiac arrest. It is observed that air embolism can lead to sudden cardiac arrest which was managed and revived immediately; however, the patient developed pulmonary oedema which was managed and the patient was shifted to Fortis Escorts Heart Institute for better care. Despite all the adequate measures, the patient had severe metabolic acidosis and hypoxaemia which lead unfortunately to refractory cardiac arrest on 4th October, 2013 at Fortis Hospital Heart Institute. It is further observed that the explanation put forth by Chairman, Cardiac Sciences, Fortis Hospital Heart Institute regarding not advising post-mortem, as is noted herein-above is found to be acceptable. In light of the observations made herein-above, it is, therefore, the decision of the Disciplinary Committee that no medical negligence can be attributed on part of Dr. Sandhya Bansal of Bansal Hospital and Dr. Ashok Seth of Fortis Escorts Heart Institut***e*****,** *in the treatment administered to complainant's wife Smt. Kaushar Jahan."*

Delhi Medical Council's order was later challenged by the complainant before the Medical Council of India. The Medical Council of India dismissed the appeal on November 20, 2019, and concluded that no negligence could be attributed:

> *"....the matter was kept in the Ethics Committee meeting held on 29.06.2019. After going through the contents of the statement submitted by Sh. Saleem Ahmed & also as*

a result of perusal of all the documents on record, the statements of the respondents, the Committee made the following observations:

i. *Air embolism is a known complication of Hysteroscopy.*
ii. *The same was explained to the patient & consent taken.*
iii. *Air embolism may lead to Cardiac arrest; that is also a known complication.*
iv. *Further, series of events were managed as per standard protocol both at Bansal Hospital & Fortis Hospital.*

Though it is unfortunate sad event; and more unfortunate that the patient could not be saved despite all efforts. Therefore, the Committee is of the view that there is no negligence on part of the treating doctors.

Thereby, upholding the Delhi Medical Council order dated 05.04.2018, Dr. Sandhya Bansal, Dr. Rahul Manchanda and Dr. Ajay Kapoor of Bansal Hospital and also Dr. Ashok Seth of Fortis Escorts Hospital, Delhi are exonerated…"

In the order, the DMC has reproduced the pleadings and contentions of the parties in pages 1 to 29. In the last two paragraphs, the DMC has summarized the facts and contentions and observed that *"despite all the adequate measures, the patient had severe metabolic acidosis and hypoxaemia which led unfortunately to refractory cardiac arrest at Fortis Hospital. It is further observed that the explanation put forth by Chairman, Fortis hospital regarding not advising post-mortem as noted hereinabove is found acceptable. In light of the observations made hereinabove, it is therefore the decision of the Disciplinary Committee that no medical negligence can be attributed on part of Dr Sandhya Bansal of Bansal hospital and Dr. Ashok Seth of Fortis Escorts Heart Hospital in the treatment administered to complainant's wife Smt. Kaushar Jahan"*

18. We have noted that though the complaint was originally filed against both Dr. Sandhya Bansal and Dr Ashok Sheth and further that Dr. Rahul Manchanda and Dr. Ajay Kapoor were "added" or "examined" at the instance of Dr. Sandhya Bansal, the operative part has not categorically evaluated their roles or the inherent discrepancy in the documentation at all. There is no attempt by the DMC to correlate its findings to either the specific allegations as levelled by the complainant or to the evidences produced by the parties. In the final decision, only Dr. Sandhya Bansal and Dr. Ashok Seth have been exonerated and there is no finding with regard to Bansal Hospital, Dr. Rahul Manchanda and Dr. Ajay Kapoor. The complainant in his complaint to DMC in para no. 29 to 32 had categorically urged the DMC to invoke its powers of investigation to examine the manipulation of records and non-maintenance of records and also the circumstances which required the shifting of the patient and also those which led to the untimely demise of the 31 year old patient. Not only there is no investigation, analysis or finding with regard to any of these aspects, there is absolutely no link between the lengthily narrated facts and averments of parties on one hand and the finding of no medical negligence on the other. More importantly, the DMC has arrived at the finding of absence of medical misconduct exclusively on the basis of documents submitted or maintained by the OPs without going into the specific allegation regarding manipulation, interpolation, *inter-se* inconsistency and incompleteness or otherwise of such records. Similarly, the order of the Medical Council of India confirming the finding of the DMC vide their order dated 20.11.2019 in appeal filed by

the complainant, also primarily proceeds on the premise that air embolism is a known complication of hysteroscopy without examining the merit of the DMC's decision in light of the allegations in the complaint and the quality and completeness of the medical evidence on record. We also find that the decisions by both these statutory expert bodies have not resolved the allegations and counter-allegations between Dr. Sandhya Bansal and Dr. Rahul Manchanda and the inherent inconsistency, incongruency and incompleteness of the evidence maintained and produced by both these doctors. Further, there is no link of reason between the evidence and the findings. Therefore, we are of the view that not much credence can be assigned to these orders of DMC and MCI.

19. The second issue is whether there is any negligence or misconduct or deficient service on the part of any of the OPs. It is the case of the complainant that the patient was taken to the operation theater on 04.10.2013 at around 6.45 a.m. after consultation with Dr. Sandhya Bansal and for surgery to be performed by Dr. Sandhya Bansal. At around 9.35 a.m. complainant (husband of Kaushar Jahan) was informed that during operation, the patient developed some complications and immediately after 10 minutes Dr. Sanjeev Bansal further informed that the doctors in the operation theater are unable to handle the complications and they are shifting her to Fortis Escorts Hospital for better management. The consent for shifting was accordingly given. In Fortis Hospital, the patient died within next 5 hours. A young lady of only 31 yearś has suffered death within 8 hours after she was taken to the OT. It was for OP-1 and OP-2 to explain how exactly and under what circumstances the condition of the patient became critical and death occurred. The consent for surgery was obtained without explaining the risk of air-embolism and heart attack. Neither at the time of shifting nor subsequently when demanded, nor under RTI, has the OP-2 provided the details of treatment, actions and equipments; and even when filed before the Commission, the same are manipulated and interpolated to enable the OP-1 and 2 to defend the case. As per the complainant, as mentioned in the referral summary prepared by Dr. Sandhya Bansal, the patient suffered suspected Air Embolism during the surgery when the hysteroscope was being withdrawn from cervical canal due to which the patient suffered a heart attack. *"It is well recognized fact that complication in operative hysteroscopy occur only when contra indications are ignored and when proper techniques are not followed or equipments/instruments are used in an inappropriate manner"*. The Air Embolism does not happen if proper care before and during the hysteroscopy is taken. When the Air Embolism and consequent heart attack did occur, it was the duty of the doctors in the operation theater to have effectively and efficiently managed the same. It was also recorded in the admission form and further progress notes in the Fortis Escort Hospital that there was frothy secretion in the endotracheal tube of the patient which was not properly suctioned which ultimately led to "non-cardiogenic respiratory edema" as noted in the death summary. These negligence/omissions are clear acts of medical misconduct on the part of OP-1 and OP-2 and the damage due to untimely death resulting from such deficient service on their part needs to be compensated. The fact that the patient died within eight hours of entering the operation theater and who also needed to be taken to a higher and more equipped hospital, needed a comprehensive and evidence based explanation from the OP-1 and OP-2. Rather than providing any explanation or evidence or information as to what happened, the OP-2 hospital has provided no information. Though patient never met OP-3 and he did not perform the surgery, even if he did perform the surgery, he is equally and jointly liable for the joint poor

surgery and post-surgery cardiac arrest and wholly unexplained mismanagement of the patient thereafter.

20. As against this, OP-1 in her written version has stated that she had no role to play and rather it is Dr. Manchanda and Dr. Ajay Kapoor who are responsible and who should explain the whole chain of events. It has been submitted with requisite documentary support that OP-2 hospital is a reputed hospital which has been empanelled by CGHS and which has also obtained NABH accreditation vide certificate Annexure R1/1 for which the inspection was carried out in June, 2013. It is a fully equipped multispeciality hospital duly authorized in the area of gynecology. It is also submitted that the deceased Kaushar Jahan and her husband have had multiple admissions in the past in the OP-2 hospital and deceased also had multiple gynecological consultations and treatments of OP-1 at OP-2 hospital and every time they have not only been satisfactorily treated but have happily and repeatedly reposed faith in OP-1 and OP-2 for every medical need as and when arose. Apart from this, the deceased was suffering from hepatitis. Because as per diagnosis of OP-1 the deceased required a hysteroscopic procedure, the name of best expert in town was duly suggested to the deceased and her husband, who after agreeing to undergo hysteroscopic surgery by Dr. Manchanda got admitted in OP-2 hospital. Preoperative investigation and screening were carried out in OP-2 hospital after examination by Dr. Manchanda in the evening of 03.10.2013. Thereafter, Dr. Manchanda arrived with his team in the morning of 04.10.2013 and patient was taken to the OT. Right from entry of the patient into the OT till her shifting to the Fortis Hospital, she was under the treatment and care by Dr. Manchanda and Dr. Ajay Kapoor. Only the nursing staff and the OT were provided by the OP-2 hospital. Dr. Manchanda informed the complications to the complainant no. 1 and explained the need for shifting the patient to Fortis Hospital for which consent was obtained from the complainant. As per the OT note prepared by Dr. Manchanda and as per the anesthesia notes prepared by Dr. Ajay Kapoor, the patient suffered Air Embolism (which is a likely complication of hysteroscopy) and subsequent cardiac arrest. Such risk was duly explained to and consented by both the deceased and her husband as per consent form. The referral summary along with the relevant other case papers were provided to the team of Fortis Hospital ambulance. Thus, there is no way that OP-1 is personally concerned with or responsible for any of the alleged events of medical misconduct or negligence. Relying on annexures R1/8 to R1/17, the OP-1 and OP-2 submitted that surgery was carried out uneventfully and successfully by Dr. Rahul Manchanda after the anesthesia was administered by Dr. Ajay Kapoor. At the time when hysteroscope was being withdrawn, it was noticed by the anesthetist Dr. Ajay Kapoor that the patient was getting disoriented and her BP was dipping when he also shouted whether air has entered. The patient immediately thereafter suffered a cardiac arrest on account of suspected Air Embolism. Air Embolism is though rare but a distinct complication of hysteroscopic surgeries which can result into a further complication of cardiac arrest despite the best precaution, technique and skill adopted by the surgeon and anesthetist. The information regarding such complication was provided to the deceased and her husband who also signed the high risk consent form of the hospital. Once the cardiac arrest occurred, the resuscitation efforts as per ACLS protocol were undertaken resulting into successful resuscitation as evidenced by Annexure R1/15 and R1/16. Dr. Biswas, the physician, was also consulted. As per the anesthesia notes of Dr. Ajay Kapoor Annexure R1/15, about 50 ml. of blood was suctioned from endotracheal tube. The patient was put on Central Venous Catheter. Dr. Manchanda and his team advised for shifting the patient to higher center for better medical

management which was followed. The ambulance was called at around 9 a.m. and the shifting formalities took some time and the patient was safely admitted in Fortis Hospital at 10 am. As per the hospital papers of Fortis Hospital filed by the complainant, the patient received further critical treatment and attention at the Fortis Hospital where she suffered a further cardiac arrest and was declared dead at 3 pm. The OPs relied on medical literature and DMC orders in other cases to support the contention that air-embolism, as a complication of hysteroscopy, when it does occur, can often be fatal wherein no negligence can be attributed to the doctor

21. We have carefully considered the submissions in light of the evidences on record. The allegation of the complainant in the complaint as also during the course of hearing is firstly that the surgery by Dr. Sandhya Bansal was without due exercise of requisite skills. Air Embolism which occurred during/around withdrawal of the hysteroscope by the surgeon, could have been avoided if contraindications of the same were taken care of by the OP-1 and OP-2. It is the categorical averment as noted above that "it is well recognized fact that complications in operative hysteroscopy occur only when contraindications are ignored and when proper techniques are not followed or equipments are used in an inappropriate fashion". The allegation is attempted to be supported by further allegation against OP-1 and OP-2 that necessary medical records have been removed, manipulated and not provided to the complainant by the OP-2 hospital. However, once we have come to the conclusion that records are manipulated, and there is apparent blame game between Dr. Sandhya Bansal and Dr. Rahul Manchanda, who also differ as to what exactly transpired during the surgery and thereafter during the deceased's stay in OT/hospital, and when the 31 year old lady within about 90 minutes of the start of the surgery was left in "a very critical condition" (as noted by Fortis Hospital), we have no hesitation in concluding that the heavy onus of transparently documenting and explaining the events, roles and accountability by the concerned professionals has not at all been discharged. First and foremost, we may reproduce the anesthesia note as also the reply given by Dr. Ajay Kapoor to the DMC and to this Commission.

> *"Just when the surgeon was about to pull his surgical uterine scope out of the uterine cavity, he asked his assistant manning the irrigating fluid to check as he noticed air bubbles in the uterine cavity. At the same time the anesthetist found that the patient was becoming irritable and disoriented. He shouted out as to whether the air had gone in. The surgeon immediately pulled the surgical scope out of the uterine cavity. The monitor was showing absent plethysmograph, with sudden loss of pulses and ECG showing normal electrical cavity soon which became irregular and the patient had a cardiac arrest. All these events happened very fast in less than a minute."*
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> "

22. Thus, what we perceive to be the likely event in the OT is that either the hysteroscope was not sufficiently state of the art, or, Dr. Sandhya Bansal who performed the surgery was not skillful enough to instruct her team and to handle the measures to prevent the entry of the air into the uterine cavity and also to perform hysteroscopy. The narration of the anesthetist in the anesthesia notes clearly mentions that the surgeon not only saw the air bubbles in the uterine cavity, but also shouted to "his team" whether air has gone inside, and after which, the hysteroscope was abruptly withdrawn by the surgeon. Also, the cardiac event which occurred in the OT is stated to have been reversed in as much as the patient was resuscitated

and the heart condition has been noted by Fortis Hospital to be normal (EF 60% and RA/RV normal and no regional wall motion abnormalities and no evidence of pulmonary evidence, as noted by Fortis Hospital). In that scenario, how and what event led to the fact that the endotracheal tube had "blood coloured frothy secretions" despite aspiration of 50 ml blood by the anesthetist and why "copious amounts of frothy expectorations" were required to be suctioned off, the ET at regular intervals in OP-2 as also in Fortis Hospital, has not at all been attempted to be explained by the OPs. Also, while Fortis Hospital has noted that the X-ray showed that "patient had chest creps and bilateral diffuse opacities with persistent hypoxemia and mixed acidosis". By 8.18 am, the patient had already suffered the episode and had been resuscitated, still however, the patient could not be shifted to Fortis hospital before 9.55 am. The explanation for delay and detailed consultation and progress notes as to which diagnostic tests were carried out and what diagnosis were arrived at and what treatment/management was provided is not brought on record by the OPs. As a matter of fact, which particular condition after the patient was resuscitated required the shifting to a "higher center" has also not been explained. Lot of stress has been put by the OPs on the fact that "air embolism" is a likely complication of hysteroscopy. However, it is not explained how not random and small quantity of air bubbles but copious amount of air of "beyond tolerance limit" could enter the uterine cavity so as to generate visible air bubbles in the uterine cavity and continuous frothy expectoration in the Endotracheal Tube as has been noted by Fortis hospital. Also the cause of death as noted in the Death Summary is acute pulmonary edema (non-cardiogenic), persistent hypoxemia and severe mixed acidosis which were noted by Fortis Hospital also at the time of admission at 10 am immediately after admission and after 2D Echo reports were received. In view of these facts, and on account of absence of any credible and independent and contemporaneous document of diagnostic tests, results and management in the light of such diagnostic findings which could support the version of the OPs that the "suspected air embolism" which happened was only a chance outcome, and that the same happened despite necessary precautions, and that Dr. Sandhya Bansal possessed necessary training, skill and experience in hysteroscopy, we have no option but to hold that the surgery has been performed with less than requisite skill and expertise expected of the surgeon undertaking the hysteroscopy. One of the medical articles relied upon by the OPs (page 85 of reply of OP-3) in connection with risk of air embolism, has the following concluding remarks which perhaps sums up what really might have transpired and what has been attempted to be covered up by furnishing self-serving and made up OT notes, which are contrary to the anesthesia notes:

> *"If the contraindications to hysteroscopy are observed, complications should be kept at a minimum. The risks of fluid overload, especially in operative cases, is the single most common and critical complication. Accurate recording of fluid intake and outflow are absolutely essential. This and all other complications are most likely to arise in the hands of an inexperienced and unsupervised surgeon."*

23. Apart from this, there is marked contradiction in the versions of Dr. Sandhya Bansal and Dr. Manchanda firstly as to when actually the cardiac arrest was noticed. Dr. Manchanda maintains that the patient suffered cardiac arrest immediately after the surgery was successfully completed. Dr. Sandhya on the other hand, as supported by Dr. Ajay Kapoor, has stated that the surgeon firstly had noticed air bubbles in the uterine cavity and just when the hysteroscope was being "immediately withdrawn", the patient suffered a cardiac arrest. It is therefore very likely that the fluid irrigation and similar measures for securing the uterine

cavity against air inflow during surgery was also not skillfully handled or managed. Dr. Ajay Kapoor in his reply before Delhi Medical Council as also before this Commission has categorically noted that "with a strong suspicion of air embolism in mind, Dr. Kapur put in a central venous catheter via subclavian route and aspirated 50 ml of blood. The blood was foamy in appearance because of the obvious presence of air bubbles." While Dr. Sandhya Bansal has maintained that she was not present in the OT, Dr. Manchanda in his reply has stated that Dr. Sandhya Bansal was very much present during the whole of the surgery. Who actually took the decision to shift the patient and what is the basis of this decision has not at all come on record. Further, at the time of admission in Fortis Hospital, the patient had severe "metabolic acidosis and pulmonary edema". There is no evidence of the progression and management of the patient leading to this stage. All these factors equally point to inept handling and management of the patient.

24. The OPs have drawn our attention to the medical literature on the issue of risk of air embolism as a complication of hysteroscopy. In "Complication of Laparoscopy and Hysteroscopy" edited by Randle S. Coffman and Michael P. Diamond (second edition) five case studies of gynecologic endoscopic gas embolism have been discussed before conclusive discussion. All the cases suffered cardiac event during or immediately after the hysteroscopy and died or suffered severe damage. in the article. Case 1 is of 27 year old woman who underwent curettage on separate occasions. Subsequently, for a hysteroscopic procedure she was taken to the OT and was placed in trendelenburg position and when the hysteroscope was being reinserted the anesthetist team marked sudden decrease in heart rate, falling oxygen saturation, falling blood pressure and cyanosis. Creoutabce was detected in both inguinal areas and a femoral venous tap produced frothy blood. Gas was aspirated from both cardiac ventricles. Despite resuscitative efforts the patient died. In Case 2, a 27 year old woman was taken to OT for hysteroscopic examination for diagnosis of abnormal uterine bleeding. She was administered general anesthesia and hysteroscope was inserted. During examination and before any surgical manipulation other than inspection of the cavity, bradycardia developed at 9 minutes into the case. Trans-esophageal ultrasonography demonstrated gas in all four chambers of the heart. Though she finally could be revived, the permanent brain damage could not be avoided. In case 3, the 32 years old patient underwent hysteroscopy and the videograph showed that within 35 seconds from initial incision, there was considerable bleeding. For clearing the lens, the hysteroscope was removed and within two minutes thereof, the oxygen saturation decreased and bradycardia was noticed. Similarly case study 4 and 5 the patient succumbed to the complications of air embolism of hysteroscopy. It has been emphasized by OPs that based on this medical article that air embolism and consequent cardiac condition is a complication of hysteroscopy which though rare cannot wholly be ruled out. The OPs have also drawn our attention to the orders passed by the Delhi Medical Council dated 01.12.2009 and dated 10.10.2011, respectively in the cases of complaints/reference against doctors of Gauri Hospital and G.M. Modi Hospital to re-emphasize that even Delhi Medical Council not only in the case filed by the complainant against OP-1 but also in other cases have taken a categorical view that instances of air embolism followed by cardiac events during hysteroscopy procedures are rare but unavoidable and most often fatal complications for which the involved doctors cannot be held liable for medical negligence on the ground of occurrence of such complication alone. Similarly, the article in Journal of American Association of Gynecologic Laparoscopist titled

"Complications of Hysteroscopy-Their Cause, Prevention, and Correction" by Franklin D. Loffer, M.D. having the following extract:

Abstract: Complications of hysteroscopy occur more frequently in operative than in diagnostic cases. Problems related to uterine distension are common, usually preventable, and potentially extremely serious. Perforation of the uterus may occur during hysteroscopy but do not always cause significant problems. In procedures of high risk perforation, the use of mechanical energy is safer than either laser or electrical energy. Laparoscopy and ultra sonography have some limited use in facilitating operative hysteroscopic procedures. Most complications occur during the hysteroscopic surgical procedure. However some problems may not be apparent until the post operative period.

Complications of hysteroscopy may occur when, contraindications are ignored, for example, when proper surgical techniques are not followed or equip- ment is used in an inappropriate fashion. They also may occur when the procedure has been performed correctly on well-chosen patients.

Air and Gas Embolism:

Intravascular air embolization can occur whenever uterine veins are open during surgery and the air pressure is greater than venous pressure." Although uncommon, it is a risk of hysteroscopic surgery when the patient is in Trendelenburg position and the uterus is elevated over the heart. Spontaneous ventilation may increase this risk. It may also occur from bubbles in the inflow tubing or gases that form during the procedure.

Early therapy of an air embolism is mandatory. Hyperbaric oxygen can be used to treat patients who survive the initial insult. Hyperbaric consultation can be obtained without charge 24 hours a day through the Divers Alert Network, Duke University, Durham, NC, (919) 684-8111.6

Another cause of gaseous embolization that has resulted in death and serious injury is using air, CO2, and nitrous oxide with coaxial fibers of the neodymium: (Nd:YAG) laser. When gas is used with these fibers in the uterus with or without a sapphire tip, death and serious injury can occur because the high flow rate that is delivered does not vary with the pressure created. Only a liquid should be introduced into the uterus through the coaxial laser fiber.

Death

Fortunately, deaths related to hysteroscopy are infrequent, and many large series do not report any. The true rate is not known, since deaths may go unreported and the denominators are not generally given in published case reports. A rate of 1.7/10,000 cases has been reported."

Summary

If the contraindications to hysteroscopy are observed, complications should be kept at a minimum. The risk of fluid overload, especially in operative cases, is the single most common and critical complication. Accurate recording of fluid intake and outflow are absolutely essential. This and all other complications are most likely to arise in the hands of inexperienced and unsupervised surgeon."

25. OPs are indeed correct, on the basis of this literature, that complications of air-embolism can occur during or immediately after the hysteroscopy. However, in our opinion, when the event has happened in the OT, within the special, exclusive and expert knowledge of the Medical Professionals, the mere doctored documents of complication and literature supporting such likely complications would not be sufficient. The Hospital and the professionals must establish, in such peculiar circumstances, primarily through contemporaneous record of parameters as noted on various monitoring equipments in the OT, diagnostic test-results, and progressive treatment notes of treating experts, that the particular precautions keeping in mind the likely complications were taken and that the patient was managed expeditiously and as per prescribed protocols. For example, the air-embolism is more likely in trendelenburg position, and irrigating systems need efficient management. In expert hands, the complication is least likely. The reason for frothy secretions in endotracheal tube need to be investigated and treated.

26. The OP has also relied on Delhi Medical Council's orders in complaint no. 583 of 2009, 861 of 2011 and 1885 of 2019 wherein it has been observed that a rare but devastating complication of hysteroscopy is venous air entrapment and embolism. The events in venous air embolism are so sudden and so severe that management is extremely difficult. Similarly, OP relied on following decisions of Hon'ble Supreme Court to strongly contend that a professional may be held liable only for one of the two findings namely, either he was not possessed of the requisite skill or he did not exercise the skill which he possessed with reasonable competence in a given case, both of which are evidently absent in the present case:

a. ***Jacob Mathew Vs. State of Punjab (2005) 6 SCC 1***

18. *……. 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 necessary for every professional to possess the highest level of expertise in that branch which he practises. 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."*

(b) ***Dr. Harish Kumar Khurana Vs. Joginder Singh (2021) 10 SCC 291***

11. *…….However, in unfortunate cases, though death may occur and if it is alleged to be due to medical negligence and a claim in that regard is made, it is necessary that sufficient material or medical evidence should be available before the adjudicating authority to arrive at a conclusion.*

(c) ***Bombay Hospital & Medical Research Centre Vs. Asha Jaiswal & Ors.***

2021 SCC Online SC 1149

34. *Recently, this Court in a judgment in Harish Kumar Khurana v. Joginder Singh [Harish Kumar Khurana v. Joginder Singh, (2021) 10 SCC 291 : (2022) 1 SCC (Civ) 215] 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. Every death of a patient cannot on the face of it be considered to be medical negligence……..*

35. *……The doctors are expected to take reasonable care but none of the professionals can assure that the patient would overcome the surgical procedures. Dr Kripalani has been attributed to have informed the complainant that the patient's legs were not working but Dr Kripalani denied all the averments by filing of an affidavit.*

d. ***Kusum Sharma Vs. Batra Hospital & Medical Research Centre***

(2010) 3 SCC 480

89. On scrutiny of the leading cases of medical negligence both in our country and other countries specially the United Kingdom, some basic principles emerge in dealing with the cases of medical negligence. While deciding whether the medical professional is guilty of medical negligence following well-known principles must be kept in view:

I. Negligence is the breach of a duty exercised by 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.

II. Negligence is an essential ingredient of the offence. The negligence to be established by the prosecution must be culpable or gross and not the negligence merely based upon an error of judgment.

III. The medical professional is expected to bring 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.

IV. A medical practitioner would be liable only where his conduct fell below that of the standards of a reasonably competent practitioner in his field.

V. In the realm of diagnosis and treatment there is scope for genuine difference of opinion and one professional doctor is clearly not negligent merely because his conclusion differs from that of other professional doctor.

VI. The medical professional is often called upon to adopt a procedure which involves higher element of risk, but which he honestly believes as providing greater chances of success for the patient rather than a procedure involving lesser risk but higher chances of failure. Just because a professional looking to the gravity of illness has taken higher element of risk to redeem the patient out of his/her suffering which did not yield the desired result may not amount to negligence.

VII. Negligence cannot be attributed to a doctor so long as he performs his duties with reasonable skill and competence. Merely because the doctor chooses one course of action in preference to the other one available, he would not be liable if the course of action chosen by him was acceptable to the medical profession.

VIII. It would not be conducive to the efficiency of the medical profession if no doctor could administer medicine without a halter round his neck.

IX. It is our bounden duty and obligation of the civil society to ensure that the medical professionals are not unnecessarily harassed or humiliated so that they can perform their professional duties without fear and apprehension.

X. The medical practitioners at times also have to be saved from such a class of complainants who use criminal process as a tool for pressurising the medical professionals/hospitals, particularly private hospitals or clinics for extracting uncalled for compensation. Such malicious proceedings deserve to be discarded against the medical practitioners.

XI. The medical professionals are entitled to get protection so long as they perform their duties with reasonable skill and competence and in the interest of the patients. The interest and welfare of the patients have to be paramount for the medical professionals.

(f) Chanda Rani Akhouri Vs. M.A. Methusethupati (2022) SCC Online SC 481

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.

27. We have very carefully gone through these decisions and the mandate of the apex court therein. The OPs are absolutely right in contending on the strength of these decisions

that neither the mere unfortunate outcome nor every error of judgment can lead to the inference of negligence of the treating doctor or hospital. Similarly, the negligence has necessarily to be established positively by reference to the duty cast on the professional and a breach thereof. However, in our considered opinion, this would not imply that the Hospital and the treating doctors are entitled not to maintain or not to provide to the complainant the requisite basic record of advise, treatment and diagnostic reports, and not file such best evidence before this Commission and then to rely on absence of such evidence to plead that there is no evidence on record establishing the negligence. We have concluded that Dr. Sandhya Bansal was unduly confident in advising and undertaking the specialised procedure of hysteroscopy which require expertise, experience and skills in anticipating and avoiding the likely complication of air-embolism. This mis-adventure is negligent and deficient medical misconduct which led ultimately to complications and untimely death of the patient. The precedents relied upon cannot come to the aid of OP-1 and OP-2.

28. In conclusion, we firstly hold the fact that a perfectly healthy lady of 31 years is taken to the operation theatre and after remaining under expert and professional care of OPs 1 to 4 for about two hours, she has come out in an unconscious and critical condition is *prima facie* an inexplicable outcome which was required to be explained cogently by OPs, which has not been done. We hold secondly that because the facts and events inside the OT are under special and expert knowledge of the OPs 1 to 4, the onus is on them to duly and cogently explain the chain of events which took place within the close doors of the operation theatre and to establish the same with contemporaneous medical evidence. The contemporaneous medical evidence in the form of ECG reports, CT scan reports, Blood reports, ABG reports, etc., must exist in the normal circumstances, which have been withheld by the OPs from the complainant as also from this Commission. In view of this we hold that there is an active withholding of relevant evidences by the OPs. Further, there is palpable manipulation of records. Consequently, we hold that the onus of explaining and establishing the chain of events as canvassed by OPs has not been discharged by OPs 1 to 4. Therefore, we have no hesitation in concluding that the death of the patient is attributable to the insufficient precaution, skill, experience and care on the part of the OPs 1 and 2. It is not sufficient for OPs, in such circumstance, to merely indicate through literature the likelihood of of a complication. In view of this, we rely on Supreme Court's decision in *Krishna Rao v. Nikhil Speciality* and Kerala High Court judgment in *Dr. M.K. Gourikutty and etc. Vs. M.K. Raghavan & Ors. AIR 2001 Ker 398 supra* decided on 08.08.2001. We hold that the eventual death of the deceased Kaushar Jahan at Fortis Hospital is solely on account of the inept and deficient surgery and post-surgery management of the patient by OP-1 and her team at OP-2, exacerbated by unavailability of specialists and critical care professionals and that principle of *res ipsa loquitur* is squarely applicable. We are satisfied on the basis of medical evidence on record that given the condition of the patient at the time of admission there, no fault or negligence can be attributed to either the professionals at Fortis Hospital or the hospital itself because the patient who was already in a critical state was admitted there and who also suffered a further refractory cardiac arrest. OP-1 has after professing to be possessing requisite skills for hysteroscopy, performed hysteroscopy for which the evidence of expertise and skill could not be furnished by her, and, on the contrary, clear and palpable effort has been made to withhold the best and contemporary evidence and to doctor the evidence. Accordingly, OP-1 is held guilty of medical misconduct and negligence in undertaking the surgery without the skill necessary for surgery and for ensuring that the requisite tests, pre-

medication and insulation against likely risk of air embolism, could be provided by her or her team. There is no evidence also that the hysteroscope used by her for the surgery was state of the art. OP-2 hospital, where she has professed to be the consulting gynecologist, is held vicariously liable for negligence of Dr. Sandhya Bansal. OP-2 hospital is also liable for laxity in not ensuring the proper documentation of the events, progress notes, nursing notes and reports of the diagnostic tests and for manipulating and withholding the same. OP-3 is held liable for unethical partnership with OP-1 and OP-2 in manipulating the medical records. As there is no categorical allegation or evidence of any lack of skill or lapse on the part of OP-4, there is no question of any finding of medical negligence qua OP-4.

29. Now we turn to the quantum of compensation to be awarded. Hon'ble Supreme Court in *National Insurance Co. Ltd. Vs. Pranay Sethi (2017) 16 SCC 680* has laid down the principles to be followed for awarding compensation under the Motor Vehicles Act, 1988. While doing so, Supreme Court has further directed that the court shall be guided by paras 30 to 32 of the decision in *Sarla Verma Vs. DTC (2009) 6 SCC 121*. This Commission has been consistently applying these guidelines issued by the Supreme Court in computing the compensation to be awarded in the cases of medical negligence also. It is noted that the age of Ms. Kausar Jahan, the victim of the negligence of the OP-1 and OP-2, at the time of filing of the complaint, was 31 years. Ms. Kausar Jahan has suffered eventual death within eight hours of start of surgery. The loss of income of the patient and loss of active love, affection and warmth of the husband and the child would need to enter the consideration for award of compensation. The complainant has originally sought compensation of Rs.10 crores by adopting a methodology of computing the compensation in cases of clinical trials and while adopting the monthly income of the deceased at Rs.64,726/-. Though there is no evidence of the deceased's income filed by the complainant, it has been supported by affidavit of the complainant that the deceased was M.Sc. in Biotechnology from Bangalore University and was working with TATA Consultancies as IT Analyst and Biostatistical Programmer. On a conservative side, her monthly income is therefore taken at Rs.50,000/-, which translate to yearly income of Rs.6 lakhs. Applying the principles of computation of compensation as laid down by Supreme Court in *Pranya Sethi and Sarla Verma (multiplier of 16* and future prospect at 40%) and after applying a reduction of 40% towards expenses for self and employment, the compensation payable for loss of income would come to Rs.80.64 lakhs (6*16*1.4*0.6). In addition thereto, we deem it appropriate to award a lump sum of Rs.5 lakhs towards loss of love and companionship for complainant no. 1 and loss of motherly love and care for complainant no. 2. The total compensation is thus Rs.85.64 lakhs. However, after taking into account the fact that the deceased's parental side has not joined in the complaint as complainants, and also that the complainant himself has got remarried on 25.07.2015 with medical doctor Dr. Manzalat Fatima, we deem it appropriate to grant only half of the quantum so arrived at as compensation, which would come to Rs.42.82 lakhs and which is rounded off to Rs.45 lakhs. We also award Rs. 1 lac towards expenses for last rites and medical-bills. We also award cost of Rs. 2 lakhs. While OP-3's liability, out of this, is fixed at Rs. 5 lacs, the balance liability shall be upon Dr. Sandhya Bansal and Bansal Hospital jointly and severally. Hence we pass the following order:

ORDER

In view of the aforesaid discussions, the complaint is partly allowed. OP-1 Dr. Sandhya Bansal and OP-2 Bansal Hospital are jointly and severally held liable for payment of

compensation of Rs.40 lakhs along with interest at 6% from the date of filing of the complaint till the actual date of payment. OPs-1 and 2 are also liable to pay Rs. 1 lac towards expenses for last rites and medical-bills. OP-3 Dr. Rahul Manchanda is also liable to pay Rs.5 lac as compensation to the complainants with interest at 6% from the date of filing of the complaint till the actual date of payment. OP-1 and 2 shall also pay total cost of Rs.2 lakhs to the complainants. The compliance shall be made within a period of three months.

.....J
RAM SURAT RAM MAURYA
PRESIDING MEMBER

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BHARATKUMAR PANDYA
MEMBER