How to Avoid Litigations in Medical Practice

ANAESTHESIA

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Anaesthesia is second most vulnerable branch for medical litogations after Obs and Gynae. Please go through following example cases. Each case teaches us lessons.

1.It should be known that anesthetists, who participates in the process of delivery of medical services is as much liable as the main surgeon if the anaesthetist's negligence is established even if his services have not been hired directly by the patient.

Mumbai Grahak Panchayat vs Dr (Mrs) Rashmi B. Fadnavis and Others.[1996(1),CRP,137:1998(1)CPJ,49(NCDRC)],

Anesthetist also ows a duty of caretowards patient , even if there is no direct contract betweeen him and patient.

2. The husband of complainant had some injury and deformity of his right arm for which he was operated upon by Dr Rashmi Vohra. He died during the operation in OT. The complainantsalleged that amount of drugs used for anaesthesia were more than maximum and death was direct result of such use of drugs, and gave reference of book- Lee's synopsis of anaesthesia. They alleged that proper monitoring of the patient was not done. The State Commission noted that complications and death occurred in operation theatre where patients attendants have no access whatsoever and onus, therefore, lies on doctors to explain the events that happened there. In such circumstances, the only avenue open to them was post-mortem, which was not done. One does not need consent to inform police of such unexplainable death during operative procedures and establish beyond all doubt the cause of death; that the relatives declined post-mortem in writing or expressed their unwillingness is not valid excuse. The State Commission held Dr. Shailesh Desai, physician and cardiologist negligent both for acts of omission and commission. Dr Desai, in his preoperative assessment, noted BP of 150/100 mmHg and associated S- T and T wave changes in anterolateral leads of ECG. As this was not a life-saving surgery he should have advised proper investigation and treatment prior to declaring patient fit for surgery. He was, therefore, answerable for this act of omission. Incidentally Dr. Desai came to the OT only when the patient was practically dead and had no information, on which he could medically say about the death of the patient and yet he issued the death certificate for not acting on the preanesthetic report, not ensuring presence of defibrillator and failed to prove that the patient did not have "hypoxia" and "anoxia". The surgeon Dr Rashmi Vora was the master of the OT and availability of defibrillator was her look-out. Although the surgical part of the operation was not the cause of cardiac arrest, still she had to bear the responsibility of her called anesthetist and cardiologist. Since there was no proof that the patient was of Navdeep Hospital, it was only providing a nursing home with available facilities, and hence it was not held liable. The appointment of liability was held as follows Dr Rashmi Vora(surgeon) 30 percent; Dr Minaxiben (Anesthetist) 60 perecent; and Dr.Sailesh Desai (Physician-Cardiologist) 10 percent.

Aruna Ben D Kothari and Others vs Navdeep Clinic and Others.[1996(3)CPJ605 (Gujarat SCDRC)],

Iportant lessons learnt from above citedcase.

If death occur in OT than onus to prove non guilty lies on doctor not the attendant.

Always inform Police and insist on Post mortem in case of death on table, no need of attendent's consent.

Always do detailed pre-anesthetic checkup. Do not ignore the findings.

In non emergency cases do not rush unless patient is 100 % fit.

Do not operate if faciities are not adequate to handle complications.

Do not certify cause of death if you are not certain.

3. The patient went into laryngospasm during surgery. While patient's condition was still critical, the

anesthesiologist left to attend to another operation. Although he claimed that another qualified anesthesiologist was in the operating room and treating the patient at the time when he left, the surgical log book indicated and gap of several minutes and no anesthesiologist was present during that time. The patient later developed cardiac arrest. The court found the first anesthesiologist negligent in treatement and guilty of abandonment for failing to remain with a patient who was in such obvious difficulties .*Ascher vs Gutirrea,553F 2d,1235,DC CA 1976,*

Do not leave your patient till surgery is over and patient has recovered to your satisfaction. Notes during and after surgery should be meticulous. Handover the patient to qualifiedand competent person only.

4. Patient was being taken up for appendicectomy but when surgeon found it normal proceeded to remove gallbladder, in the process patient was administered chloroform for more than two hours. Patient had compromised kidney functions. It was held that with regard to the anaesthetic, the person ultimately responsible for its correctness would be the person administering it. It is impossible for the surgeon to direct and supervise its administration. Merely because a surgeon insists upon a particular anaesthetic procedure, it would not exonerate the anesthetist. Both were held llaible.

It's the anaesthetist's responsibilty to decide which anesthesia is to used and to see that the patient was safeguarded until he/she returned to consciousness. Surgeon was held liable for doing job more than what the patient consented for.

5. In another case, doctors were prosecuted for offence under 304-A, IPC in criminal law and also for civil liability. It was alleged that "patient died for acute respiratory failure, asequel to spinal anaesthesia. Anesthetist failed to assess during preoperative anesthesia as to whether patient would withstand 3 ml heavy bupivacaine given through spinal route to patient, an accident victim, suffering from multiple road traffic injuries, including head injury." Court held only the anesthetist may be held criminally liable, not the doctors who performed operation as there was no proximate nexus between death and negligent act of the surgeons. "However, all of them may be proceeded against for damages by invoking civil law on the basis of negligence attributed to them in handling the patient who died on the operation theatre. The death of the person on the operation table by itself is not sufficient to prove negligence against the doctor. The criminality lies in running the risk of doing such an act with reckless and Indifference to the consequences. The opinion given by the doctors is that the death was due to acute respiratory failure issequel to spinal anaesthesia administration. So, the cause of death is directly attributed to the act of anaesthetist. The part played by Dr Parthasarathy, anesthetist by having failed to check- up during the preoperative anaesthesia check as to whether the patient would with stand 3 ml local anaesthesia drug,especially, when he had sustained injuries both on the head and leg, may amount to criminal negligence which would warrant only anesthetist to face the proceeding under section 304A Indian Panel Code. But, such a criminal negligence cannot be attributed to the petitioner surgeons, though it is stated by the prosecution that both the surgeon doctors, who were responsible for the medical treatment of the patient, who had allegedly not check whether all the medical check-up formalities including preoperative anaesthesia test well properly performed by anaesthetist before operation." The anesthetist and the operating doctors were also held liable for damages under civil law for their negligence, which lead to death of the patient-*Dr Lakshmanan Prakash vs State, 2001ACJ 1204 (Mad.-HC).*

Again issue of meticulous pre-anaesthetic checkup and adjusting the doses according to the condition of the patient. Surgeon should also see that protocol is strictly adhered to.

6. In a case of tubectomy,it was alleged that anesthetist and other Hospital staff were negligent and also government hospital was vicariously liable. In this case, plaintiff (patient) lost her consciousness after the operation.The defendants could have produced records to show the condition of the patient before operation, whether the patient was medically fit to undergo operation. Court alleged that " if some records had been produced regarding this aspect, probably, there would have been some justification in the case of the defendants (doctor ,staff and Hospital)." The court below adopted the principle of res ipsa loquitur. The Government constituted a medical board. The board examined the case and found that Smt Rohoni had a cardiac arrest following the operation. It was also pointed out that"this was an unforeseen accident which unfortunately happened on the table by which she sustained on irreparable brain damage as a result of brain anoxia. Thus, it was admitted that the brain anoxia occurred during the time of

operation. No doubt, the defendants (doctors, staff and Hospital) put it as an unforeseen accident. Thus,it is a case where if proper care had been taken, damage to the brain could have been avoided." Weather proper care had been taken was not proved. Hence, the court below was correct in holding that there was negligence on the part of dependents. Compensation of Rs 3.8 Lacs under different heads awarded against the government hospital, anaesthesiologistand other staff . *Dr MK Gourikutty and, etc. vs MK Madhavan and Ors. [AIR2001 (Ker.-HC) (DH)398].*

As I say repeatedly, documentation can be your best friend as well as worst enemy. Document everything. We spend hours in process of surgery and fail to spend even few minutes in putting proper notes.

7. In an opertaion for removal of stone from urethra under spinal anesthesia postoperatively patient had paralysis of left-side of body and ridiculities. It was held that radiculitis is an infrequent complication arising in one percent cases of spinal anesthesia which does not amount to negligence. Court held that " what was done by the anesthestist was as per accepted medical procedure and settled position on the subject. In such circumstance, he cannot be held guilty of any negligence especially when all over the world it is an accepted procedure having less than one percent of spinal anesthesia and suffered radiculities a known but infrequent complication. *" Charan Singh vs Healing Touch Hospital and others. [2003 (2) CRP 95:2003 (3) CPJ 62:2003 (6) CLD 46 (NCDRC)].*

Do not be scared of known complcations. Only thing is you should be well prepared to handle them.

8. In one case, petitioner doctor performed tonsillectomy operation on a thirty year-old patient at his nursing home after administering him local anesthesia himself and did not call an anesthetist. Patient then developed laryngospasm or bronchospasm and oxygen was not arranged within time. Patient dies during transportation. State Commission dismissed the petitioner's appeal against the order passed by the district forum applying the principle of res ipsa loquitor and held doctor negligent. The doctor made a revision petition to national commission which was also dismissed.

Dr G Vivekananda vs Chintha Bharamaramba and others [NCDRC) CTJ 2007 p.4O7].

As a surgeon do not cross limit of your expertise. Do call anesthetist whenever required. Have all facilities ready to manage anesthesia comlications.

In several cases, surgeons and anesthesiologists have been held negligent and liable for proceeding with non-emergency , elective surgery in which inhalation anesthesia was used when the patient had a contraindications for same. Such cases have resulted in death or cardiac arrest. Since many symptoms are usually obvious from casual observation of the patient, courts usually find the performance of the surgery was negligent.

(Quintal vs Laurel Grove Hospital, 397 P2d 161,Cal 1964; Butler vs Layton, 164 NE 920, Mass 1929; Jackson vs Mountain Sanitarium, 67 SE 2d 57, NC 1951).

In a case, patient suffered cardiac arrest whilst under anesthesia. The court held that a fit heart does not stop under anesthesia without negligence. Res ipsa loquitur was applied. There was no need for the patient to show the cause of cardiac arrest as the doctor had offered no explanation to prove that the cardiac arrest was not due to his negligence." *(Saunders vs Leeds Western HA, (1993)4 MedLR 355: (1994) CLY 2320).*

Proper preanesthesia check and informed consent should be taken in each case.

American Sociery of Anesthesiologists (ASA) risk stratification should be done and emergency cases must be marked accordingly.

Anesthetic technique chosen for the case, must be in accordance with the standard anesthesia practice world wide. While administering other techniques, the reasons for it must be clearly stated in the notes.

The statistical risk of anesthestic procedure, drugs, blood, blood product transfusion, postoperative ventilatory support and recovery must be clearly explained to patient and relatives.

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Ps. soon will start articles on medico-legal cases pertaining to various specialties. If you have any query related to your specialty please mail it to dr.arun.medicolegal@gmail.com or WhatsApp 9811106056