NATIONAL CONSUMER DISPUTES REDRESSALCOMMISSION
NEW DELHI

ORIGINAL PETITION NO. 208 OF 1993

1. Shri S.R. Shivaprakash
son of Shri Rajeshekara Murthy

1. Shri S.R.R. Prasad
son of Shri Rajeshekara Murthy

2. Shri S.R. Prabhudev
son of Shri Rajeshekara Murthy … Complainants

Versus

1. M/s. Wockhardt Hospital Limited,
Cunningham Road, Bangalore,
Rep by its Chairman/Managing Director
Sri J.S. Khorakiwala
No.167, Ready Money Terrace
Dr. Annie Besant Road
Bombay-400 018.

1. Sri Rajan Saklecha
General Manager

2. Dr. U.B. Khanolkar, Cardiologist,

3. Dr. Murali, Chief Anaethetist

4. Dr. Sunil Basavaraj

5. Dr. Kiran

6. Sister Rosalyn

8. Dr. Subba Rao .. Opposite Parties

ORIGINAL PETITION NO. 209 OF 1993

S.R. Rajashekhar Murthy(Justice Retd)
son of late S.C. Rudraiah
R/o No.639, Garudachar Buildings,
Bangalore-560 002 .. Complainant

Versus

M/s. Wockhardt Hospital Limited
Cunningham Road, Bangalore .. Opposite Party

BEOFRE:

HON'BLE MR. JUSTICE M.B. SHAH, PRESIDENT
MRS. RAJYALAKSHMI RAO, MEMBER

For the complainants In both the petitions:	Mr. S.S. Javali, Senior Advocate Mr. R. Rajashekhar Murthy and Mr. E.C. Vidyasagar, Advocate
For the Opposite Party Nos. 1, 2,4,7 in Original Petition No.208/93 and Opposite Party No.1 in Original Petition No.209/93 :	**Ms. Geeta Khanuja, Advocate.**
For the Opposite No.8 :	**Mr. Dayan Krishnan, Advocate.**

Dated 4th October , 2005

O R D E R

M.B.SHAH, J. PRESIDENT.

At the outset, we would mention that it is the obligation of the hospital or the doctor who treated the patient, to supply all the records containing

the treatment given including the medicines administered and also the nature of the operation. In many cases, statements are made by the complainants that hospitals or doctors are not supplying the relevant record including Nurses Flow Sheet and the notes of the duty doctors and specialists at the time of discharge to the patient or to the relatives in case of death of the patient. In our view, this attitude is totally unjustifiable. They are required to furnish all the relevant documents. The Medical Council has also framed rule to that effect. We may also observe that in cases of non-supply of the relevant documents, adverse inference could possibly be drawn with regard to deficiency in service. This we are holding because it is the say of the complainant that treatment chart and other documents were not supplied.

Brief Facts:

Complainants, who are the husband and the sons of the deceased, Smt.Nirmala, have approached this Commission claiming damages/ compensation on the ground of deficiency in service for the sum of Rs.25,00,000/- etc., for the negligence on the part of the doctors of the hospital (O.P. No.1) in not providing proper post-operative treatment to the deceased, Smt.Nirmala. It is the contention of the complainant that on 10.7.1992, as stated by the doctors of the hospital, Coronary Artery Bypass Graft Surgery (hereinafter referred to as the CABG) was performed successfully but, thereafter, because of deficiency in

service or negligence on the part of the nursing staff and the attending doctors, the patient expired, after two days of surgery. In the complaint, various allegations are made. However, at the time of hearing of this complaint, the learned counsel for the Complainant, Mr.Vidyasagar, confined his submissions to the deficiency in the service rendered on 12.7.1992, i.e., after two days of the surgery which resulted in Cardiac Arrest and death of the patient due to sudden extubation of endotracheal tube (herein after referred to E.T. tube) at 8.05 a.m. and thereby non-supply of oxygen.

Submissions:

I. The learned counsel for the complainants submitted that this is a case where principles of Res Ipsa Loquitor (facts speak for themselves) will apply and in support relied upon the decision of the Apex Court in Savita Garg Vs. National Heart Institute, (2004) 8 SCC 56, burden is on the hospital or doctors concerned who treated the patient, in defence to substantiate their allegation that there was no negligence. He relied upon the following passage from the judgment:

> "It is the hospital which engages the treating doctor, thereafter, it is their responsibility. The burden is greater on the institution / hospital than that on the claimant. In any case, the hospital is in a better

position to disclose what care was taken or what medicine was administered to the patient. It is the duty of the hospital to satisfy that there was no lack of care or diligence." ….. "Even otherwise also given that, as held above, the burden to absolve itself shifts on to the hospital / doctor, the Institute has to produce the treating physician concerned and has to produce evidence that all care and caution was taken by it or its staff or justify that there was no negligence involved in the matter".

He has further submitted that :

(a). there is no explanation as to why there was sudden development of extubation and thereafter intubation which resulted in cardiac arrest as stated;

(b). the unanimous opinion of the Surgeon and the Cardiologist of the Hospital that the patient had maintained stable condition from the evening of 11th July till 8 am on 12th July leading to the commencement of weaning process as confirmed by the Cardiologist Dr.Khanolkar and the planning for extubation as stated by the Surgeon Dr.Subba Rao, completely contradict the contention of the Hospital that the condition of the patient was deteriorating merely by their erroneous interpretation of clinical charts and graphs of B.P. and heart rate.

(c). On 12.7.1992 morning, admittedly the patient was stable and the weaning process was also in progress. The cause for forced extubation of E.T. is not explained by the treating doctor.

(d). The patient was reintubated is not in dispute. That the nurse was able to see the displacement of E.T. tube inside the mouth, in the absence of alarm, cannot be believed. According to Sister Rosalyn, The E.T. tube did not come out but it was in the mouth and it was pushed inside by Doctor. The question that arises is : Why then did it lead to bradycardia and asystole (Arrest)? This is obviously because the reintubation was delayed or not properly done, since no one had noticed the tube coming out. No duty staff was alerted by any alarm. Absence of alarm is not disputed.

(e). Reintubation is claimed to have been done on an awake patient without administering sedation or muscle relaxant. It is impossible to intubate an awake patient who will resist with all force if the patient's trachea is meddled with laryngoscope and E.T. tube.

That the E.T. tube was reintubated is itself in doubt since nobody speaks to all these precautions which were absent in the present case.

(f). None of the specialist, the Cardiologist Dr.Khanolkar, the Surgeon Subba Rao, the Anaesthetist Dr.Murali or others such as Dr.Vivek Javali or Dr.Kausal Pande claimed to have talked or consulted the attending Doctor Sunil Basavaraj in any manner as to the developments surrounding the critical conditions of patient on the fatal morning at 8.05 am or thereafter at any time, casting serious doubts on his alleged presence.

(g) The very reference in the clinical chart and the Doctor's notes stating that the patient suffered violent cough resulting in forced extubation of the E.T. tube, stood contradicted and disproved by the description of cough in the words of the duty Nurse Roseline that the patient coughed once or twice.

(h). In the absence of affidavit of the treating doctor, there is total lack of evidence describing the nature of procedure adopted in the weaning process started before the arrival of the duty nurse Roseline (as confirmed by the Cardiologist Dr.Khanolkar), and the procedure later adopted in forced extubation and reintubation allegedly performed by the attending Doctor, Dr.Sunil Basavaraj. Consequently, there is total lack of evidence as to the impact produced by these procedures and the consequences experienced by the patient. The significance

of these undisclosed procedures, is highlighted by the failure of the Hospital to explain the sudden arrest suffered by the patient at 8.05 am.

(i). The ECG record and lab tests are not made available. The failure of the Hospital to produce the attending Doctor (during the night of 11.7.1992 till the fatal arrest on 12.7.1992) has resulted in not informing and in not explaining the crucial matters inter alia:

(i). the use of ambulatory or oxygen mask;

(ii). sedation or muscle relaxant before reintubation;

(iii). whether the E.T. tube was deflated before taking it out and inserting it again;

It is submitted that the E.T. tube cannot be just pushed inside unless:

- it is deflated;
- taken out;
- new tube is used;
- inserted again & inflated;
- connected to ventilator again;
- to make sure whether the supply of oxygen is restored.

(iv). Whether the E.T. tube was again inflated to keep it in place;

(v). whether E.T. tube was connected to the ventilator again and

oxygen supply was restored;

(vi). Till all this was done, whether the patient was given 100% oxygen to keep the patient alive and whether reintubation was done by sedation;

(vii). In case of awake patient, whether reintubation was possible without sedating the patient.

(Trachea is very sensitive and any irritation will not be tolerated by the patient).

(viii). The alarm system is not borne out by any record or evidence.

II. As against this, learned counsel, Ms.Geeta Khanuja, submitted that the surgery of the patient, no doubt was successful but it was a high risk case and even during the post-operative treatment there were chances of Cardiac Arrest for no fault of the staff or the attending doctors.

In support of her contention, learned counsel referred to the 'case history of medical treatment' of the patient. For this purpose, she has pointed out as under:

a. On 31.10.1991, patient, Smt.Nirmala visited the Heart and Blood Pressure Centre, Bangalore, for the treatment, and was examined

by Dr.B.V.Dugani. Again, she visited the same doctor on 3.11.1991, 9.11.1991 and 3.3.1992.

b. Thereafter, she consulted the Diacon Hospital (Diabetes Care & Research Centre), Bangalore, and was examined by Dr.S.R.Aravind, Diabetologist & Physician. In his report, Comprehensive Assessment was made to the effect that the type of diabetes was NIDDM (IRDM); complications of diabetes were 70 BE evaluated; associated illness was hypertension.

c. Thereafter, again she contacted Dr.Dugani on 9.5.1992 who gave treatment for insulin and other related diseases.

d. Finally, on 21.6.1992, she was admitted to Wockhardt Hospital and Heart Institute, Bangalore, and was examined by Cardiologist and the diagnosis was as under:

"**DIAGNOSIS**

- CORONARY ARTERY DISEASE
- 80% DISTAL LEFT ANTERIOR DESCENDING ARTERY STENOSIS WITH DIFFUSE ATHEROSCLEROSIS OF DISTAL LEFT ANTERIOR DESCENDING ARTERY
- 60% PROXIMAL LEFT CIRCUMFLEX STENOSIS
- DIFFUSE 95% STENOSIS OF MAJOR OBTUSE

MARGINAL

- MULTIPLE STENOSIS 75 – 90% IN PROXIMAL TO DISTAL RIGHT CORONARY ARTERY
- OVERALL SMALL SIZED VESSELS WITH POOR DISTAL CALIBRE

RECOMMENDATION

MEDICAL THERAPY

S.O.S. CORONARY ARTERY BYPASS GRAFT"

e. She was discharged on 23.6.1992 after Angiogram. During Angiography, the doctors observed as under :

"**VIEWS**

LEFT CORONARY ANGIOGRAPHY

a. PA
b. RAO 20º + CAUDAL 20º
c. PA + CAUDAL 20º
d. PA + CRANIAL 20º
e. LAO 45º + CRANIAL 30º
f. RAO 25º + CRANIAL 15º

RIGHT CORONARY ANGIOGRAPHY

a. LAO 45º
b. LAO 30º + CRANIAL 15º

LEFT VENTRICULAR ANGIOGRAPHY NOT PERFORMED DUE TO PERSISTENT ANGINA AFTER RIGHT CORONARY ANGIOGRAPHY"

f) Thereafter, she was readmitted to ICU in emergency condition on 7.7.1992. A consent letter was obtained by the doctor for performing operation of CABG [coronary artery bypass surgery].

g) On 10.7.1992, surgery was performed and it took 7 hours, i.e., from 12.30 PM to 7.30 PM. It is contended that there was first Cardiac Arrest during that time, as stated by Dr.Kaushal Pande, a witness of the opposite party, in his cross-examination.

h) On 11.7.1992 at 8.40 AM, T-piece is connected – weaning mode where the patient breathes on her own.

i. On 11.7.1992 at 9.00 AM, she was connected back to the ventilator. Again at 9.30 AM, she was connected to the T-Piece. Thereafter, at 10.30 AM, she was extubated and remained without ventilator till 5.40 PM. She was reintubated at 5.40 PM and at that time there was second Cardiac Arrest.

j) It is pointed out that on 12.7.1992, there was a violent cough with displacement of the E.T. tube, which was immediately intubated. However, there was a third Cardiac Arrest which resulted in her

death at 9.00 AM.

A. FINDINGS:

(i). Extremely high risk case:

For this purpose, reference is to be made to the Specific Operation Informed Consent letter dated 9th July, 1992, wherein it is stated that before performing the operation, specific information was given to the deceased and her relatives and thereafter express consent was obtained for performing Coronary Bypass Grafting surgery which was to be performed by Dr.R.Subba Rao and his team. ***Patient and the relatives were explained that operation scheduled to be performed was an extremely high-risk operation***. They were also informed about the alternative treatment available and/or to seek another opinion of any other expert. In the said consent letter, it has been further stated that after consultation amongst them and the patient, they have deliberately ***and knowingly chosen the course of surgery in spite of being aware of the very grave consequences that could arise during operation and/or after the operation***. It was also specifically stated that operation would be performed by Dr.Subba Rao and his team and the post-operative treatment will continue under the care of Dr.Uday B. Khanolkar.

Dr.R.Subba Rao was of the opinion that risk factor was severe and

also with regard to limitation in respect of post-operative relief symptoms. For this purpose, the complainant himself has produced on record a letter dated 8.7.1992 which was signed by him and his two sons as well as Dr.Subba Rao, wherein it has been specifically stated as under:

> "I have spoken to the husband of the patient and his sons at length and explained the increased risk of surgery i.e. 12-15% and ***also the limitations in terms of post operative relief symptoms***. The risk factor being severely diffused by diseased vessel, diabetes and hyperlipidemia they understand and accept the risks and benefits."

2. In the detailed reply filed by Opposite Parties No.1,3,4,5 & 7, it is revealed that all throughout the concerned doctors were in the hospital along with the nursing staff. They have also produced on record Nurses Duty Schedule as well as that of Duty Doctors and the Registrars' Duty Schedule and also averred that doctors posted at Hospital at the relevant time were competent to take care of any eventuality. It is rightly pointed out that considering the aforesaid record, it is apparent that there was no negligence on the part of the hospital staff or the doctors.

3. Further on behalf of the complainants, Complainant No.1 and his son

are examined. As against this, opposite parties have examined Dr.Uday B.Khanolkar, Dr.Murali Chakravarthy, Staff Nurse Roseline K.Joseph, Dr.Vivek Javali, Dr.Kaushal Pande, Dr.Uday M. Gandhey and Nurse Elizabeth Kurikose. All throughout it has been pointed out by the said witnesses that operation was involving high-risks. The blood vessels were of small size with poor distal caliber. The condition of the patient was continuously monitored. On 11.7.1992, at 5.45 PM, complainant was informed that the patient was having Cardiac Arrest and not Bronchospasm. As per the doctors opinion, 48 hours of the post Bypass surgery is considered to be very critical, more so, when the patient had a Cardiac Arrest within 24 hours of the surgery. This itself was a serious set-back to the condition of the patient. It is also stated that on the morning of 12.7.1992 at 8.05 AM, patient was irritable and had a violent cough and endotracheal tube was displaced. However, Dr.Sunil Basawaraj reintubated and Dr.Vivek Javali who was present in the ICU was also summoned and necessary treatment including external cardiac massage was continued for 30 minutes but there was no response and the patient expired at about 9 AM.

4. **Evidence of Subba Rao**:

In our view, it is not necessary to refer to the evidence in detail because the complainant has failed to point out any deficiency in service during the post-operative period. However, we would refer to some part of evidence

tendered by Dr.Subba Rao, who performed the operation. He has stated that he had worked as Cardio-Thoracist in various Hospitals and he has undertaken major cardiac operations with CABG in not less than 5000 cases. He has also carried out other surgeries like Mitral Valve Replacement, etc. It is his say that after studying the Angiogram of Smt.Nirmala (the deceased), he informed the relatives that her surgery would carry very high risk and they should better continue medical therapy. He also informed that surgery might be carried out provided the patient and the relatives fully realize the consequences of the surgery with the increased risk thereof. On 7.7.1992, he was informed by the doctors of the hospital that complainant's family members were insisting on the operation of the patient. He operated the deceased on 10.7.1992 and the surgery turned out to be even more complicated than was expected; it involved Endarterectomy (coring out) of two of the left side coronary arteries. The operation was, however, successful and the patient withstood the operation well. This is admitted by the complainant. One of the relatives of the patient, namely, Dr.Rajashekhar, was allowed to witness the entire surgery, who in turn had informed his family members that all had gone reasonably well in the operation theatre. After the operation, Dr.Subba Rao spoke to the patient's relatives and explained to them that 48 to 72 hours was critical as the patient had to have two vessel endaterectomy, but till that moment every thing looked stable. On the said day, he remained in the hospital till about 10.30 PM and he was also informed

about the patient's condition even at dead of night. At about 1.00 AM on 11.7.1992, he was informed that the patient's Blood-Pressure had fallen, L.A. Pressure had gone up and Urinary Output had fallen. He, therefore, suspected that blood clot might be compressing the heart of the patient and he instructed the duty doctor to take chest x-ray. Dr.Murali had taken the chest x-ray and Dr.Subba Rao was informed that there was no evidence of clot pressing on the heart and that the patient's condition had improved after medication. On the next day morning, he examined the patient and found that the deceased was conscious and alert and at 10.30 AM her breathing efforts were adequate. He also informed the relatives of the patient that so long as the patient stayed in the ICU, her condition should be regarded as critical and at no time he had informed that she was out of critical condition. On the same day, at about 7.00 PM, Dr.Murali called him and informed him that the patient had respiratory arrest and that the patient had to be reconnected to the ventilator. On the next day, i.e., on 12.7.1992, at about 7.25 AM, he made an enquiry about the patient's health and he was informed that the patient had a satisfactory night and was doing well. But, around 8.05 AM, he got a call from the hospital that the patient had a Cardiac Arrest. He, therefore, immediately rushed to the hospital and reached there at about 8.25 AM. He found that there was no spontaneous heart beat and resuscitatory measures were being carried out by Dr.Jawali – a consulting Cardiac Surgeon and Dr.Suneel Basavaraj – the Registrar in the Department of

Cardio-Thoracic Surgery. He also joined the team of doctors and continued to revive the patient's heart. He went out of the ICU and informed the waiting relatives of the patient that she had a Cardiac Arrest and attempts were being made to revive her. But subsequently, all the efforts of the doctors proved futile and the patient failed to respond to resuscitatory measures. He thereupon informed the relatives of the patient that the patient had died. Thereafter, he enquired with the relatives of the patient whether they desired the post-mortem to be conducted, but the relatives refused the permission.

It is his further say that the sudden collapse of the patient could have been due to maassive heart attack and he denied that if the patient had proper ventilation, she would not have suffered Heart Attack. He also clarified that on 11.7.1992 at 5.30 PM, patient had Respiratory Arrest but it was not Cardiac Arrest. It is his say that the Wockhardt Hospital is one of the best-equipped hospitals in Bangalore – both in personnel and in equipments. Mrs.Nirmala was attended on 10th, 11th and 12th July by trained nurses in ICU/Management. He has also denied that patient's death was due to lack of intensive care in the ICU.

It has been exhaustively pointed out that the deceased was having Diabetes Mellitus since 15 years. It was initially controlled by oral medication. However, she was required to take Insulin. Thereafter, she developed Insulin Resistance requiring more and more Insulin and the Diabetes was uncontrolled.

This has been admitted by the complainant in his cross-examination. However, in cross-examination, the complainant has denied that he did not know that his wife was Insulin resistant and has stated that he was the one who used to take his wife to the doctors for their advice and was having personal knowledge that with Insulin she did improve. For this purpose, there is also cross-examination of the witness wherein he was put to the question as to whether Dr.S.R.Aravind had explained to him and informed that his wife was an Insulin Resistant Diabetes Mellitus patient, his answer was that he did not remember. For this, he has also referred to the Diacon Hospital (Diabetes Care and Research Centre) wherein history relating to Diabetes is mentioned and in Comprehensive Assessment it has been stated:

Type of diabetes : NIDDM (IRDM)

IRDM means Insulin Resistant Diabetes Mellitus

3. **Evidence of Sister Roseline K.Joseph**:

Next, we would refer to cross-examination of Sister Roseline K. Joseph, who was the Staff Nurse at the relevant time. In her cross-examination, she has stated as under:

"Q.6 At what time, did you take over Mrs.Nirmala on 12th July 1992 ?

Ans. Our handing over and taking over time is from 7.30 AM to 8.00 AM. So I took over the patient by this time.

Q.7 When you took over the patient 7.30 to 8.00 AM was she in a conscious and alert condition. Is that correct ?

Ans. When I took over on 12.7.1992 at 7.30-8.00 AM, she had been sedated and was conscious.

Q.8 Was she alert ?

Ans. **Neurologically she was alert and she was asleep**.

Q.9 Sister, where were you when the endotracheal tube came out ?

Ans. When the endotracheal tube displaced, I was there next to the patient and the Night Nurses, duty doctors, Registrar and Specialists.

Q.10 Who were the night nurses, Sister? Who were there?

Ans. Sister Christine and Sister Bernadamma.

Q.11 Who were the Duty Doctors ?

Ans. **Dr.Sunil Basavaraj, Dr.Sheikh, Dr.Patil, Dr.Ganesh and Dr.Kiran**.

Q.12 Who was the Specialist ?

Ans. Dr.Sunil Basavaraj was the Specialist. He has the same qualifications as Dr.Subba Rao.

Q.13 What is the qualification of Dr.Subba Rao and what is the qualification of Dr.Sunil Basavaraj?

Ans. The qualification of Dr.Subba Rao is MBBS, MS and the qualification of Dr.Sunil Basavaraj is MBBS, MS.

Q.14 What did you do to prevent the **endotracheal** tube coming out?

Ans. The endotracheal tube already secured by putting **plaster and umbilical tie**.

Q.15 Did you see the endotracheal tube coming out of the

patient's mouth ?

Ans. The question is wrong. The endotracheal tube does not come out from the mouth ; it is displaced from the trachea to the mouth.

Q.16 Were you there when that happened ?

Ans. Night Nurses, Duty Doctors, Dr.Sunil Basavaraj, Dr.Patil and I was there. All of us were there.

Q.17 What did you do to prevent the displacement of the endotracheal tube ?

Ans. **Dr.Sunil Basavaraj** put the tube inside the trachea i.e. reintubation. I gave the laryngoscope which was kept on the ventilator which is connected to the same patient.

Q.18 Do I take that you did nothing to prevent the displacement of endotracheal tube ?

Ans. When the Doctors, Specialists are available on that time, I did not put the tube inside. I was helping them to give the equipment whichever they wanted immediately."

6. **Evidence of Dr.Murli Chakravarthy**:

Other important evidence is that of Dr.Murali Chakravarthy, who was at the relevant time, Chief of Cardiac Anesthesia Services and exclusively catering to Cardiac Surgical patients in the hospital. He has stated as under:

"Q.8 What was your role in the post-operative management of this patient ?

Ans. As in the records and also admittedly I have been

actively involved in the post-operative care of this patient. Chronologically listing:

1) After the anesthetic was ended at about 5 O'clock on the evening of the 10th July 1992, we observed the patient for a period of an extra one hour.

2) After shifting the patient to Intensive Care, I made sure that her haemodynamic ventilatory and bio-chemical parameters were within normal limits and waited for a further four hours.

3) In the wee-hours of 11th July 1992, when the patient had hypertension and elevated LA pressure, I appeared on the scene again at 2 AM and got a chest x-ray repeated and ruled out cardiac tamponade which was suspected at the time.

4) Throughout the night, I continued to monitor the patient and made suitable changes in the treatment while all the time having a teleconference with Dr.Subba Rao and Dr.Uday Khanolkar and discussing the same with the on-the-spot Registrar Resident and the Nurses.

5) In the morning of 11th deliberate and careful weaning off the ventilator was performed and

patient was extubated by me at about 10.30 AM in the presence of my colleagues. Dr.Subba Rao appeared soon on the scene and was also satisfied.

6) I continued to stay with the patient and monitored her throughout the day and left the hospital at about 7.30 or 8.00 that evening. I was a part of the team that treated and resuscitated successfully the Cardiac Arrest that occurred at around 5.30 PM.

7) As per the records, I have kept a continuous touch with the hospital during the nights of 11th, the early hours of 12th, till the morning. Notwithstanding the fact that I spent about 33 hours or so of the entire 44 hours or so of the patient's staying in the ICU and the OT.

In my opinion I have gone beyond the realms of human endurance to **take care of the patient**, in order to uphold the Hippocratic Oath."

Q.11 Were you present when the endotracheal tube suffered an unplanned extubation on the morning of 12th July 1992 ?

Ans. **When the displacement of endotracheal tube that occurred in the morning of 12th, the entire post-operative management team was present viz**.

1) Dr.Sunil Basavaraj and Dr.Patil - Registrars
2) Dr.Kiran and Dr.Ganesh - Residents
3) Sisters Sunilaraj, Jasmine and Roseline K.Joseph - Nurses

Dr. Subba Rao, Dr.Uday Khanolkar and myself had through a telephonic call by 7.30 AM on 12th July planned to be in hospital in the morning.

Q.12 When were you informed of the unplanned extubation of endotracheal tube and what did you do thereafter ?

Ans. On the morning of 12th, when I was all in readiness to leave the house I got a phone-call of a successful reintubation of the abovesaid patient by Dr.Sunil Basavaraj, who had also done a similar procedure in the past on the same patient under similar condition. This was informed to me by a doctor from the Intensive Care Unit as it appears on 87D, unfortunately the smudged out Xerox copy does not reveal to us the name which appears as Doctor … … and on Page-82 Doctors Note to the same effect at 8.05 AM although at this length of time over a decade, I do not remember the Doctor's name but I do remember the information. Thereafter, I reached the hospital on the double. … … … …

Q.16 I put it to you, Doctor, that the cause of death in the instant case was **due to the unplanned extubation and unsuccessful reintubation of the endotracheal**

tube.

Ans. I deny the suggestion for the following reasons :

Displacement of endotracheal tube from its position is nothing new to the medical profession. In the depositions by Dr.Uday Khanolkar, Dr.Vivek Javali, Dr.Uday M.Gandhe, Dr.Kaushal Pande have reiterated my statement. In the medical literature, pertaining to the period during which the patient was operated there is a sea of literature. In addition to the article of Farad Kapadia which Dr.Kaushal Pande mentioned, there are articles by Tominaga from the USA (who **was** found displacement of tube even after sedation was adequate or more), Benjamin from Boston (has given an incidence of 3%), Coppolo in 1990 (says 69% of self-extubation occurs despite restraint and sedation). Razek in the recent article from Pennysylvania quoted “61 displaced endotracheal tubes out of about 1000 patients in a period of just 1½ years and some patients had more than one displacements”. It is my own personal knowledge, other doctors who have deposed and admission by concerned complainants in their complaint (Pg.23 outer pg.27 of the amended complaint) **where it is clearly borne out that the complainants on their own have contacted eminent** Specialists, both in India and abroad and were told that a patient **can breathe for a few minutes** after extubation) **that a patient** who is on a **ventilator who has not** received muscle relaxant (in order to protect

the muscle tone, safe reflexes of the patient) can breathe in the event of **displacement of tube**. The successful reintubation of the patient by Dr.Sunil Basavaraj who had intubated the same patient on the previous day also is a matter of record. As well as being reiterated by the doctors concerned. Having been a witness to Dr.Sunil Basavaraj's ability to reintubate the same patient previous day, I have no doubt about his ability to reintubate the same patient when the tube was just outside the trachea inside the mouth. Dr.Vivek Jawali in his depositions has deposed that on his arrival found the endotracheal tube already in place and the patient was on ventilator. Therefore, I vehemently deny your suggestion about both the aspects of the issue.

Dr. Subba Rao in his affidavit Pg.No.12, Para No.12 has denied that patient did not have proper ventilation. On the other hand, as I have already mentioned about the minutes of the meeting that we had on the 12th at about 10 O'clock, he has reiterated my statement which I have made now *that the sudden collapse of the patient was due to massive heart attack*. It is denied that if the patient had proper ventilation, she would not have suffered heart attack.

Also referring to the affidavit of Dr.Veerappa who is the expert witness of the complainants mocks at the suggestion of surgery being successful in his affidavit

dated 14th August 2000 if one wants to presume this hypothesis on the cause of death due to massive heart attack, how can one justify “Surgery was successful” (he also pleads that “Only Almighty God should help our profession).

Dr. Kaushal Pandey has made it clear in the answer to Question No.17 about the ten points occurring in the same patient can have only one outcome. *To me this patient’s surviving for over 36 hours in the ICU itself appears to be surprising*. These patients in most other hospitals would have succumbed earlier and also he has gone to say the result would be no different in esteemed hospitals such as the Cleveland Clinic, USA.

The impression of Dr.Subba Rao, who put forth heart attack as the reason for death, Dr.Veerappa (the expert witness of the complainant), Dr.Kaushal Pandey have all highlighted one point i.e. **in spite of a technically successful operation, functionally the bypassgrafts could not carry the oxygenated blood which is a primary aim of the bypass surgery due to the inherent diseased process that a patient has been going through for a long many years**.

Also Dr.Kaushal Pandey in his answer to Question No.20 has highlighted about same patient who had many pathological conditions which did not allow the bypassgrafts to function as they were expected to. These points have also been reiterated by Dr.Uday

Khanolkar, Dr.Vivek Jawali, Dr. Uday M. Gandhe. I, therefore, am also of the same opinion that :

1) patient could breathe in the event of displacement of endotracheal tube,
2) the inherent condition of the patient did not allow the way it was functionally expected to,
3) As a matter of record and fact, this patient has been immediately reintubated."

7. For contending that operation was successful and the condition of the patient was improving, learned counsel for the complainant has relied upon:

"Immediately after going on bypass, Right Coronary Artery was opened. It was thick walled, 1.5 mm in diameter. Routine vein grafts sown in using 6/0 prolene continuous sutures. Aorta was clamped, cardioplegia given. Obtuse Marginal was exposed. It was totally occluded, endarterectomy performed with good clearance – proximally and distally. Routine anastamosis performed with a vein using 6/0 prolene continuous sutures. Left Anterior Descending Artery was opened, it had diffuse atheroma with patchy calcification and the lumen would not accept a 1.0 mm probe. Endarterectomy performed with good clearance, proximally and distally. Routine vein grafts anastamosed doing 6/0 prolene continuous sutures. Aortic cross clamp was removed. Top ends of the vein grafts were anastamosed to the aorta using 5/0 prolene continuous sutures. Patient was weaned off GPB, but she developed ST elevation and her LA pressures were over 25 mm with arterial pressure of around 60 mm. But with time, she improved and was stable. **However, she**

developed multifocal ectopice which necessitated treatment with xylocard. After this, there were no problems.

Chest closed with 2 drains after haemostasis.

Patients peripheral coronary arteries are of very poor quality and I would not be surprised if the long term result of this surgery is not very good"

In our view, there cannot be any doubt that during the operation as well as post-operative treatment, appropriate care is required to be taken by the attending doctors. In such cases, even if the appropriate care is taken, still it cannot be said with 100% certainty that patient would survive during the operation or during the post-operative treatment.

The learned counsel for the complainant submitted that it is for the doctors to explain for what reasons the patient expired.

The learned counsel for the opposite parties rightly submitted that all the necessary treatment was given to the patient by the attending doctors and the staff nurses. Therefore, there was no question of any deficiency in service and that in such cases Cardiac Arrest may result for the reasons not known to the medical jurisprudence. For this they rightly relied on the evidence of Dr.Kaushal

Pandey, wherein he has replied to the suggestion that the patient died because of surgery, as under:

> "Here is a patient who for the following reasons would have had only one outcome:
>
> (1). Female diabetic patient of long standing,
>
> (2). Unstable angina,
>
> (3). Poor LV function,
>
> (4). Emergency surgery,
>
> (5). Angiographic evidence of small calibre diffusely diseased arteries,
>
> (6). Patient requiring endarterectomy for LAD and OM arteries,
>
> (7). Patient having gross ST elevation soon after bypass surgery in theatre,
>
> (8). Patient requiring ionotropic support to maintain a borderline Blood Pressure of 60 to 90 mm of Hg.,
>
> 1. Patient having runs of multifocal ventricular ectopics including V.fib requiring DC shock,
>
> (10). Patient leaving theatre in unstable condition with evidence of severe LV dysfunction and perioperative myocardial infarction."

Further, we refer to the medical case papers, on 12.7.1992, wherein there is an endorsement to the following effect : [pg.79,81 (vol.I)]

> "Pt. was irritable.
>
> Suddenly violent coughing.
>
> Endotracheal tube was displaced.
>
> Emergency Re-intubation done and connected her back to

ventilator.
Pt. went in for Bradycardia and Asystole.

External cardiac massage started immediately and Intracardiac Adrenalin 1 amp. given.

Meantime, _____ came down from Medical ICCU as he was informed. He was present throughout and guided the situation. Then we gave her Soda Bicarb, Calcium, Atropine and Dopamine on flow.↑

No response to above Rx

External Cardiac massage continued for about 30 min. in spite of that pt. was not responding.

Again intracardiac Adrenalin repeated.

Inj.Soda biacarb 100 ml. given stat

Inj.Atropine 2 mg rpt. With the above Rx pt. was not responding.

Dr.Subba Rao, Dr._____ informed."

Thereafter, there is further endorsement at 8.30 A.M. [Pg.82(Vol.I)] [highlight last line]

"8.30 AM
* pupil dilated not reactive and fixed.
* External Cardiac massage was continued till 9 AM
* Intracardiac Adrenalin was repeated

No cardiac response.

9 AM
* with all above procedure pt. was not recovered.
* pt. Declared dead at 9 AM on 12.7.92

_____ asked pt's relatives whether they like a postmortem to done which they don't want."

The aforesaid treatment does not reveal any deficiency in treatment. It is difficult to hold that as endotracheal tube was displaced by sudden violent coughing, doctors or staff nurses were negligent.

8. Considering the facts brought on record, it is apparent that there was no deficiency in service during post-operative treatment because:

(i) from the very beginning it was known that it was extremely high-risk case of Coronary Artery Bypass Grafting Surgery;

i. limitations of benefit to the patient, if a Bypass was performed because of poor caliber of distal vessels, diabetes mellitus and hypertriglyceridemia;

ii. patient and relatives were repeatedly explained the pros and cons of the treatment considering the poor physical condition of the patient and unsuitableness of coronary arterial anatomy.

(iv) Despite this, as a last resort, as it became absolutely necessary, surgery was performed. Admittedly, the deceased was brought to the hospital on 7.7.1992 in a critical condition on a wheel chair with persistent angina and was straightaway admitted in ICU.

(v). The learned counsel for the opposite party also rightly pointed out that even though operation was successful, it cannot be said that patient was out of danger. She has referred to Dr.Vivek Jawali's cross-examination wherein he has stated the reason why operation was not successful. It is his say that :

> "The aim of coronary artery bypass grafting operation is to satisfactorily or adequately revascularise the patient in short and long term so as to also have an adequate haemodynamic stability. In this given patient, the patient had elevation of the ST segment of the monitored ECG, had a low systemic pressure and a high left atrial pressure with a requirement of ionotropic drugs suggesting that there was an insufficient revascularisation and the patient was not doing well".

i. To the same effect Dr.Subba Rao has stated. The relevant part is as under:

(a). Operation was difficult "*The surgery turned out to be even more complicated than was expected*";

(b). I felt that her cardiac arrest was sudden considering the fact that her condition was stable ….. Against this backdrop, sudden collapse of this patient could have been due to

massive heart attack";

(c). He has also admitted that **in spite of technically sound operation**, the myocardial infarction that the patient had, was due to her inherent systemic diseases like diabetes, hypertriglyceredemia, small caliber vessels etc. on the 12th of July 1992;

(d). After the operation on 10.7.1992 Dr.Subba Rao has noted that:

"Poor long term outcome "*patient's peripheral coronary arteries are of very poor quality, and I would not be surprised if the long term result of this surgery is not very good*",

9. From the evidence of Roseline K. Joseph, Nurse, it is apparent that the deceased was neurologically alert but she was asleep; nurse was present when the endotracheal tube was displaced; Dr.Sunil Basavaraj, Dr.Sheikh, Dr.Patil, Dr.Ganesh and Dr.Kiran, were present and Dr.Sunil Basavaraj was a specialist; for preventing the endotracheal tube coming out, it was secured by putting plaster and umbilical tie; the endotracheal tube was only displaced from trachea to the mouth and was reintubated by Dr. Basavaraj. This reveals that there was no negligence on the part of the nurse or doctors. There is no reason

to disbelieve the evidence of Nurses who were present at the relevant time. It is true that Dr.Sunil Basavaraj was not examined because he has left the service of the Opposite Party No.1. The Hospital has examined Dr. Subba Rao, Dr. Murli and Sister Roleline. It is not necessary in such cases to examine all the doctors who attended the deceased.

10. Further, the evidence of Dr.Murali Chakravarthy reveals that he has taken all the necessary care for saving the life of the patient. He has denied the suggestion that the cause of the death was due to unplanned extubation and unsuccessful reintubation of the endotracheal tube and that such displacement of endotracheal tube from its position is nothing new to medical profession. He has specifically stated that the sudden collapse of the patient was due to massive heart attack. He has also referred to evidence of Dr.Kaushal Pandey who is also a heart specialist wherein he has stated that it was surprising that patient's surviving for 36 hours in the ICU. He has pointed out that in spite of a technically successful operation, functionally the bypassgrafts could not carry the oxygenated blood which is a primary aim of the bypass surgery due to the inherent diseased process that a patient has been going through for a long many years.

11. It is to be stated that **the main factor responsible for the patient's death was poor preoperative inherent condition of her health**. It is also difficult to find out the cause of sudden cardiac arrest. But, considering the case

history of the patient it was apparent that it was a high risk case, and in such cases there was all possibility of cardiac arrest at any point of time.

(a) This is supported by the evidence of Dr.Kaushal Pandey wherein he has replied to the question as to how did he interrelate unsuccessful surgery, cough, displacement of ETT and the death of the patient, as under:

> "This is a very common problem. There is a research article by Dr.F.N.Kapadia, from Hinduja Hospital on this subject. At Hinduja Hospital we had 10% incidence of displacement of endotracheal tube in all the patients in the ICU. The figure for patients getting ventilated over 24 hours is higher around 12-15%. I have worked in Melbourne and Brisbane for 5 years and it used to happen there also"
>
> "Patient was hemodynamically unstable and in cardiogenic shock and in acute pulmonary oedema"

(b) Even the Complainant has admitted that pre-operative condition of the patient was poor towards the end of the year 1991; her general condition was perceptibly not good and required constant attention; ECGs were being taken more frequently. This is admitted in the complaint itself.

12. Considering the aforesaid record, it is difficult to arrive at the

conclusion that there is negligence or deficiency in service on the part of the Doctors or the staff of the Hospital. Further, from the evidence as it is, we cannot draw the inference on the principle of res ipsa loquitor.

This is in conformity with the settled aw in Achutrao Haribhau Khodwa Vs. State of Maharashtra & Ors. (1996) 2 SCC 634 at pp.645-46), wherein the Apex Court held as under:

> "Courts would indeed be slow in attributing negligence on the part of a doctor if he has performed his duties to the best of his ability and with due care and caution. Medical opinion may differ with regard to the course of action to be taken by a doctor treating a patient, but as long as a doctor acts in a manner which is acceptable to the medical profession and the court finds that he has attended on the patient with due care, skill and diligence and if the patient still does not survive or suffers a permanent ailment, it would be difficult to hold the doctor to be guilty of negligence".

In the result, the original complaints are dismissed. There shall be no order as to costs.

……Sd/……..J.
(M.B.SHAH)
PRESIDENT

.....Sd/-.....
(RAJYALAKSHMI RAO)
MEMBER