NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION
NEW DELHI

CONSUMER CASE NO. 155 OF 2001

1. DR. REBA MODAK & ANR.
W/O SH. GIRIJA SANKAR MODAK
R/O FLAT NO. 3D DD/53
NARAYANTOLA E CALCUTTA - 700059 .....Complainant(s)

Versus

1. SANKARA NETHRALAYA & ORS.
UNIT OF MEDICAL RESEARCH FOUNDATION
18 COLLEGE ROAD
CHENNAI - 600006 .....Opp.Party(s)

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

For the Complainant : Appeared at the time of arguments
For the Complainants : Mr. Partha Sil, Advocate
Mr. Soumya Dutta, Advocate
Mr. Tavish B. Prasad, Advocate
Mr. G. S. Modak, Complainant No. 2 in person

For the Opp.Party : Appeared at the time of arguments
For the Opposite Parties : Mr. C.S. Vaidyanathan, Advocate
Mr. S. Gurukrishna Kumar, Advocate
Mr. S. Hari Haran, Advocate
Mr. Arvindh Gupa, Advocate a/w
Dr. Kannan, Anesthetist (in person)

Dated : 26 Aug 2022

ORDER

Pronounced on: 26th August 2022

ORDER

DR. S. M. KANTIKAR, PRESIDING MEMBER

Complaint:

1. The Complainants Dr. Reba Modak and her husband Girija Sankar Modak are the parents of deceased son Master Anamitra Modak. The Opposite Parties are Sankara Nethralaya, Chennai (OP-1), Dr. T. S. Surendran (OP-2) and Dr. R. Kanan (OP-3) the Anesthetist. The Complaint was filed under Section 21 of the Consumer Protection Act, 1986 by the parents of deceased for alleged gross medical negligence and deficiency in service causing death of their only child during surgery for squint correction.

2. The Complainants' son Anmitra, about 6 years of age (hereinafter referred to as the 'patient') for his squint eyes was taken to Chennai at Sankara Nethralaya (hereinafter referred to as the 'OP-1 - Hospital'). Dr. (Mrs.) S. Agarkar examined the child on 12.06.2000 and advised minor surgery to correct the squint. She proposed the name of Senior Surgeon - Dr. T. S. Surendran for the operation to be done on 14.06.2000. The preoperative investigations, blood and urine tests were conducted. On 13.06.2000, Dr. Sujatha clinically examined the child and noticed faint functional systolic 'murmur' and chest wall abnormality. The same was brought to the notice of Dr. S. Bhaskaran, a Senior Cardiologist, who further examined the child with some exercises and concluded about no murmur and he also ruled out further need for any tests like ECG, ECHO or Chest X-ray etc. He declared the child "Fit for General Anesthesia". The surgery was fixed on 14.06.2000. As advised, the Complainants took their child on empty stomach to the hospital at 9.00 a.m., but the bed to the child was allotted at around 2.00 p.m. The child was administered three injections and at about 3.00 p.m., he was taken to Operation Theatre. At about 6.00 p.m. the Complainants were given shocking news by Dr. J. Biswas that their child expired on the operation table. It was further alleged that the hospital issued patient's case summary after two days i.e. on 16.06.2000. The discharge summary was vague without details of Cardio Pulmonary Resuscitation (CPR) and the happenings in the operation theatre. Despite repeated requests, the OPs failed to provide complete medical record. Therefore, they approached the Prime Minister's Office and, finally after six months (11.12.2000) entire medical record including Post mortem report was handed to the Complainants.

3. The Complainants further alleged that there was excessive gap between the last oral intake and commencement of the surgery. The patient was fed at 6 a.m. with just two biscuits and juice but, he was taken to OT at 3.00 p.m. Thus, the child was kept on fasting for 9 hours 20 minutes, due to which he became hypoglycemic, which could lead to cardiac arrest. Halothane was used as an anesthetic agent which was known to cause bradycardia (heart rate slows down). Atropine was given as a pre-medication in all the cases to prevent bradycardia. The timing and dose of injection atropine is very important to prevent Endotracheal intubation (ETI) induced bradycardia and cardiac arrest. Atropine will have to be administered at least 45 minutes pre-operatively. In the present case, it is evident that the child was not administered the correct dose at right time. There was huge gap between atropinization and actual surgery; it was administered as per the convenient schedule or to accommodate the Surgeon. The Anesthetist failed to intubate, which was the cause of death. The Complainants alleged that on that day, Dr. T. S. Surendran had already completed 16 operations and there was no hurry to operate on the child on the very day itself, wherein high degree of care was needed. Being aggrieved by the gross medical negligence on the part of Opposite Parties, the Complainants have filed the Complaint before this Commission and prayed for Rs. 1,00,20,000/- as compensation.

Defense:

4. The Opposite Parties filed their replies and denied allegations of negligence. They expressed their deep sympathies for the death of patient. They took preliminary objection of jurisdiction that such complaint needs extensive and elaborate evidence, therefore Civil Court would be effective for adjudication. It was further submitted that the parents took the child to OPD on 12.06.2000 with the complaints of squint of eyes, developed after attack of malaria. Initially, the patient was examined by Optometrist, Ms. J. Jayajdnee, and subsequently by a Squint Specialist, Dr. Agarkar. After examination, corrective surgery for both eyes was advised. The patient was further referred to neuro-ophthalmic examination to rule out any associated neurological problems.

5. Thereafter, Ms. Latha Suresh, the Head of Surgery fixing center, gave the date of 14.06.2000 for surgery. The Physician, Dr. S. Sujatha examined the patient on 13.06.2000 and requested the Cardiologist - Dr. Bhaskaran, to see the patient since she felt a questionable faint murmur. Dr. Bhaskaran reviewed the case sheet and lab investigation reports, took the history and further ascertained that the child was able to play games and climb three storied stairs without any difficulty. Dr. Bhaskaran put the child to various positions and exercise, and auscultated. He concluded no cardiac problem to undergo surgery under General Anesthesia (GA). It was submitted that as per medical guidelines, routine pre-operative ECG, ECHO and X-ray were not necessary for children and persons below the age of 40 years accept medically warranted.

6. The OP-1 hospital submitted that for squint surgery the infrastructure and operation theatre (OT) is fully equipped with monitor, centralized Oxygen and all facilities for administering GA or any type of anesthesia. The patient was taken to the OT for surgery at 3.10 p.m. The Anesthetist In-charge of the case -

Dr. Kannan, (OP-3) and operating surgeon Dr. T.S. Surendran, (OP-2) were present in the OT. The OP-3 connected the patient to ECG, NIBP and Pulse Monitor. Before surgery, he scrutinized all the systems in OT which found everything in order. It was further submitted that the child did not co-operate to place IV drip in OT, therefore, the child was reassured and asked to breathe through a mask by which 50% Oxygen(O_2) with 50% Nitrous Oxide (N_2O) was administered. Then, Halothane was administered in the gas mixture using fluotec vaporizer, with starting concentration of 1% and gradually increased to 3% over a period of 1 to 3 minutes. Then IV line for 5% Dextrose started. Thereafter, the mask was removed and child was successfully intubated. At 3.20 pm, the Anesthetist noticed that the ECG Monitor was showing steady drop in the heart rate to a sinus bradycardia of 50 per minute. However, the oxygen saturation was 99%. Immediately IV Injection Atropine 0.3 mg was administered. ECG showed gradual and steady rise in pulse rate to 140 -150. Then the rhythm changed from Sinus Rhythm to Ventricular Tachycardia of around 200 which progressed to Verntricular fibrillation.

7. Immediately, the Anesthetist cut off Nitrous oxide and Halothane and the patient was ventilated with 100% oxygen. Dr. G.V. Sailendar and Dr. Banulakshmi Indermohan joined the OP-3 for cardio pulmonary resuscitation [CPR]. The CPR was started with cardiac thump, external cardiac massage and DC Shock of 50 Joules. EGG was continuously monitored and 100% oxygen ventilation continued. Injection Adrenaline and Injection Atropine given intravenously and cardiac massage continued. At 3.25 P.M, the EGG monitor showed ill sustained agonal rhythm with Asystole. Physician joined the team. DC shocks were repeated twice with 50 Joules and cardiac massage was continued with 100% oxygen ventilation. Dr. S. Bhaskaran, Cardiologist joined in the resuscitation efforts. Other resuscitative measures to correct acidosis were carried out with Injection Sodium bicarbonate, administration of Hydrocortisone, Injection Ephedrine and cardiac massage was continued. In spite of all resuscitative measures, the patient could not be saved and around 5.30 p.m., the team abandoned the CPR and declared the patient dead.

8. The OP-1 submitted that it extended all cooperation to the Complainants to see the dead body, but they refused. There was no mortuary in the Sankara Nethralaya; therefore the body of the child was shifted to the mortuary in the General Hospital, Chennai with the permission of the parents. After postmortem the body was handed over to the Complainants on 15.06.2000.

9. The Opposite Parties denied the contention of the Complainants about non issuance of medical record. The required details and the entire medical record were issued on the request letter dated 30.10.2000. Therefore, there was no deficiency in service.

10. The Government of Tamilnadu, in response to the representation made by the Complainants to the Prime Minster and the Railway Minister, appointed four - committees to enquire the matter. After enquiry, the committees did not observe any adverse comment or report on the hospital facilities and on the treatment aspect. The death was occurred due to Cardio-respiratory arrest.

11. The Opposite Parties further submitted that informed consent form was signed by the father of the child (Complainant No. 2) in the presence of a witness. Risk of cardiac arrest is low risk with general anesthesia. The Opposite Parties further submitted that the Complainants filed police complaint, exerted political pressure and wrote to PMO & Railway Minister. The Complainants also indulged in media trial, press releases against the Opposite Party to tarnish the reputation of Sankara Nethralaya. It was submitted that the Opposite Parties have made their attempts to refund the cheque as a relief on complementary ground.

Arguments:

We have heard the arguments from the learned Counsel for both the sides. Perused the material on record, *inter alia,* the Medical Record and gave our thoughtful consideration.

12. The learned Counsel for **the Complainants** argued that this is a case of ***res ipsa loquitor***. The Opposite Parties have failed to discharge their burden on the facts and circumstances of the present case. The Complainants are entitled compensation for the damages for the careless and negligent treatment. The Counsel reiterated the facts in detail. He further argued that, Atropine was given as a pre-medication in all the cases, which prevents bradycardia. Therefore, the timing and dose of Atropine injection are very important to prevent ETI induced bradycardia during surgery and the further cardiac arrest. Atropine should

be administered at least 45 minutes before surgery but, in the instant case it was administered as per the convenient schedule of the surgeon. The Counsel further argued that the 1st attempt of ETI was failed, and during 2nd attempt between 3.10 to 3.20 p.m. Scoline was injected and intubation was performed. It caused severe bradycardia and cardiac arrest. Thus, it was the failure of duty of care of the anesthetist. The operating team would have stopped the procedure, which could be avoided death of child.

13. The squint surgery was an elective surgery and it was not an emergency. The operating surgeon was not aware about the special warnings to use of Scoline in pediatric cases and the anesthetist failed to warn to the surgeon about it. It was further argued that the Opposite Parties have manipulated the documents. The child died at 3.30 pm but the Complainants were informed after 5.30 pm, for the reason that the doctors were busy in reviving in child for 2 hours. The learned Counsel brought our attention that the deceased was the only child and the mother already underwent hysterectomy in 1997. Thus, she lost the chance of other child.

14. The learned Counsel **for the Opposite Parties** argued that Sankara Nethralaya is a charitable non-commercial, non-profit making institution in Ophthalmology, started in September, 1978. About '40% of the' patients are treated entirely free of cost every year. He further submitted that Complainants have made vague and sweeping allegations against the OPs. Even after the filing of Complaint, they carried media trial, compelling the OPs to obtain orders of restraint from this Commission. He reiterated the entire treatment details as per the standard of practice. The treatment given to the patient was reviewed by four independent committees of experts, who had not made any adverse comment or report on the treatment aspect and hospital facilities etc. The learned Counsel submitted that the Complainants have not produced any expert evidence to justify their allegations of negligence.

15. The learned Counsel argued on the allegations of administration of incorrect "dosage of atropine and improper timing. The normal dosage of atropine depends on the weight of the patient (0.01-0.02 mg/kg). The patient was administered 2/3 ml Inj. Atropine which amounts to 0.4 mg since his weight was 25 kg, the patient was required to be administered in the range of 0.25 to 0.5 mg. Hence the dose of 0.4 mg administered was within the normal range. The nursing chart in case records clearly shows that preoperative administration of Atropine was at 1.30 pm.

16. The learned Counsel for the Opposite Parties further argued the Halothane mask induction was followed by Suxamethonium (scoline) and the patient was intubated with endotracheal tube. It was the standard and most commonly used practice in children. In a survey conducted in 1996 on the routine usage of suxamethonium (scoline) for elective trachea! Intubation in children, it was reported that 84 % of anesthetists use suxamethonium routinely. The life threatening reactions are rare and until a truly comparable alternative is produced this drug will continue to be used in children.

Observations & Discussion:

17. The issues before us are that whether the treating doctors at Sankara Nethralaya committed the breach in their duty of care, which was the proximate cause of death of Child. We have carefully perused entire medical record, the expert opinions, and the evidence and cross examination.

18. **The Role of Cardiologist:**

i) One Physician Dr. Sujata examined the child and found faint systolic murmur and functional chest wall abnormality. She referred the child to the Cardiologist Dr. Bhaskaran, who after examination, did not notice any murmur, therefore, not suggested further tests like ECG, ECHO or X-ray Chest and declared the child fit for general anesthesia. No doubt, the child was about 8 years, school going, thus, there was less possibility of congenital anomaly. But, we cannot ignore that the child was suffering from bilateral squint and chest deformity, which were congenital anomalies. Therefore, the cardiac anomalies cannot be ruled out in this case. Moreover, if one physician (MD) notices functional murmur, then the expected skill from the Super Specialist i.e. the Cardiologist was more and higher degree of care should be there. It is lacking in the instant case and unfortunately, the child was declared fit for GA.

ii) We have perused the evidence of Dr K P Mishra, a senior Cardiologist and an author of books on Cardiology. According to him the maneuvers as conducted for the child by the cardiologist were

sufficient to rule out murmur and it was standard practice. There was no requirement to do any further tests by way of X-Ray, EGG, Echo Cardiogram etc. Dr. Mishra has further stated that if the murmur is Grade I, the patient will be examined in two or three positions or with some exercises, and then if the murmur is not heard, no further investigation is required. The PM did not show any cardiac disease.

iii) We do not accept the evidence of Dr. Mishra in totality for the reasons stated in para (i). In our view, it was the failure of duty of care and the casual approach of the Cardiologist. Moreover, the entries made in the progress report appear to be an afterthought and added later on.

19. We do not find any significance about fasting state of child. Several studies revealed that there is no uniform fasting practice for children before effective surgery. Fluids in small quantity are acceptable 2-3 hours prior to GA. The Complainant No.2 (father) signed the Informed Consent. The child was not administered Atropine in correct dose at proper time. We don't find importance to the pre-medication by Atropine for Antisialagogues to decrease the flow rate of saliva is not routinely used. In the recent days it is not regularly in practice by the Anesthetist.

20. The Tracheal intubation is a standard technique used during GA. Local anesthesia was not resorted to as it requires the co-operation of the child. The mask anesthesia was not resorted to in any head and neck surgery which also obstructs the surgical field of eyes. Tracheal Intubation may be done under deep inhalation anesthesia (Halothane) or with the use of other muscle relaxants. In the Instant case, as the vocal cord was anterior, it was not possible to intubate the patient in the first attempt. It is not clear from the record that Scoline was administered before first intubation, as such the possibility cannot be ruled out.

21. We note the OP-3 second time attempted to intubate the patient, but as the vocal cords were anterior, he brought down the Halothane from 3% to 1% and ventilated the patient, he satisfied himself that all vital parameters were normal. He administered muscle relaxant (Scoline) as an accepted protocol and intubated the patient with 6.0 mm portex ETT under direct vision ensuring oxygen saturation was 99% throughout the entire procedure. Vitals were normal throughout the procedure. However, it is pertinent to note that use of Scoline further precipitated the bradycardia which was already occurred due to Halothane anesthesia.

22. In our considered view it was the **Oculocardiac Reflex (OCR**), also known as the Aschner reflex or trigeminovagal reflex (TVR). It is a reduction in the heart rate secondary to direct pressure placed on the eyeball. It is defined by a decrease in heart rate by greater than 20% following globe pressure or traction of the extraocular muscles. Most commonly, the reflex induces bradycardia. However, OCR also has a reported association with reduced arterial pressure, arrhythmia, asystole, and even cardiac arrest. This reflex has most notably been depicted during ophthalmologic procedures, more specifically during squint / strabismus Ocular Surgery. The complications secondary to the OCR are related to the vagal responses and may include Sinus bradycardia, Arrhythmia, Ventricular fibrillation, Asystole & Cardiac arrest etc. Therefore, in the instant case the Intra-Operative diagnosis of OCR was missed and the child suffered Cardiac Arrest. The patients who are considered at-risk for the OCR should warrant particular attention.

23. It is pertinent to note that all drugs used in anesthesia have adverse minor to major life threatening complications. Anesthetists are aware of such effects and use the drugs depending on the patient, nature and requirements of surgery, disease profile and the situation. The anaesthetist after ensuring that all vital parameters of the patient were normal with oxygen saturation of 99 % use Scoline 50 mg IV as a short acting drug as compared to other drugs such as Atracurium, Vecuronium, etc. As per the treating doctors the scheduled squint surgery of the child was only a short duration surgery. It is not clear from the record that whether and when Atropine was given as a premedication before induction or following episode of bradycardia. It is also not clear that whether it was administered IV or Intramuscularly (IM). In the instant case Halothane was an elective choice of OP-3, therefore anticholinergic like atropine or glycopyrolate has to be given prior. Halothane itself is known to cause bradycardia. The failed intubation cannot rule out possibility of wrong intubation (in the esophagus). After failed 1st intubation, Scoline was injected for 2nd intubation and then child suffered hypoxia- bradycardia and arrest. In our view it was the effect of Halothane and Scoline. The anesthetist (OP-3) should have altered/ cautioned the operating surgeon (OP-2) about the warning signs of Scoline. The surgeon was not aware that any special warnings for the use of Scoline in pediatric cases.

24. In our considered view, the argument that surgery could have been abandoned is justified. The operation was fixed on 16.04.2000 in the morning at 9 a.m., but it was conducted in the afternoon after 3.00 p.m. It is also evident from the record that the operating surgeon Dr. T. S. Surendran had already completed 16 operations before 3.00 p.m. Therefore, the question arose in our mind why the squint surgery was not deferred to another date. Moreover, it was a planned surgery and there was not an emergency at all or the Complainants have not forced for it. The child was not co-operative. Halothane was used as an anesthetic agent, a known hypotensive. During the procedure, after removal of halothane and nitrous oxide mask, there was difficulty in intubation. The 1st attempt was failed and therefore, the Opposite Party No. 3 intubated by injecting relaxant – injection Scoline, which also induces bradycardia. Thereafter, there was reduction of oxygen saturation and the child suffered cardiac arrest. The discharge / death Certificate did not mention about intubation for general anesthesia.

25. Let us examine in the law laid down by Hon'ble Supreme Court on medical negligence. In the **Kusum Sharma and ors v. Batra Hospital and Medical Research Centre & Ors.**[1], it was discussed the breach of expected duty of care from the doctor, if not rendered appropriately, it would amount to negligence. It was held that, if a doctor does not adopt proper procedure in treating his patient and does not exhibit the reasonable skill, he can be held liable for medical negligence. Similarly, in **Dr. Laxman Balakrishna Joshi vs. Dr. Trimbak Bapu Godbole & Anr**[2]. and **A.S. Mittal vs. State of U.P**[3]**,** certain duties of the doctor have been laid down. The doctor owes to his patient certain duties which are (a) a duty of care in deciding whether to undertake the case; (b) a duty of care in deciding what treatment to give; and (c) a duty of care in the administration of that treatment. A breach of any of the above duties may give a cause of action for negligence and the patient may on that basis recover damages from his Doctor.

26. In the instant case the Cardiologist Dr. Bhaskaran, the OP-2 and OP-3 have failed to exercise their duty of care with required ordinary skills and standards, thus, we hold them liable for medical negligence. The doctors are liable for medical negligence, where they act carelessly, results an action in torts. The Hon'ble Supreme Court in the case of **Spring Meadows Hospital v Harjyot Ahluwalia**[4]**,** observed as:

> "Very often in a claim for compensation arising out of medical negligence a plea is taken that it is a case of bona fide mistake which under certain circumstances may be excusable, but a mistake which would tantamount to negligence cannot be pardoned. In the former case a court can accept that ordinary human fallibility precludes the liability while in the latter the conduct of the defendant is considered to have gone beyond the bounds of what is expected of the skill of a reasonably competent doctor…'

27. 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[5]. 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. 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. Accordingly, we hold the OP-1 Sankara Netralaya to be vicariously liable for the acts of omission and commission committed by the OP-2 and 3 as being jointly and severally liable to pay compensation to the Complainants.

28. The Complainants had claimed Rs. 1,00,20,000/- as compensation The mother of deceased underwent hysterectomy and there is no chance to have another baby. Human life is most precious; therefore it is extremely difficult to decide on the quantum of compensation in the medical negligence cases, it is highly subjective in nature. Different methods are applied to determine compensation. The multiplier method which typically used in motor accident cases is often not conclusive for '*just and adequate compensation'*. The Hon'ble Supreme Court has held that there is no restriction that courts can award compensation only up to what is demanded by the complainant(s). The grant of compensation to remedy the wrong of medical negligence is within the realm of law of torts. It is based on the principle of *restitutio in integrum*.[6] The said principle provides that a person is entitled to damages which should as nearly as possible get that sum of money which would put him in the same position as he would have been if he had

not sustained the wrong. Thus, having regard to the finding that the incidence occurred in year 2000 and we are now in 2022, the litigation has been pending for over 2 decades.

29. In the case **National Insurance Co. Ltd. v. Kusuma[7],** the Hon'ble Supreme Court has held that payment of compensation to parents for the death of a child, including a stillborn, in an accident must be just and not be a pittance. Thus, in our view, no amount can be just and adequate in an absolute sense. By no stretch of imagination, we should award a paltry sum for gross negligence; conversely exemplary compensation need not be awarded in case minimal negligence.

30. Based on the discussion above, having medical negligence conclusively attributed to the treating doctor at Sankara Nethralaya and having regard to that the Complainants lost their only son, in the ends of justice, we are of the considered view the compensation of Rs. 1 Crore is *just and fair* in the instant case.

31. In the instant case, since, the Cardiologist – Dr. Bhaskaran has not been arrayed as a party, therefore, monitory liability cannot be fixed upon him, and therefore, the OP-1 is held vicariously liable. Accordingly, we direct the Sankara Nethralaya (OP-1) to pay Rs. 85 lakh; the Anesthetist, Dr. R. Kanan (OP-3) shall pay Rs. 10 lakh and the operating Ophthalmologist, Dr. T. S. Surendran (OP-2) shall pay Rs. 5 lakh to the parents of the deceased child (Complainants) within 6 weeks from today. Beyond 6 weeks, the amount shall carry interest at 9% per annum till its realization. The OP-1 shall further pay Rs. 1 lakh towards cost of litigation.

The Complaint is partly allowed.

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[1] (2010) 3 SCC 480

[2] AIR 1969 SC 128

[3] AIR 1989 SC 1570

[4] (1998) 4 SCC 39

[5] Savita Garg v. National Heart Institute (2004) 8 SCC 56

[6] Malay Kumar Ganguly v. Sukumar Mukherjee, (2009) 9 SCC 221

[7] (2011) 13 SCC 306

.....J
R.K. AGRAWAL
PRESIDENT

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DR. S.M. KANTIKAR
MEMBER

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BINOY KUMAR
MEMBER