CONSUMER CASE NO. 104 OF 2002

1. DR. (MRS.) INDU SHARMA
W/o. Dr. Narhari Sharma, R/o. T-43, Main Road, Tekhand, Okhala Phase-I,
New Delhi - 110 020 .....Complainant(s)

Versus

1. INDRAPRASTHA APOLLO HOSPITAL
Through its Chairman, Dr. Pratap C. Reddy, Sarita Vihar, Mathura Road,
New Delhi

2. Since deleted from array of parties vide Order dated. 23.04.2004

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3. Indraprastha Apollo Hospital
Dr. (Mrs.) Sohini Verma, Gynaecology, (Infertility Specialist) Sarita Vihar, Mathura Road,
New Delhi

4. United India Insurance Company Limited.
Kanchanjunga, 18, Barakhamba Road, Connought Place,
New Delhi - 110 001 .....Opp.Party(s)

BEFORE:

HON'BLE MR. JUSTICE J.M. MALIK, PRESIDING MEMBER
HON'BLE MR. DR. S.M. KANTIKAR, MEMBER

For the Complainant : Mr. Madhukar Pandey, Advocate with
Mr. Sanjeev K. Verma, Advocate
Ms. Anirudha Mishra, Advocate
Ms. M. Malika Chaudhary, Advocate

For the Opp.Party : For the Opp. Party 1 : Dr. Lalit Bhasin, Advocate with
Mr. Ravi Gopal, Advocate
For the Opp. Party 3 : Mr. K. G. Sharma, Advocate
For the Opp. Party 4 : Dr. Sushil Kumar Gupta, Advocate

Dated : 22 Apr 2015

ORDER

PER DR. S. M. KANTIKAR, MEMBER

"The most important and emotional event in the life of a couple is the birth of a child and it's always a joyous occasion in the family when a newborn arrives. Most parents have a niggling fear that the nine months of pregnancy is comparable to walking through a minefield. Things can go wrong at any time. They only breathe a sigh of relief when they've counted all ten toes and fingers of their newborn. It's no wonder they feel that way because it can be the most devastating thing if your baby is born with a birth defect".

Complaint:

1. The complainant, Dr. Indu Sharma, B.A.M.S., (herein referred as "patient") during her first pregnancy, was under observation and follow-up of Dr. Sohni Verma, opposite party (OP-3) at Indraprastha Apollo Hospital, the OP-1. Previously, she took treatment from OP-3, for infertility, thereafter, spontaneously, she got conceived, after 4½ years. On 10.6.1999, after midnight, due to rupture of membranes, she got admitted in OP-1 hospital for her delivery. No senior doctor was available at that time, the resident doctor examined her. In the morning, at around 7.00 a.m., Dr. Sohini Verma (OP-3) examined her and advised her medicines, started IV fluid with 1 ampule of Syntocinon (herein referred as "Oxytocin") for speeding up the process of delivery. But, the patient noticed that the dose was maximum, and the CTG machine showed that the heart rate of the child began to sink (80/min.), during the midnight of 11/12-6-1999. None attended the patient, immediately. Thereafter, the patient was shifted to operation theatre at 2.00 a.m. for emergency caesarean (LSCS), and at 3.36 a.m. a female baby (named "Nistha") was delivered by LSCS, weighing 3.7 kg. The baby did not cry immediately, after birth and it took almost five minutes. Therefore, it was alleged that, baby suffered birth asphyxia and seizures. The baby was kept on ventilator in NICU. The OP assured that all the reports were normal. The condition of baby deteriorated further, till 29.6.1999. The baby was unable to suck milk. Meanwhile, the patient was discharged on 16.6.1999, while the baby was discharged from OP-1, on 30.6.1999. The OP-1 did not issue entire medical record, CTG graphs etc. The complainant paid approximately 2.5 lakhs towards hospitalisation.

2. After 2 ½ months, from 23.08.1999, the baby, Nistha, was admitted to Holy Family Hospital, for loose motions and strong clonic seizures from 23.8.1999. After doing EEG and C.T. Scan, it was revealed that the baby was severally affected by the atrophy of brain, which may lead to severally mental retardation. The complainant observed that her baby, at age of 1 year 8 months, the milestones were delayed, and the episodes of seizures persisted. Baby was unable to hold her neck and unable to suck milk. Therefore, the complainant had to appoint a special nurse for her care. Further, from 21.09.1999 to 03.12.2002, the child was treated at AIIMS, where, the Paediatric Neurologist, Dr. Veena Kalra, opined that, a full term baby having such problems were because of the negligence during the delivery. The complainant alleged that OP-3 failed to perform LSCS within, 12 to 18 hours after rupture of membrane. It was abnormally delayed for about 27 hours. The OP-3 advised excessive dose of Syntocinon, which caused foetal distress and cerebral anoxia- palsy. The child was further investigated by CT scan and x-ray reports, but the OP declared reports as normal. In this regard, the complainant sought opinion of doctors in USA and from her brother, who is a paediatric surgeon, in USA. The opinion was that severe atrophy of baby's brain cortex due to birth asphyxia and the child might remain severally mentally retarded for as long as she lives. The Disability Board of AIIMS, New Delhi certified the baby as '95% disability'. Nishtha survived for 12 years with disabilities

and with mental retardation. Unfortunately, baby Nistha died on 15.1.2012.

3. Complainant further alleged that OPs made number of corrections /interpolations on the case sheets. The neo-natal record was also tempered. The OP purposely concealed Cardiotocograms (CTG) tracings, which was the vital document in this case. The OP-3 failed to take proper care during delivery, which resulted in birth of an asphyxiated baby. Thus, alleging medical negligence, the complainant filed this complaint and has prayed total compensation of Rs.2.5 crores plus Rs.5 lacs for the mental agony and Rs.25,000/- as costs of litigation.
Defense:
4. The OPs filed written version and three separate affidavits of evidence by, Dr. Sohini Verma, Senior Consultant and Gynaecologist, (OP-3), the Neonatologist, Dr. Saroja Balan working at OP-hospital, and the Medical Superintendent, Mr. Singhal of OP-1. In addition, the OP filed affidavit evidence of 2 witnesses from hospital, one of the Sister In-charge Retnamma K. Nair and the other of Dr. Poornima Dhar, the Anaesthetist. The respective interrogatories were properly replied. OPs filed voluminous medical literature.

5. OP-3 in her affidavit evidence dated 11.11.2003, explained about her qualifications and experience; and stated that, the complainant was satisfied, therefore, she decided to take the treatment from OP-3. The complainant's case was not a normal one and the ANC record, shows the extra visits made by patient to OP-3. The patient was obese 88 kg; hers was a case of initial infertility and late conception. During 3rd ANC visit on 28.12.1998, patient was advised by OP-3 to undertake Triple Marker tests, but patient ignored it. During 5th visit on 22.3.1999, the patient also suffered with persistent diarrhoea /gastroenteritis for more than 2 months, she was treated by Gastroenterologist from 15.04.1999. The Ultrasonography (USG) done on 27.03.1999 showed abnormality in growth of foetal head size, i.e. one of the diameters of foetal head at 29th week corresponds to 35 weeks; thus repeat USG was advised after one week, but patient chose not to follow instructions. During 8th visit on 2.5.1999 at 33 weeks, patient complained of significant reduction of foetal movements from preceding day. OP-3 advised USG, Colour Doppler and repeat CTG tracings, which were found to be within normal limits.

6. OP-3 specifically stated that, in this case, duration of trial of induction of labour by use of Syntocinon was about 17 hours, which was well within the normal range. The time interval between the rupture of the amniotic membrane and the delivery of baby is a different matter altogether and depending upon the circumstances of the case, the treating Gynaecologist could wait for a few hours to a few days. As per treatment chart of the OP-3, it reveals that at 00 hrs on 12.6.1999, due to non-progress of labour, the patient had consistently objecting to LSCS and requesting to wait for 2 more hours, since the Fetal Heart Rate (FHR) was normal. The OP-3 denied that the FHR of the child began to sink (80/min.). The heart rate never dropped to 80/min, if indeed, there was drastic drop, patient would not have waited further 2 hours to give her consent for LSCS .

7. The OP-3 denied that complainant's daughter suffered brain damage due to negligence of the OPs. The Oxytocin drug per se is non-toxic to foetus. There was no hyper stimulation of uterine activity, thus, it was not a foetal distress. On the contrary, in the instant case, there was no response to oxytocin infusion. Thus the complainant failed to show any evidence of alleged foetal distress. OP-3 submitted that the complainant filed this complaint with mala fide

intention without any scientific basis; it was filed after 8 months of limitation period. It was filed on the basis of presumptions and the allegations are false and baseless.

8. OP-3 submitted that, International prevalence rate of Cerebral Palsy (in short "CP") is 1-2/1000 full term births and in the majority of these cases, 90% cases are due to unidentified cause of ante-natal origin. About only 10% cases of CP are due to intra-partum (during labour) reasons, like severe hypoxic events such as, acute severe ante-partum haemorrhage, ruptured uterus or cord prolapse and delivery of the baby, with low APGAR Score of < 3 for more than 5 minutes (usually 20 minutes). Therefore, OP-3 stated that, none of the above occurred in this instant case; also there is no correlation between the care during labour and the child's CP. It, unfortunately, was a case of Spastic Cerebral Palsy as certified by the Disability Board of AIIMS, New Delhi. The complainant relied upon the version of Dr. Veena Kalra, AIIMS, but there is no affidavit or any certificate in this regard. The fact that the baby suffered birth asphyxia cannot be proved because the APGAR score was not < 3 at 5 minutes of birth but, it was 7. Even the CT scan reports of OP-1 hospital and thereafter by Dr. Rajesh Gothi of Diwan Chand Satyapal Aggarwal Imaging Research Centre, Delhi, are not supportive to the complainant's allegation. The OP further submitted that the complainant, at the time of filing rejoinder, filed CT scan review report issued by Dr. Sudhir Gupta, MD Radiology of Sanjeev Spiral CT Scan Centre, Mata Chanan Devi Hospital, New Delhi, it was a manipulated one (annexure 5). It did not mention the name of any hospital, referring doctor and there is no signature. Also, the report made in USA by Daniel R. Backlas of Knapp Medical Centre, Texas addressed to unrelated/unknown person Dr. Pathak, gives totally contradictory version to the report dated 30.8.1999 made by Dr. Rajesh Gothi.

9. The OP-3 referred to various medical literatures to show that in the absence of any major clinically identifiable hypoxic event, in this case, intra partum (during labour) hypoxia cannot be the cause of brain damage. There were many signs and symptoms during the Complainant's antenatal period (during pregnancy), which, in retrospect, strongly suggest that it was a case of prenatal foetal brain mal-development or damage which could not have been foreseen nor prevented or corrected. She explained the course of treatment during labour. She stated that all management was done as per recommended protocols and there was no negligence on her part or on the hospital and therefore, Complaint is not maintainable. The OP-3 was indemnified by United Insurance Co.Ltd, the PO-4.

10. Affidavit filed by Neonatologist- Dr. Saroja Balan:
She submitted that the patient/complainant delivered a live female baby, on 12.06.1999 at 03.07 a.m. by LSCS, because of non-progress of labour due to non-effective uterine contractions and cervical dystocia. The patient had history of loss of foetal movements, during the last trimester of pregnancy, but the CTG and ultrasound pregnancy during that period were reported as normal, hence pregnancy was continued. There was history of spontaneous rupture of membranes approximately 27 hours back. Induction of labour was attempted by oxytocin infusion but, it failed. Foetal heart was regular throughout the trial of labour and no foetal distress was reported, at any time prior to delivery. The C- section was performed under general anaesthesia. The baby was found to be limp/depressed at birth and did not cry even on physical stimuli. The baby was ventilated with bag and mask for 45 seconds. APGAR score was 3 at 1 minute and picked up quickly to 7 at 5 minutes, however, despite a normal heart rate and

normal pink colour of the whole body, the baby remained hypotonic. Oxygen and intravenous fluid were started and baby was admitted to NICU. That, at one hour of age, baby had tonic convulsions which were treated, baby was intubated accordingly. Baby was extubated after 10 hours, but needed re-intubation on 3rd day for persistent seizures. A cranial USG and CT scan were done to look for any focal injury, but reported as 'normal'. The EEG done on day 2 of age, showed "left hemispheric amplitude attenuation" suggestive of underlying structural lesion, normal background rhythm. Metabolic screening was negative.

11. Affidavit of Mrs. Retnamma K. Nair, Sister-in-charge of OP-1 Hospital
She has stated that maternal and foetal condition was continuously monitored by one nurse, and intermittently, by the doctor and subordinate staff at regular intervals. One Gynaec Registrar was also on duty, for labour was, throughout. She has stated that uterus of C was not responding to Syntocinon infusion and C had only mild irregular uterine contractions. She has stated that fetal heart was recorded as regular between 120-140 per minute, throughout the labour and it never dropped to 80 per minute. She stated that OP-3 and Dr. Niharika, Registrar on Duty, regularly examined C. She stated that C refused to give consent for LSCS which was given after lot of arguments and belatedly at 02.00 a.m. on 12.06.1999.

12. Affidavit of Dr. Purnima Dhar, Anesthetist at OP-1 Hospital
The witness stated that she was called for anaesthesia for LSCS of the patient at 02.00 a.m. On examination, the patient was angry on being forced to undergo LSCS, though, she was declared a case of failure to progress in first stage of labour by OP-3. There was no record of foetal distress/ hypoxia during labour. The patient was offered spinal anaesthesia as there was no acute urgency to deliver baby in the absence of foetal distress, but the patient refused, and hence, LSCS was performed under general anaesthesia.
OP-3 filed several medical literatures on the subject of use of Oxytocin, Labour, the birth asphyxia etc. OPs filed affidavit of evidence from the witnesses from hospital (discussed in "Our Findings")
Arguments:
13. Counsel for the parties argued the matter extensively. The counsel for complainant, Mr. Madhukar Pandey reiterated the facts in the complaint. His main arm of argument was that the OP-3 administered excessive dose of Syntocinon, by which, the baby suffered birth asphyxia leading to cerebral anoxia. To prove his case, the counsel produced medical literature, the opinion of Dr. Daniel R. Backlas of Knapp Medical Centre, Texas, which was sought from US. The counsel submitted that the OPs filed the baby's record at very late stage during arguments i.e. on 20.11.2014; further brought our attention to areas of tampering in the original medical record of the patient and the baby's record (neonatal). The counsel vehemently denied that, at the time of discharge, the OP gave any CTG tracings. He contended that OP intentionally concealed the CTG. The counsel relied upon the medical literature, the medical text book like William's OBG 20th edition and various judgments of Hon'ble Supreme Court.

14. During rival arguments, Dr. Sohini Verma (OP-3) was also present, in person. We have allowed her to argue and assist the counsel for OP. The counsel argued that the complaint was filed after delay of 264 days, barred by limitation. The OP-3 argued the matter and narrated the submissions made in her affidavit. She further submitted that the complainant was on

Syntocinon, only for 17 hours and not for more than 24 hours. Total 66 U of Syntocinon was administered, it was given by controlled infusion pump with proper monitoring, and it was not an excess dose. The patient did not show any signs of distress, the FHR was normal throughout. There was no delay in taking decision for C-section. Due to non-cooperative attitude of patient, OP-3 waited for progress of labour, till 2 a.m. of 12.6.1999, thereafter, due to non-progress and cervical dystocia C-section was performed, as an emergency. Patient was on continuous CTG, which was monitored by duty doctor and nursing staff. She denied that during the last two hours of the progress of the labour, in question, i.e. 12.00 – 02.00 AM of 12.06.99, no uterine activity and foetal heart rate (FHR) recording were mentioned in the nursing chart. The FHR at 12.00 midnight, 01.00 a.m., 02.00 a.m. and 02.40 a.m., the FHR was within the normal range. She specifically submitted that all the CTG records were handed over to the complainant at the time of discharge, along with other documents. The counsel vehemently argued that there was no negligence either from the hospital (OP-1) or by OP-3. Hence, the complaint should be dismissed. The counsel for OP submitted voluminous medical literature on the subject of labour, oxytocin and birth asphyxia. The relevant important articles/ literature are:

- Ann Johnson 1998-Intrapatum hypoxia.....xxx.....
- Illingworth R S BMJ 1979, Essential to look behind obvious difficulties in labour....xxxx.....
- S. Arukumaran & M. Symonds- Intra partum foetal monitoring medico-legal implication,
- Elective induction of labour when and how? Review
- Fetal surveillance during labour
- Recent advances in Obstetrics and Gynecology
- Cerbral Palsy-Medicolegal aspects(Journal article)
- ACOG/SMFM Obstertic Care Concencsus
- NICE(UK) Clinical Guidelines on Intrapartum Care
- WHO manual. Integrated management of pregnancyand child birth.
- Asim Kurjak et al article on Cerebral palsy
- Oxytocin for induction of labour-Jennifer G Smith.
- Medical text books like Turnbull's Obstetrics, Integrated Obstetrics and Gynaecology for Postgraduates, Nelson's Paediatrics 16th edition.

Our Findings:

15. Condonation of Delay

On 03.03.2003, the Complainant filed an application for Condonation of 264 days delay in filing the complaint. The application was already decided on 16.12.2011 by the Bench headed by Hon'ble Mr. Justice V. B. Gupta and Hon'ble Mr. Suresh Chandra, and the delay was condoned. Moreover, this is the case of medical negligence and the cause of action remains continuous till the patient or the complainant comes to know about the real injury. Therefore, we are not inclined to dismiss the complaint on the point of limitation.

16. The Expert Evidence

The Complainant has not produced any medical expert evidence, and has not produced any witnesses from Holy Family Hospital and AIIMS where the baby was treated after discharge from OP-1. Initially on 27.03.2006 complainant filed one application for referring the case to the medical expert of AIIMS to take medical expert opinion but she withdrew the said application. The Complainant relied upon the medical textbooks, the research articles.

17. The OPs produced three expert opinions from doctors in own hospital, namely Prof (Dr.) Kamal Buckshee, Senior Consultant with Department of Obstetrics & Gynaecology of OP-1 Hospital, Dr. (Mrs.) Urmil Sharma and Dr.(Mrs.) Harmeet Malhotra, all have examined the treatment papers, opined that the treatment given to the patient was correct, and that there was no deficiency or negligence on the part of the treating doctors.

18. We are of considered view that after rupture of membranes and prolonged administration (> 24hrs) Syntocinon with increasing dose did not yield successful induction, thus there was delay to perform LSCS by OP-3. The OP-3 should not have waited for more than 24 hrs. FHR should be carefully monitored. On 12.06.1999 at 02.00 a.m.; i.e. at a very late stage, OP-3 declared that it was a case of cervical dystocia and non-progress of labour. As per text book by Dr. Friedman, the first stage of labour consists of 3 phases, i.e. (i) Preparatory dilatation division, which includes the latent and acceleration phases, (ii) a dilatational division, occurring in the phase of maximum slope of dilation, and (iii) a pelvic division, encompassing both deceleration phase and second stage while concurrent and the phase of maximum slope of descent. The latent phase lasts for 20 hrs for nulliparous women. Since in the instant case, spontaneous rupture of membranes had already occurred in late night of 10.06.1999 and the patient wasn't responding to increasing dose of Syntocinon, it was a gross negligence on the part of OP-3 to wait so long, before declaring non-progress of labour.

19. Therefore, it was the case of not managing dosage of Syntocinon carefully. As per Williams Obstetrics, under Chapter-Risk Versus Benefits of Oxytocin, it is stated, as under; "One characteristic of intravenous oxytoxin is that when successful, it usually acts promptly, leading to noticeable progress with little delay. Therefore, the drug needs not to be used for an indefinite period of time to stimulate labour. It should not be employed for more than a few hours, if, by then the cervix has not changed appreciably and if predictably easy vaginal delivery is not imminent, caesarean delivery should be performed. On the other hand, oxytocin should not be used to force cervical dilation at a rate that exceeds the normal".

20. In the instant case, it was an admitted fact that OP gave Syntocinon to the maximum of 66 units, which certainly will induce excessive uterine contractions and foetal distress. The foetal distress is proved from the evidence of Neonatologist, Dr. Sohana Balan, and the clinical notes, ABG reports of the baby, after birth. The ABG reports are consistent with metabolic acidosis. It has been mentioned that the child suffered intractable seizures just within one hour, after the birth. This view dovetails from medical literature as there are several causes for such seizures like:

(i) Leaving the child in the birth canal too long, causing a lack of oxygen to the brain.
(ii) Failure to perform a c- section in the presence of foetal distress.
(iii) Not responding to changes in the foetal heart rate.

21. It is pertinent to note that, complainant took another opinion and reviewed the CT Scan (16.06.199 and 30.08.1999) and MRI (07.04.2001) from another Radiologist Dr. Sudhir Gupta; wherein it was reported as:
"Cerebral parenchyma shows swelling with lost grey-white matter differentiation in 1st scan (16.09.1999)-suggestive of diffuse axonal injury to both cerebral hemispheres. Both later scans (30.08.1999) and 07.04.2001 (MRI) show atrophy of the frontal and occipital lobes."

It was reported as findings are suggestive of "DIFFUSE ISCHEMIC INJURY TO THE MOST OF CEREBRAL PARENCHYMA WITH RESULTANT ATROPHY. HOWEVER, PLEASE CORRELATE CLINICALLY."

22. Also, the medical record clearly revealed us that, the child was consulted at several hospitals like Holy Family Hospital, New Delhi from 29.091999 to 08.09.1999. Further, took the treatment at AIIMS from 29.09.1999 to 2003 for cerebral palsy and brain atrophy. The child underwent several investigations and procedures in between. The Physically Handicapped certificate was issued on 17.03.2003 stating that Kum. Nishtha was a case of spastic cerebral palsy with quadriparesis, microcephaly, severe mental retardation, myoclonic seizures and declared 95% physically handicapped. Thereafter, till her death, child was under constant health check-ups and treatment from several hospitals like Gangaram Hospital, Max Health Care etc.

23. Further, if it was Induction failure, then it should be declared only after 24 hrs from start of Oxytocin. (Spong et al 2012). Therefore in this present case, as per Dr. Anita's advice, Oxytocin was started at 06.00 a.m. on 11.06.1999 thus OP-3 ought to have waited till 06.00 a.m. on 12.06.1999 before declaring induction failure. Therefore, we do not agree that OP-3 was justified to declare it, as induction failure. We are of considered view that under those circumstances, OP-3 decided emergency LSCS because of foetal distress/non-reassuring foetal heart rate, and not by induction failure. We also don't accept, the contention of OP-3 that the baby was born with pre-existing (prenatal) neurological disability in the absence of any signs of foetal hypoxia or birth asphyxia. Also, we cannot ignore that the OPs produced medical records of baby, after lapse of a decade i.e. on 20.11.2014, the reasons best known to them.

Discussion and Reasons:

24. A person may lie, but the documents will speak the truth. We have perused the original medical records of patient- Indu Sharma maintained by the OP Hospital. Also, the affidavit filed by the Complainant and the relevant medical literature. Accordingly, she was under treatment of OP-3 and she conceived first child, after 4½ years' of marriage and has spent about 4-5 lakhs. She attended the OPD and antenatal check-ups at OP-3, visited OP-1 Hospital 13 times during her course of pregnancy. Regularly, her blood and urine test, USG, colour Doppler, CTG were done which were found to be normal. She admitted that triple marker test was not done, because there was no previous family history of any genetic disorder. Therefore, it has no nexus with the suffering of child herein as the child suffered from Quadriplegic Cerebral Palsy along with severe mental retardation and acquired microcephaly due to Hypoxic-Ischemic-Encephalopathy (HIE). We have perused the USG reports of the patient on 27.03.1999, 03.05.1999 and the last one on 29.05.1999; showed normal foetal growth. We do not find any co-relation between the increased OFD foetal head and mal development of brain of a baby. Patient suffered gastro-enteritis during 24-30 weeks of pregnancy which was properly treated by Dr. Sanjay Sikka, thereafter patient showed weight gain of 10 kgs. Thus, there was no nutritional deficiency to the baby, it proves that the Complainants antenatal care (ANC) period was uneventful. There was lack of feeling of foetal movements in 3rd trimester, it may be due to maternal improper perception. It is also pertinent to note that during her each visit the CTG was conducted and the findings were normal. Therefore, we do not think that the bio-physical profile of the foetus was abnormal till its delivery; the foetus reached its full term without any complications. It is relevant from the last USG done on 29.05.1999. It is clear that the patient was admitted in OP-1 hospital at 01.45 a.m. on 11.06.1999, the Resident doctor

who attended her did not mention her about the risk factors. He did not inform the seniors. At that instance, repeat ultrasound was not performed to recheck to a loop of cord around neck which was seen in previous USG done 12 days back. He did not check pelvic adequacy by clinical pelvimetry. No adequacy of fluid was checked even the patient was leaking profusely. The FHS recorded was 146/minute, therefore the condition of foetus was good prior to delivery.

26. Clinical Findings in Patient (Mother) after hospitalization:
It is most relevant to mention about the sequence of events after admission to OP-1 as stated in medical record:
• At the time of admission uterus was 36 weeks' in size. There was Cephalic presentation, 2/5 fixed, FHR 144/minute and the PV findings are leaking ++. Cervix was long, with uneffacement, OS was closed and the head was at Station 2. The OP advised for " start 5 units Syntocinon, 40 ml per minute, (10 drops per minute) ↑ every 30 minutes by 10 drops till desired contractions, 3/10 minutes". Continuous CTG monitoring.
• The note at 08:10 a.m. at 11.06.1999 revealed cervix was uneffaced totally, OS was 1 cm. CTG-FH 130 per minute and there was "Poor beat to beat variability otherwise regular" The OP continued the same treatment.
• At 11.50 a.m. the cervix gel (prostaglandin) was instilled in posterior fornix and also injection Pethedin was advised stat, but not available hence, not given, but injection Drotin was given.
• At 03.00 p.m. there were mild contractions and Syntocinon ↑ to 100 ml per minute, at 05.50p.m. Syntocinon ↑ to 150 ml per minute and at that time CTG showed beat up to 100 beats per minute and the same was informed to OP-3.
• At 06.00 p.m. the OP-3 mentioned that FH satisfactory and the OS was 1.25 cm, syntocinon 10 units induction continued @ 200 ml/min.
• At 09.00 p.m.: cervical OS admits one finger, cervix was 60-70% effaced; findings explained to the patient and her husband, they wish to continue labour requesting USG to confirm presentation (Pt. obese)-Agreed.
• The USG was conducted and the findings were informed to the patient and her husband and they wish to continue labour. At 00.00 hours on 12.06.1999, the notes are that "explained poor prognosis LSCS advised, but the patient and her husband refused and wished to wait for 2 more hours as FH satisfactory agreed to wait for only 2 more hours.
• Thereafter, at 02.00 a.m. the OP examined the patient and there were same findings and the Syntocinon was stopped and performed the LSCS.
• The clinical note at 02.40 hrs as below:
"Patient feeling unhappy and very bitter about being taken for LSCS. Says, "brought to OT against her wishes", although consent signed ! Explained the reasons for C-Section again. Foetal Heart heard-Regular-120/ml."

27. On careful perusal of clinical notes (supra) reveal that; at the first instance, OP-3 examined the patient at 7.00 am, the CTG findings taken at 08.00 a.m. clearly establish that there was poor beat to beat variability. The subsequent findings and nursing notes on 11.6.1999 at 9.00 am, Hypertonic contractions were noticed, thereafter at, 11.30am revealed the FHS decreased < 120, informed Dr. Geeta, again at 5pm , FHR was dipped below 100/min . Thus, the danger signals were noted thrice, and brought to the notice of OP-3, but, OP-3 did not take any prompt action or decision for emergency C-Section. Also, it was quite obvious that, due to

continuous leaking of liquor, the urine contractions went on unnoticed. Under these circumstances, in addition to Syntocinon, administration of Cervigel i.e. PGE caused further stimulation to the uterus. Therefore, OP-3 should have taken the decision for urgent C- Section at least at 5pm. It was the duty of Obstetrician to counsel the patient properly about the progression of labour for every 2 hours. We do not find any such counselling was done by OP-3 or by her staff. The OP-3 was aware that the patient was treated for infertility who conceived spontaneity after 6 years of marriage; therefore, it was a precious pregnancy. Thus, we are surprised that why the OP-3 delayed the decision to perform C-section. It is apparent from the medical record that there was poor Bishop's score.(ref para 28- Cervical Favorability).

28. Clinical Notes of baby-Neonatal Record:-
Baby delivered at 3.07 on 12.6.1999, did not cry at birth even after stimulation
Bag mask ventilation for 1 min (pg 13 neonatal record)
4 am- tonic convulsions- bag mask ventilation. Suspected ? Metabolic acidosis.
Arterial Blood Gas (ABG)= at 3.30 am pH 7.12, PCO2-50, PaO2-38, HCO3-16, BE-12
On the basis of medical text books and literature ,we are of considered view, that all these findings are of asphyxia that baby suffered during birth process.
Medical Literature:
29. We have gone through the medical literature provided by both the parties and several texts books like Williams Obstetrics 24th edition, Nelson's Paediatrics, the research articles from scientific medical e-journals etc. We would like to discuss some of important medical information as below:
• From William's Obstetrics 24th Ed,

453: Dilatation rates of 1 to 2 cm/hr are accepted as evidence of progress after satisfactory uterine activity has been established with oxytocin. This can require up to 8 hours or more before caesarean delivery is performed for dystocia. The cumulative time required to effect this stepwise management approach permits many women to establish effective labour. This management protocol has been evaluated in more than 20,000 women with uncomplicated pregnancies. Importantly, these labour interventions and the relatively infrequent use of caesarean delivery did not jeopardize the foetus newborn.

523: Induction implies stimulation of contractions before the spontaneous onset of labour, with or without ruptured membranes. When the cervix is closed and uneffaced, labour induction will often commence with cervical ripening, a process that generally employs prostaglandins to soften and open the cervix.
Augmentation refers to enhancement of spontaneous contractions that are considered inadequate because of failed cervical dilation and foetal descent.

525: Cervical "Favorability"
One quantifiable method used to predict labor induction outcomes is the score described by Bishop (1964). As favorability or Bishop score decreases, the rate of induction to effect vaginal delivery also declines. A Bishop score of 9 conveys a high likelihood for a successful induction. Put another way, most practitioners would consider that a woman whose cervix is 2-cm dilated, 80-percent effaced, soft, and midposition and with the fetal occiput at –1 station would have a

successful labor induction. For research purposes, a Bishop score of 4 or less identifies an unfavorable cervix and may be an indication for cervical ripening.

529: Oxytocin Dosage. A 1-mL ampule containing 10 units usually is diluted into 1000 mL of a crystalloid solution and administered by infusion pump. A typical infusate consists of 10 or 20 units, which is 10,000 or 20,000 mU or one or two 1-mL vials, mixed into 1000 mL of lactated Ringer solution. This mixture results in an oxytocin concentration of 10 or 20 mU/mL, respectively. To avoid bolus administration, the infusion should be inserted into the main intravenous line close to the venipuncture site.

Use of Oxytocin during Induction of labour :

The induction of labour by means of Oxytocin/Syntocinon should be attempted only when strictly indicated for medical reasons rather than for convenience. Administration should only be under hospital conditions and qualified medical supervision.
When Syntocinon is given for the induction and augmentation of labour, it must only be administered as an intravenous infusion, preferably by means of a motor-driven variable speed infusion pump, and not by subcutaneous, intramuscular or intravenous bolus injection. Administration of oxytocin at excessive doses results in uterine over stimulation which may cause foetal distress, asphyxia and death, or may lead to hypertonicity, tetanic contractions or rupture of the uterus. Thus, the use of Oxytocin (Syntocinon) reduces the supply of oxygen to the infants brain, and the powerful and numerous contractions give the baby less time to recover because of the decreased interval between each contraction wherein the baby replenishes his/her oxygen supply. The loss of oxygen to the brain alone is sufficient to cause serious brain damage leading to hypoxic event.
SIGNS & SYMPTOMS OF FETAL DISTRESS / NON-REASSURING HEART CTG TRACINGS
A heart rate greater than 160 (tachycardia), a heart rate lower than 110 to 120 for an extended period of time (bradycardia), decrease foetal heart rate variability, variable decelerations which become longer-lasting, late (the foetal heart rate returns to baseline after the contraction has ended), are considered “non-reassuring" or an indication that the baby is in foetal distress. This may signal that the baby is not getting enough oxygen and if not delivered soon, could suffer birth asphyxia (hypoxic ischemic encephalopathy).
Mean umbilical artery blood pH and gas in pre-term & term infants are similar

	Pre-Term		Term	
pH	7.21	-7.29	7.27	-7.28
pCO2	(mmHg) 49.2	-51.6	49.2	-50.3
HCO3	(mEq/L)	22.4-23.9		22.0-23.1
Base deficit	(mEq/L) 2.5	- 3.3	2.7	- 3.6

• From Practiclal Guide to High Risk Pregnancy& Delivery (Arias’ 4th edition)
Inappropriate action with suspicious or pathological CTG:
Once a diagnosis of suspicious or pathological FHR trace is made-action must be taken depending on the severity of CTG abnormality. Thus may mean continued observation, change in maternal position, administration of tocolytic, hydration, omission of oxytocin infusion in cases with suspicious traces and in addition fetal blood sampling/immediate operative delivery

in cases with pathological traces. Accurate documentation of the time of observation and any other actions taken is very important from a medico-legal view point. The importance of considering the clinical picture in planning management is essential. In the presence of an abruption, cord prolapse or scar rupture intervention should take place when the diagnosis is made as they warrant immediate delivery (within 15-30 min). In these situations a CTG may suddenly present with acute bradycardia. In cases of bradycardia <80bpm the pH can decline by 0.01 every min and with prolonged decelerations that have transient recovery to the baseline rate the pH can decline by 0.01 every 2-3 min. Fetal scalp blood sampling (FBS) is an inappropriate action in such situations and is likely to compromise the baby. Special arrangements should be in place in each unit to deliver these cases as category 1 caesarean section.

Team work and communication

Effective intrapartum FHR monitoring requires good teamwork. All members of the maternity team (doctors, midwives, nurses) should be aware of how FHR traces are interpreted, which FHR patterns are associated with actual or impending fetal acidaemia and within what time frame the senior team member should be notified of abnormal FHR pattern.

Storage of CTG

CTGs should be stored for at least 25 years and the hospital should make adequate provision for safe storage and easy retrieval.

Comments:

30. We have gone through the medical text, medical literature and WHO manuals. In the instant case, it was due to a breakdown in communication amongst the team of doctor and nursing staff during delivery of patient. The resident and nurses failed to appreciate the signs of distress on the foetal heart monitor, and they failed to inform the attending OP-3 of the non-reassuring heart tracings.

31. The Nurses chart notes at 10 am on 11.6.1999, itself clearly revealed that there were hypertonic contractions and the Syntocinon was decreased to 80ml/hr, again at 10.30am it was increased to Synto 100/hr , pt was getting moderate contraction and at 1130 am FHS decreased below120/min. Also, at 5 PM FHR dipped below 100/min. Those findings were brought to notice of OP-3 ,but the OP-3 failed to take decision for emergency C-section. Thus at that time , the uterus was in a hypertonic state, or a state of almost constant contraction. Contraction causes the vessels in the placenta to be compressed, which means they cannot easily refill with fresh, oxygen-rich blood to be transported to the baby through the umbilical cord. This can lead to be severely deprivation of oxygen to the baby and can result in permanent brain damage, as was the case with baby Nistha. Therefore, it was against the standard of care for a hospital to quickly deliver a baby by emergency C-section when necessary.

32. Standard of care allow obstetricians two options to ensure that the continuation of labour is safe for the baby. One option is to perform a test to make sure that the baby is not acidotic. (If a baby is acidotic, it means inadequate gas exchange is taking place and the baby is being deprived of oxygen.) If that test is not performed, the Oxytocin must be stopped. However, if stopping the Oxytocin did not improve the heart tracing, the standard of care required C-section delivery since vaginal delivery was not imminent. Even if the foetal acidosis test is not familiar to some obstetricians, all obstetricians are familiar with the necessity of calling a stat C-section

when a foetal heart tracing does not improve despite resuscitative measures. A good trial on fetal resuscitation would require randomization based on fetal distress diagnosed using the "gold standard" of fetal scalp blood pH < 7.2, testing the methods used for resuscitation, and accounting for the variables.

33. In the instant case, there was the long labour process brought about by poor and negligent medical management caused the birth of asphyxiated child with cerebral palsy and seizures/ fits. As per medical literature, we confirm that the long hours in labour caused pressure on the umbilical cord and placenta; that the oxygen supply to the foetus and very importantly to the brain was reduced and or off completely, and this caused hypoxia. In addition the liquor was completely drained out due to prolonged period, which in turn exerted direct compression of placenta, because of pressure from contacting uterine wall. This was happened because the labour process was poorly handled. A lot of time was wasted and critical warning signs were missed by OP-3. The cause of the baby's traumatic birth resulting in her being a cerebral-spastic quadriplegic was attributable to the fact that during the long labour process from the rupture of the membranes to the time she was delivered after 27 hours, there were stages when his brain had insufficient amounts of oxygenated blood, and as a consequence, hypoxia and peri-natal asphyxia occurred. The birth record voluminously speaks about the asphyxia.
Res ipsa loquitur :
The principle of res ipso loquitur has been discussed elaborately by by the Hon'ble Apex Court in V.Kishan Rao vs. Nikhil Super Speciality Hospital [(2010) 5 SCC 513], wherein it has been held as follows:
43. In Spring Meadows (supra) this Court was dealing with the case of medical negligence and held that in cases of gross medical negligence the principle of res ipsa loquitur can be applied. In paragraph 10, this Court gave certain illustrations on medical negligence where the principle of res ipsa loquitur can be applied.
44. In Postgraduate Institute of Medial Education and Research, Chandigarh v. Jaspal Singh and others, (2009) 7 SCC 330, also the Court held that mismatch in transfusion of blood resulting in death of the patient, after 40 days, is a case of medical negligence. Though the learned Judges have not used the expression res ipsa loquitur but a case of mismatch blood transfusion is one of the illustrations given in various textbooks on medical negligence to indicate the application of res ipsa loquitur.
The subsequent para gave many illustrations of res ipsa loquitur.
34. The Also the applicability of Res Ipsa Loquitur to the case of medical negligence in Jacob Mathew (Dr.) Vs. State of Punjab & Anr., III (2005) CPJ 9 (SC) and has observed:
"27. No sensible professional would intentionally commit an act or omission which would result in loss or injury to the patient as the professional reputation of the person is at stake. A single failure may cost him dear in his career. Even in civil jurisdiction, the rule of res ipsa loquitur is not of universal application and has to be applied with extreme care and caution to the cases of professional negligence and in particular that of the doctors. Else it would be counter productive. Simply because a patient has not favourably responded to a treatment given by a physician or a surgery has failed, the doctor cannot be held liable per se by applying the doctrine of res ipsa loquitur."
28. Res ipsa loquitur is a rule of evidence which in reality belongs to the law of torts. Inference as to negligence may be drawn from proved circumstances by applying the rule if the cause of the accident is unknown and no reasonable explanation as to the cause is coming

forth from the defendant."

35. We have noted that, the OP-3 kept on increasing the dosage of Syntocinon and the patient was given 66.6/MIU/minute which was very high without careful monitoring and in a haphazard manner for a very longer period. In any case oxytocin should not be used more than few hours. The original medical records which clearly reveal tampering, cutting, erasing and manipulating dosage of Syntocinon. On bare perusal , it is apparent that, records are tampered at the extents which show erasing marks, pin holes. There are some handwritten insertions, over writings and discrepancies in the doctor's and sister's chart. Thus, in our view there was an obligation on the OPs to explain how the baby's cerebral palsy occurred? If the patient and the baby were accorded the requisite treatment. Thus, the absence of such exculpatory evidence to circumstances, the invocation of the maxim res ipsa loquitur, is justifiable in this case. In this context we relied upon the recent judgment of this commission decided on 25.03.2015 by the bench of Hon'ble Mr.Justice D.K.Jain and Hon'ble Mr Vinay Kumar, in the First Appeal 522/2008- Leela G Nair V Prof Dr. K. P. Haridas.

36. Medical record maintenance has evolved into a science of itself and form an important aspect of the management of a patient. It is important for the doctors and hospitals to properly maintain the records of patients. It will help the doctor to prove that the treatment was carried out properly. The proper medical record it will help them in the scientific evaluation of their patient profile, helping in analysing the treatment results, and to plan treatment protocols. It is wise to remember that "Poor records mean poor defense, no records mean no defense".

37. It is also pertinent to note that, this Commission vide its order dated 03.10.2007 directed the OP-1 and 2 to file the original medical records pertaining to the treatment of the child till 29.10.2007. But the OP did not file those records till the final arguments. But, in the interest of justice we have allowed the OPs to file the medical records on 20.11.2014. But we are unable to understand why the OPs took such a long time to file these documents.

38. OP-3 administered a maximum dosage (66.6 munit/min.) till 6 p.m. on 11.06.1999. We are unable to locate in doctor's chart whether it was stopped or not at 6 pm; but record shows that, at 02.00 a.m. on 12.06.1999 it was stopped. It surprising to note that, medical record in doctor's and sister's charts, show several cutting, erasing, rewriting at the place of Syntocinon dose, thus it was apperantly manipulated and fabricated one. (Page No 6,7,8,9,10,11 in doctor's notes and page No. 39,40,41,42 of Original Medical Records).

39. An emergency C-section delivery was finally ordered by OP-3, but it was too late. Foetal scalp pH should be checked if augmented labour is prolonged and higher dosages are given. However, the same was not done by the OP-3, it was the act of omission. The baby was born with very low Apgar scores, wasn't breathing. Resuscitation manoeuvres were initiated right after birth, by mask ventilation and further intubation, it is clearly indicative of Moderate to Severe hypoxia as per AIIMS guidelines (WHO). The umbilical cord showed that her blood pH was 7.12, indicate baby had acidosis during delivery i.e she was deprived of oxygen for a significant period of time. She began having seizures, which is also an indication that she experienced an oxygen depriving insult. In fact, hypoxic ischemic encephalopathy (HIE) is the most common cause of seizures in the newborn period. HIE is a brain injury caused by oxygen

deprivation / asphyxia. The CT scan/ head imaging of the baby was performed, it showed oedema which is also sign of asphyxia.

40. Cervical dystocia - is found in a patient who has entered active phase of labour i.e. more than 3-4 cm dilatation of cervix and not achieved rate of cervical dilatation @ 1 cm/hr for a minimum of 4 hours (WHO guidelines). In the instant case, the cervical dilation never took place more than 2 cm, thus it was unfavourable cervix; and not a Cervical Dystocia as declared by OP-3 after 27 hrs. It was not an absolute indication for emergency LSCS as stated by OP-3, but certainly there would have been foetal distress noticed on CTG which OP-3 decided for emergency c-section. In our view, the OP-3 should have done LSCS after 8 hrs of Oxytocin infusion when there was no response/ no cervical effacement of cervix.

41. As per the Complainant, she never received the CTG graphs from the OP but, the OP stated that all CTG graphs were handed over to the Complainant at the time of discharge, which was kept in separate brown folder. The CTG tracings are vital evidence in the case of HIE which caused damage to Baby Nistha at the time of her birth. OPs should have kept standby records of CTG tracings.

42. We also reject the contention of OP that, the patient was reluctant to undergo c-section, but preferred to wait for vaginal delivery. In this context, it was the bounden duty of the doctor to decide, the correct line of treatment; doctor wouldn't just blindly obey the wishes of the patient., which iItself it would be unethical as discussed by the Hon'ble Supreme Court in the case of Malay Kumar Ganguly vs. Dr. Sukumar Mukherjee & Ors. [(2009) 9 SCC 221].

43. The Complainant took opinion on the CT Scan(16.06.1999) done at Apollo Hospital to her brother who is Paediatric surgeon living in the USA, who in turn referred it to Dr. Daniel R. Backlas, MD, Chief of Radiology, Knapp Medical Center. It was reported that, evidence of global ischemia, diffusely affecting both cerebral hemispheres. There was no differentiation between white and grey due to edema. A sub-glial hematoma was identified at the left parietal vertex. Even patient took opinion of the CT Scans (16.06.1999, 30.08.1999) and MRI (07.04.2001) from Dr. Sudhir Gupta, who opined that all the three scans are suggestive of 'Disffused Ischemic Injury to the most of cerebral paranchyma with resultant atrophy'. However, the discharge summary issued by OPs mentioned the CT findings dated 16.06.1999 as normal. Therefore, the CT and MRI findings were confirmatory of anoxic brain injury.

44. We don't find any convincing evidence form USG reports that the baby had Microcephaly/ congenital brain defect which was the cause of baby's condition. Also, it was not a case of Down's syndrome or any congenital anomaly, thus point of Triple markers not done by patient pales into insignificance.

45. We reject the expert opinion produced by OP-3 from 3 experts of OP-1 hospital, because they have opined on the basis of tampered medical records, they were from same hospital and more chances of interested witnesses. In this context we took reference from a judgment in V. Kishan Rao Vs. Nikhil Super Speciality Hospital & Anr. [(2010) 5 SCC 513]. The Supreme

Court held that the Consumer Forum can permit experts evidence but it is not bound by the view expressed by the expert because medical negligence is a mixed question of law and facts which is required to be resolved by the Forum.

46. The arguments were concluded on 20.11.2014. The Counsel for the Complainant filed application to place on record of the CT scan dated 16.06.1999, it was stated that the CT films were in there possession since 1999. In the interest of justice, on 27.11.2014 we have taken the CT scan films on record, but liberty was granted to OP to argue on 16.03.2015. Accordingly, OP argued the matter on 16.03.2015. We have perused both the CT Scan films and confirmed the date, name and other details of the patient mentioned on the films. The CT findings are consistent with cerebral edema.

47. The Hon'ble Supreme Court in Kusum Sharma and others v. Batra Hospital and Medical Research Centre and Others; (2010) 3 SCC 480; 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.
The complainant is required to prove that the doctor did something or failed to do something which is the given facts and circumstances, no medical professional in his ordinary senses and prudence would have done or failed to do as held by the Hon'ble Supreme Court in case "Jacob Mathew v. State of Punjab & Anr." AIR 2005 SCC 3180.

48. Therefore, in the light of this law let us examine whether there was breach of duty by OPs and are guilty of medical negligence or not? For this we put reliance upon a catena of judgments of Hon'ble Supreme Court which discussed about medical negligence. The Bolam's Case- Bolam vs. Frien Hospital Management Committee (1957) 2 All ER 118, McNair, J. summed up the law as under :
"The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill; it is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art. In the case of a medical man, negligence means failure to act in accordance with the standards of reasonably competent medical men at the time. There may be one or more perfectly proper standards, and if he conforms with one of these proper standards, then he is not negligent."

This decision has since been approved by the House of Lords in Whitehouse vs. Jordon (1981) 1 All ER 267 (HL); Maynard vs. West Midlands Regional Health Authority (1985) 1 All ER 635 (HL); and Sidway vs. Bathlem Royal Hospital (1985) 1 All ER 643 (HL). In two decisions rendered by Hon;ble Supreme Court namely, Dr. Laxman Balakrishna Joshi vs. Dr. Trimbak Bapu Godbole & Anr. AIR 1969 SC 128 and A.S. Mittal vs. State of U.P. AIR 1989 SC 1570, it was laid down that when a Doctor is consulted by a patient, the former, namely, 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.

49. Obstetricians and nurses must carefully monitor a baby during labour and delivery in order to make sure that the baby is getting enough oxygen and is not in foetal distress. The primary way to detect whether a baby is in distress is through electronic foetal monitoring(EFM), which records both the mother's contractions and the baby's heart beat in response to contractions. Despite its standard use in hospitals today, sometimes doctors and nurses still fail to monitor their patients or improperly interpret monitor CTG tracings. This can lead to debilitating birth injuries for the baby.

50. When the CTG tracings show that the baby's heart rate pattern is non-reassuring, it means she is in distress and is being deprived of oxygen and must be delivered very soon. Often, a C-section delivery is the safest and fastest way to do this. Delaying the delivery of a baby who is in distress can cause permanent brain damage due to a prolonged lack of oxygen rich blood in the baby's brain. Indeed, it is important for obstetrician and the medical team to pay close attention to the foetal heart tracings. Medical personnel should be skilled enough in heart tracing interpretation that they notice even subtle changes in the tracings. Not only is it crucial for the medical team to recognize non-reassuring heart tracings, but the staff must be prepared to act on these findings. It is the responsibility of the medical team to pay very close attention to the heart tracings so that if the baby becomes distressed,

51. As per standard of practice, after rupture of membrane (PROM or spontaneous) the obstetrician shall wait for maximum up to 12 hours; and then supposed to proceed for C-section or alternatives. In this case, what was the need for OP-3 to conduct emergency LSCS at 2 a.m. if CTG was normal? The OP-3 visited the patient every 2-3 hours, thus, the foetal heart rate taken to waver at night which was unnoticed by the OP or by its staff. We do not find any cogent evidence that the nursing staff or labour room staff managed the FHR properly. Unfortunately the CTG tracings were not available to prove the reality. The say of OP that, the patient was informed about emergency LSCS which was rejected by the patient or by her husband, but, there is no evidence as such, the OP failed to take written consent or signature of the complainant or her husband about refusal of C-section. The progress sheet clearly shows some insertion made by OP/staff to show that patient was informed. Thus, the entry was also tampered one.

52. We can clearly infer in this case that, after rupture of membranes, within 12 to 18 hours OP should have declared the non-progress of labour. It is also obvious that if oxytocin did not cause effective dilation of the cervix even after 18-20 hours of rupture of membranes, the decision of LSCS should have been taken much earlier. Thus, the delay and heavy doses of Syntocinon resulted into foetal distress and brain damage of new born in this case.
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53. A decision in the case of Spring Meadows Hospital & Anr. v. Harjol Ahluwalia through K.S. Ahluwalia & Anr reported in (1998) 4 SCC 39. Their Lordships observed as follows: " 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."

54. To succeed Medical negligence claim the patient/complainant has to prove three elements, whereby a duty of doctor's care is owed to a patient and as a consequence of a breach of that duty, the patient suffers injury.
As long ago as 1838 Chief Justice Tindal articulated the principle that survives to this day:
Every person who enters into a learned profession undertakes to bring to the exercise of it a reasonable degree of care and skill. He does not undertake, if he is an attorney, that at all events you shall gain your cause, nor does a surgeon undertake that he will perform a cure; nor does he undertake to use the highest possible degree of skill. There may be persons who have higher education and greater advantages than he has, but he undertakes to bring a fair, reasonable, and competent degree of skill.
A similarly Lord Chief Justice Hewart who once stated that:
If a person holds himself out as possessing special skill and knowledge .... [he undertakes] to use diligence, care, knowledge, skill and caution in administering the treatment .The law requires a fair and reasonable standard of care and competence.
Compensation:
55. Human life is most precious , it is extremely difficult to decide on the quantum of compensation in the medical negligence cases, as the quantum is highly subjective in nature. Different methods are applied to determine compensation. The multiplier method which typically used in motor accident cases not often conclusive for 'just and adequate compensation'. 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.

56. In the Halsbury's Laws of England, 4th Edition, Vol. 12, page 446, it has been stated with regard to non- pecuniary loss as follows:
Non-pecuniary loss: the pattern. Damages awarded for pain and suffering and loss of amenity constitute a conventional sum which is taken to be the sum which society deems fair, fairness being interpreted by the Courts in the light of previous decisions. Thus there has been evolved a set of conventional principles providing a provisional guide to the comparative severity of different injuries, and indicating a bracket of damages into which a particular injury will currently fall. The particular circumstance of the plaintiff, including his age and any unusual deprivation he may suffer, is reflected in the actual amount of the award. The fall in the value of money leads to a continuing reassessment of these awards and to periodic reassessments of damages at certain key points in the pattern where the disability is readily identifiable and not subject to large variations in individual cases.

57. In fact, Loss of dependency by its very nature is awarded for prospective or future loss. In this context, Lord Atkinson aptly observed in Taff Vale Rly. Co. v. Jenkins MANU/AG/0452/1912 as follows:
In case of the death of an infant, there may have been no actual pecuniary benefit derived by its parents during the child's lifetime. But this will not necessarily bar the parents' claim and prospective loss will found a valid claim provided that the parents establish that they had a reasonable expectation of pecuniary benefit if the child had lived

58. In this context we rely upon observations made by Hon'ble Supreme Court in number of cases.
i) In Sarla Verma's Case 2009 (6) SCC 121 , Hon'ble Apex Court discussed "just

compensation" with a lot of clarity and precision. It was observed:
"Compensation awarded does not become 'just compensation' merely because the Tribunal considers it to be just…Just compensation is adequate compensation which is fair and equitable, on the facts and circumstances of the case, to make good the loss suffered as a result of the wrong, as far as money can do so, by applying the well settled principles relating to award of compensation. It is not intended to be a bonanza, largesse or source of profit…Assessment of compensation though involving c ertain hypothetical considerations, should nevertheless be objective. Justice and justness emanate from equality in treatment, consistency and thoroughness in adjudication, and fairness and uniformity in the decision making process and the decisions"

59. Nizam Institute Case- 2009 Indlaw SC 1047
In the Nizam Institute case 13, the Supreme Court did not apply the multiplier method. In 1990, twenty-year old Prasant S. Dhananka, a student of engineering, was operated upon at the Nizam Institute of Medical Sciences, Hyderabad. Due to medical negligence of the hospital, Prasant was completely paralysed. Compensation was claimed, and the matter finally reached the Supreme Court. The court did not apply the multiplier method and awarded a compensation of Rs. 1 crore plus interest. The court observed:
"Mr. Tandale, the learned counsel for the respondent has, further, submitted that the proper method for determining compensation would be the multiplier method. We find absolutely no merit in this plea.
The kind of damage that the complainant has suffered, the expenditure that he has incu rred and is likely to incur in the future and the possibility that his rise in his chosen field would now be restricted, are matters which cannot be taken care of under the multiplier method.

60. Kunal Saha's Case (2014) 1 SCC 384
The Supreme Court rejected the multiplier method in this case and provided an illustration to show how useless the method can be for medical negligence cases. Hon'ble Justice Mr.V.Gopala Gowda opined that;:
"The multiplier method was provided for convenience and speedy disposal of no fault motor accident cases. Therefore, obviously, a "no fault" motor vehicle accident should not be compared with the case of death
from medical negligence under any condition. The aforesaid approach in adopting the multiplier method to determine the just compensation would be damaging for society for the reason that the rules for using the multiplier method to the notional income of only Rs.15,000/- per year would be taken as a multiplicand. In case, the victim has no income then a multiplier of 18 is the highest multiplier used under the provision of Ss. 163 A of the Motor Vehicles Act read with the Second Schedule…. Therefore, if a child, housewife or other non-working person fall victim to reckless medical treatment by wayward doctors, the maximum pecuniary damages that the unfortunate victim may collect would be only Rs.1.8 lakh. It is stated in view of the aforesaid reasons that in today's India, Hospitals, Nursing Homes and doctors make lakhs and crores of rupees on a regular basis. Under such scenario, allowing the multiplier method to be used to determine compensation in medical negligence cases would not have any deterrent effect on them for their medical negligence but in contrast, this would encourage more

incidents of medical negligence in India bringing even greater danger for the society at large."

61. The Hon'ble Supreme Court in the Kunal Sha's Case, very clearly mentioned that there were problems with using a strait-jacket formula for determining the quantum of compensation. It noted the problem in the following words:

"… this Court is skeptical about using a strait jacket multiplier method for determining the quantum of compensation in medical negligence claims. On the contrary, this Court mentions various instances where the Court chose to deviate from the standard multiplier method to avoid over-compensation and also relied upon the quantum of multiplicand to choose the appropriate multiplier … this Court requires to determine just, fair and reasonable compensation on the basis of the income that was being earned by the deceased at the time of her death and other related claims on account of death of the wife of the claimant…"

62. In the case National Insurance Co. Ltd. v. Kusuma, (2011) 13 SCC 306, 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. A Bench of Hon'ble Justices D.K. Jain and R.M. Lodha said:

"The determination of the just amount of compensation is beset with difficulties, more so when the deceased happens to be an infant/child because the future of a child is full of glorious uncertainties."

In the case of death of an infant, many imponderables had to be taken into account such as life expectancy and his prospects of earning, saving, spending and distributing. Writing the judgment, Hon'ble Mr. Justice D.K. Jain said, it was quite possible that there would be no actual pecuniary benefit derived by the parents during the lifetime of the child. But that could not be a ground for rejecting their claim of reasonable expectation of pecuniary benefit if the child had lived.

The Bench said: "The word 'just' connotes something which is equitable, fair and reasonable, conforming to rectitude and justice, and not arbitrary. It may be true that Section 168 of the Motor Vehicles Act confers a wide discretion on the [Motor Accidents Claims] Tribunal to determine the amount of compensation, but this discretion is also coupled with a duty to see that this exercise is carried out rationally and judiciously by accepted legal standards, and not whimsically and arbitrarily, a concept unknown to public law."

The Bench, however, cautioned the tribunals, saying the amount of compensation awarded was not expected to be a windfall or bonanza, nor should it be niggardly or a pittance. "Whether there exists a reasonable expectation of pecuniary benefit" was always a mixed question of fact and law, but a mere speculative possibility of benefit was not sufficient.

Conclusion:

63. The corporate hospitals and Specialists, as might be expected, must perform at a higher level than other hospitals/ general practitioners. They, after all, represent themselves as possessing highest standard facilities and care; also possess superior skills and additional training. The hospital charges and the doctor's fees normally reflect this. No doubt that the compensation in medical negligence cases has to be just and adequate, that the medical professionals need to be accountable to a certain degree.

64. No amount can be just and adequate in an absolute sense. It all depends on the circumstances and the context. There is no fixed solution. Contrary to the multiplier method,

some of the courts award lump-sum compensation, which may be punitive and exemplary in nature. By no stretch of imagination, the court should award a paltry sum for gross negligence; conversely the same is true that, exemplary compensation need not be awarded in case of slight or normal negligence.

65. To conclude, the first and foremost that the patient had pregnancy after 4 ½ years of infertility, thus it was a precious pregnancy. She was under regular observation during ANC period. Thus, the OP-3 should have taken prudent approach to deliver baby with utmost care and caution. After spontaneous rupture of membranes and administration of Syntocinon she should not have waited for more than 8 hours to take decision of C-section. The Nurses chart speaks volumes of negligent act of OP-3. The nursing notes on 11.6.1999 at 10 am, 10.30am and 11.30 am clearly establish hypertonic contractions and decreased FHS below120/min; thus it was foetal distress; which OP-3 failed to take proper decision for emergency C-section. It was act of omission, thus negligence. After going through several OBG and Paediatric text books, we are of considered view that, it was the case of excessive use of Syntocinon and delay in decision to perform C-section, which caused birth asphyxia to baby Nistha. In addition there is unflappable evidence that, the medical record of baby and mother are tampered in several places, noted interpolation, pinholes, overwriting the doses of Syntocinon. Therefore, the OP and it's nursing staff failed in a duty of care to accord the obstetric and paediatric care with the reasonable skill and diligence prevailing in the medical profession in order to the safe delivery of the baby.

66. Thus, in this instant case, the patient with precious pregnancy was unnecessarily suffered during prolonged labour; there was administration of excessive Syntocinon which caused birth asphyxia to the baby Nishtha, who further suffered Cerebral Palsy and 95% disability. She survived in such pathetic condition for 12 years. Keeping in the view that during this period certainly her parents were whole time engaged in care of Nishtha, incurred heavy expenditure for care, medical assistance, regular medication and physiotherapy etc. from several hospitals in Delhi. Also, the parents sustained distress and suffered metal agony, further embracement in the society for 12 years. They sustained a loss of their baby forever. In case of precious full term pregnancy, no prudent Obstetrician/Gynecologist will wait for more than 24 hours after rupture of membranes and allow induction by Oxytocin stimulation. Thus, the complainant had established a prima facie case of negligence against the OPs. The complainant's evidence stood uncontroverted, and that there was no cogent evidence adduced by the OP. Thus, accordingly, the complaint deserves for just and proper compensation. The higher the level of hospital had specialised facilities and specialist doctors available and also the cost of treatment will be higher, thus the level of expectation of the patient certainly will be high. Most of the hospitals either government or private sector who treat a large number of patients and must be held accountable in cases of negligence. It is very disappointing that, the sky- rocketing costs in health care spurred public and private reform. Knowing full well how the corporate hospitals now function and huge amount of fee they charge, it is very well evidenced by the currency counting machine in the cashier section of each of these hospitals.

67. Grief to parents after death of child
For all parents and grandparents, birth is a joy, a wonder and a renewal of hope. But, one of the most devastating, life-changing events for parents is finding out their child suffered cerebral

palsy. Parents often go through stages of grief similar to those they would have if they had lost the child. Caring for a child with a Cerbral Palsy can negatively impact the physical and mental health of parents and caregivers. Many parents experience significant depression, fear and anxiety, which may have a devastating effect on the whole family. These feelings are often suppressed due to embarrassment, shame or guilt. Many families suffer a financial burden when they have a child who has a birth defect due to a variety of factors. There are also other factors that impact family finances such as travelling for care, medical costs, and other healthcare-related costs such as special equipment, housing changes, and specialized childcare arrangements. In some cases, the financial burden on families gets so great that families must change residences and adjust their standard of living, which can cause stress for all involved. If the child needs regular physical, occupational, or speech therapy, this can create debilitating financial strain which can stigmatize the child who has a birth defect. Many parents live with a sense of isolation, particularly if the birth defect their child has is rare and there is little support. This can cause significant anxiety in social settings and even lead distressed parents to further isolate themselves.

68. Therefore, we are of considered view that, in this instant case due to substandard care to the patient during labour resulted poor outcome despite using modern technology of cardiography (CTG). Inability to interpret the CTG trace, i.e., poor pattern recognition, failure to correlate to the pathophysiology that causes the CTG changes, not taking into consideration the clinical situation that may suggest foetal distress and delay in taking appropriate action due to poor communication and team work were reasons for the poor outcome.

69. Before fixing the quantum of compensation we have taken in to account the sufferings of mother and also the child's sufferings for 12 years, treatment and other expenses, the metal agony and trauma to the parents who suffered loss of their baby and thereon the quantum of interest on such amount. Therefore, putting further reliance upon the judgments of Hon'ble Apex Court for award of compensation, we are of considered view to allow a lump sum award of compensation of Rs. One crore, which according to us is just and proper.

70. It has also proved that, the OPs indulged in the unethical medical practices and professional misconduct like tampering of medical records to the maximum extent. OP had not issued entire medical record to the patient. Made false submission before this commission on 27.10.2007, that "whatever record of treatment was available with hospital has already been filed and hospital is not having other records", but produced original records of child at belated stage of proceedings in this case i.e. on 20.11.2014. The conduct of OP was to mislead the commission on the pretext of one and other. It is not acceptable to us, that OP issued CTG to the patient, but it was the duty of hospital to preserve CTG tracings. Thus OP did not follow the standard of medical practice, not maintained medical records. Therefore, we further impose punitive cost of Rs.10 lacs on the OP-1.

71. In the instant, the couple after a long treatment for infertility, the patient/complainant got pregnancy, thus it was a precious pregnancy; but the parents suffered mental grief since the birth of child. The baby Nistha suffered birth asphyxia – which further resulted in cerebral palsy and survived for 12 years with multiple health problems. In addition, the parents lost a loved one after 12 years, which life's most stressful event and cause for a major emotional

crisis. After the death of someone you love, you experience bereavement, which literally means "to be deprived by death". Therefore, considering the entirety, the complainant deserves for justifiable compensation.

ORDER:

72. Considering the peculiarity of this case in which, one mother lost her precious child, whereas the child lost all its existence since birth ..!!, therefore considering the entirety and our foregoing discussion, we partly allow this Complaint and pass the following order; The opposite parties are held responsible for medical negligence in this case, we, therefore fix total compensation of Rs. One Crore; out of which OP-1, Indraprastha Apollo Hospital, will pay Rs.80 lacs and OP-3, Dr. (Mrs.) Sohini Verma will pay Rs.20 lacs to the patient/complaint within 90 days from the date of receipt of this order. The insurance company shall indemnify the respective OPs, as per law. Further, we impose Rs.10 lacs as punitive cost which OP-1 shall deposit in the Consumer Legal Aid Account, NCDRC within 90 days from the date of receipt of this order.
If the order is not compiled within 90 days, the OPs are liable to pay interest @ 9% per annum, till its realisation.

Report the compliance by 30 July 2015.

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J.M. MALIK

PRESIDING MEMBER

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DR. S.M. KANTIKAR