Madhya Pradesh High Court
Ram Bihari Lal vs Dr. J.N. Shrivastava on 14 December, 1984
Author: C Sen
Bench: C Sen, S Awasthy
JUDGMENT C.P. Sen, J.

1. This is an appeal by the plaintiffs under Clause 10 of the Letters Patent against the judgment and decree of the single Bench of this Court dismissing their claim by reversing the judgment and decree of the trial court for damages against the defendant for his rash and negligent act in causing death of deceased Kantidevi, by removing her gall bladder during operations.

2. At the relevant time in the year 1958 plaintiff No. 1 Ram Bihari Lal was Collector, Shahdol and was aged about 40 years. His wife deceased Kantidevi was aged 32 years. She had given delivery of 7th child 41/2 months prior to her death. Plaintiffs 2 to 8 were minors at that time. Defendant Dr. J. N. Shrivastava was posted as Civil Assistant Surgeon Grade-1 and was in-charge of the Sohagpur Government Hospital at Shahdol. It was 28 bedded hospital. Although Shahdol was the district headquarters, district hospital was at Umaria and Dr. L. K. Mishta (P. W. 7) was the District Medical Officer. On the night intervening 27th & 28th September 1958 deceased Kantidevi got abdominal pain and the defendant was called to the Collector's bungalow at about 1 a.m. He gave her Streptopenicilin injection and tablet of Largactyl as she was also having some temperature. This treatment continued till the morning of 30-9-1958 when the defendant advised the plaintiff No. 1 that his wife was to be operated for appendicitis because according to him she was not responding to the treatment Her blood test for differential blood count was taken by-Dr. A. K. Dutta(D. W. 1). After some hesitation, the plaintiff No. 1 and his wife agreed for the operation and she was taken to the hospital at Sohagpur. The plaintiff No. 1 contacted D. M. O., Dr. Mishra on phone but he advised against the operation. However, they were persuaded by the defendant to get the deceased operated for appendicitis. The operation was started at about 2 p.m. by the defendant and he was assisted by Dr. A. K. Dutta and Dr. Mrs. Janki (PW. 8) who were also posted in that hospital as Assistant Surgeons and it was completed at 4 p.m. The deceased was put under chloroform anaesthesia. Before the operation, consent of the plaintiff No. 1 was taken for the operation of appendicitis. The defendant made a grid iron incision but found that the appendix was not at all inflammed. He, therefore, made another Kocher's incision and then removed the gall bladder as he found it to be blackish with stones. When the operation was going on, besides the plaintiff No. 1, D. F. O. G. P. Nigam (P. W. 5) Kripashanker (P. W. 9), Satish Chandra Sinha (P. W. 10), nephews of the plaintiff No. 1, peon Vasist (P. W. 11), Principal Suryabali Singh (P. W. 13) and Rajendra Bahadur Singh (Lalji) (D. W. 8) were waiting outside in the verandah but no consent of the plaintiff No. 1 was taken for removal of the gall bladder.

After the operation was over, the defendant came out and disclosed that he had remvoed the gall bladder and the operation has been successful. The deceased gained consciousness in the evening but sometime in the night her condition started deteriorating. On the morning of 1-10-1958 Dr. L. K. Mishra reached Shahdol and attended on the deceased. In the evening Dr. K. Y. Shrikhande (P. W. 3) Surgical Specialist accompanied by Dr. J. P. Tiwari Pathologist, (P. W. 6), Technician S. M. Goswami (P. W. 4) all from Gandhi Memorial Hospital, Rewa, and one Dr. Ramkumarsingh rushed

to Shahdol. However, her condition further deteriorated. On the morning of 2-10-1958 Dr. Shrikhande noticed icteroid tinge in the conjunctiva of the deceased and he got her urine examined by Goswami. The examination revealed granular casts with sugar traces, albumin. It was found that there was extensive damage to the kidneys of the deceased and the liver was also damaged from the development of jaundice. Dr. Mrs. Ganpathy (P. W. 2), Medical Specialist of the Gandhi Memorial Hospital, Rewa was consulted on phone. Dr. Shrikhande returned to Rewa and sent Dr. Mrs. Ganpathy in the night to attend on the deceased. Despite the treatment given, the deceased expired at 2.20 a.m. on 3-10-1958. Dr. Shrikhande was directed by the Director of Health Services to enquire into the cause of death and he, after necessary enquiry, opined that the death was due to overwhelming toximia consequent upon progressive hepato-renal failure which developed after the operation done under prolonged chloroform anaesthesia which led finally to peripheral circulatory collapse as was seen from the progressive fall in blood pressure, rapid thready pluse and high temperature. The prolonged chloroform anaesthesia on an inadequately prepared patient was probably responsible for the development of hepato-renal failure according to Dr. Shrikhande, The plaintiff No. 1 made a complaint about the treatment given by the defendant to the higher authorities and finally served a notice under Section 80, C.P.C. on 31-8-1959 and then filed the present suit claiming damages of Rs. 11,000/- due to the death of his wife because of rash and negligent operation conducted by the defendant. Rs. 5000/- was claimed for the loss of service of the deceased, and Rs. 6000/- for the loss of the estate of the deceased (Rs. 1,000/- being the compensation for pains and suffering of the deceased and Rs. 5000/- being the compensation for loss of expectation of life of the deceased).

3. The plaintiffs case is that on the night intervening 27/28 September 1958 the deceased felt abdominal pain and the defendant was called to attend on her at about 1 a.m. on 28-9-1958. She remained under his treatment till her death on 3-10-1958 in the Sohagpur hospital. On 29-9-1958 the pain subsided and the plaintiff No. 1 went on tour and came back in the night but on 30-9-1958 the defendant prevailed upon the plaintiff No. 1 and the deceased that the pain was due to inflammed appendix and needed immediate operation though they were not prepared for such a major operation being undertaken at Sohagpur without having medical facilities. After taking the blood test, the defendant confirmed his diagnosis of appendicitis and represented that any further delay in operation would endanger her life. No further examination or confirmatory tests were done. Accordingly, the plaintiff No. 1 and his wife agreed for the operation. The plaintiff No. 1 then contacted the District Medical Officer Dr. Mishra on phone and he opined, that the pain and temperature having subsided appreciably, it was not a case for operation as 48 hours have already passed. This was conveyed to the defendant who was requested not to insist upon the operation but he did not agree saying that he has already given 2 such injections and there was no alternativa for the operation. Therefore, they were prevailed upon for the operation. During operation, the appendix was found not enlarged and the defendant's diagnosis was wholly wrong. However, the defendant made further guess work and made a second incision and removed the gall bladder without obtaining the plaintiff No. 1's consent for the second operation. The operation took 2 hours and the deceased was , kept under chloroform. After the operation was over, the defendant misrepresented that it was a success and there was no cause for anxiety. It was subsequently found that there was no trouble with the gall bladder and the defendant intermeddled with the same unnecessarily as a result of his guess work. The hospital was ill-equipped for any emergency

treatment or for any major operation. Oxygen Cylinders were empty and there was no arrangement for blood transfusion, blood bank was empty and there was no facility for blood grouping and matching, saline apparatus was defective. The only anaesthesia available was the outdated chloroform. The Anaesthetist attached to the hospital was absent. Administration of chloroform was done by Dr. Mrs. Janki who was not a trained Anaesthetist. Nursing arrangements were wholly inadequate and the deceased was left in the charge of an untrained midwife. Without making any preoperative preparation for such a major operation, the defendant removed the gall bladder which was not shown to the ptainliff No. 1 or to anyone thereafter. Urine examination was the prerequisite for every such major operation which was not done. A team of doctors came from Rewa and examined the deceased but the defendant did not follow the line of treatment suggested by them. The shock received by the deceased due to operation further damaged the kidneys and the liver by the administration of chloroform resulting in hepato-renal, failure and ultimately her death on 3-10-1958 at 2.30 a.m. The death was the direct result of the defendant's rash and negligent act, want of skill and careless handling of the case.

4. The defendant in his written statement admitted that he attended on the deceased on the night of 27/28 September 1958 till 1-10-1958. As she was not responding to the treatment given and the abdominal pain got localised in the right iliac-fossa and the temperature was rising, he diagnosed inflammed appendix and advised operation in good faith and for the benefit of the patient. The defendant would not have operated if there was any objection raised by the plaintiff No. 1 or the deceased. He was not told that D. M. O. Dr. Mishra has adviced against the operation. The blood test further confirmed this diagnosis of appendicitis as there was 84% Polymarphonucleous confirming acute inflammation and the operation was advisable. The defendant possessed necessary knowledge, skill and experience for carrying out the operation having spent about 9 years in England in different hospitals and that is the reason why the plaintiff No. I and his wife wanted to get operated by the defendant. It is denied that there was any suggestion for any further examination or confirmatory tests. The defendant neither gave any two such injections which made the operation imperative nor he forced the operation on the deceased, wife of plaintiff No. 1. There was no misrepresentation on his part. On opening the abdomen, the appendix was found nol inflammed but on further probing it was found that the gall bladder fundus extended up to right iliac-fossa which was unusua! as the gall bladder is situated high up. Fundus was black and full of stones. It was therefore considered necessary to give second incision and remove the gall bladder which was successfully done. Consent of the patient could not be taken as she was under chloroform and the consent of the plaintiff No. 1 was implied having already given his consent for the operation of appendicitis. As a good and efficient Surgeon, the duty of the defendant lay in removing the malady rather than running down to plaintiff No. 1 for consulation. The gall bladder after it was taken out was shown to the plaintiff No. 1 and others present in the verandah. The plaintiff No. 1 expressed his gratitude to the defendant for the successfull operation. The deceased regained consciousness at about 5 p.m. and there was no complication. The hospital was equipped like any other Government hospital and this fact was known to the plaintiff No. 1 who was the Collector There were necessary equipments for emergency treatment or for any major operation. In case Oxygen was required, the same could be promptly arranged. It is denied that Chloroform was not in vogue. In fact, it was prevalent in all the Government hospitals in the country and it is widely used as an anaesthetic. There was no Anaeasthetist attached to the hospital; usually a compounder used

to administer the same. Dr. Mrs. Janki was fully trained to administer chloroform, being a qualified doctor. Two trained nurses attended on the deceased. Necessary medicines were available locally. The defendant fully co-operated with the team of doctors who came from Rewa to attend on the deceased. In fact, from 1-10-58 he was kept out from attending on the deceased as per verbal order of the D. M. O. and thereafter he did not attend on her. The gall bladder was also shown to the D. M. O. and also to the other doctors. No urine test could be done as no urine could be got even after Catherisation. There was no reason to suspect any damage to the kidneys prior to the operation as the deceased was his patient and he knew about her past history and general condition. The defendant's both the diagnoses were correct and there was no trouble with the kidneys. The deceased was thereafter treated by several doctors including a Vaidya and a Homeopath. The room was kept crowded and Mantras were being chanted and the patient was psychologically prepared to meet her death. She got no respite which was essential for her recovery. It is denied that the deceased's kidneys were damaged due to shock. After the operation the condition of the patient was good and satisfactory. She died due to want of rest, mishandling, mental upset due to panic created by the D. M. O. who bears ill-will against the defendant. She did not die due to renal failure on account of administration of Chloroform. Her death was not due to any rash or negligent act on the part of the defendant. He handled the deceased with due care and caution and he is not liable to pay any damages.

5. The learned District Judge held that the deceased remained under the treatment of the defendant till her death on 3-10-1958. The defendant told that the blood test confirmed his diagnosis of appendicitis and any further delay would endanger her life. The D. M. O. was contacted on phone who opined against the operation but the defendant did not accept the advice. The pain of the deceased subsided appreciably on 29-9-1958 and she considerably improved on the morning of 30-9-1958. So the plaintiff No. 1, the deceased and the other friends and relations tried to persuade the defendant not to insist upon the operation but he paid no heed and prevailed upon them to get her operated. The diagnosis of appendicitis was not correct. There was no implied consent to the second operation for removal of gall bladder although the plaintiff No. 1 was waiting outside. The Hospital was ill-equipped for major operation and the defendnat did not take proper precautions prior to the operation. It is not proved that the defendant did not follow the course of treatment suggested by the Rewa team of doctors. It was necessary for the defendant to take the consent of the plaintiff No. 1 before removing the gall bladder. It is not proved that the gall bladder was not shown to the plaintiff No. 1 or to other doctors. The room of the deceased was not crowded. The -shock received by the deceased due to operation further damaged the kidneys and the liver as a result of administration of chloroform in renal failure and ending her life. Urine examination of the patient was a must before a major operation and it was not a case of emergency. It is not proved that there was puss formation or the gall bladder was gangrenous as the colour was red, and not black as alleged but there stones in the gall bladder. Therefore, the death of the deceased was due to rash and negligent act of the defendant and he is liable to pay the damages. The plaintiffs are only entitled to Rs. 3000/-for the loss of service and Rs. 1000/- for pain and suffering,

6. Aggrieved by the judgment and decree, the defendant preferred First Appeal in this Court. The learned single Judge held that the deceased was not responding to the treatment of the defendant and the symptoms found by the defendant confirmed his tenatative diagnosis that it was a case of

appendicitis. The plaintiff No. 1 and the deceased were at first hesitant for the operation but they were prevailed upon to get her operated as it was a case of emergency. She was prepared for the operation after preliminary tests were done. Pain persisted and got gradually localised in the right iliac-fossa and the temperature rose to 99.4 and the blood count showed 84% Polymarphonucleous. After grid iron incision was done, the appendix was found normal but the defendant found the gall bladder fundus had descended up to the appendicular region. It was of abnormal size and so second incision was done by Kocher's incision and the gall bladder was removed. The defendant was assisted by the two other doctors Dr. Dutta and Dr. Mrs. Janki. The deceased was a healthly woman and the defendant knew her past history. The anaesthesia had no adverse effect during the course of the operation. She regained consciousness at about 5 p.m. and the progress was satisfactory till the afternoon of 1-10-58. Thereafter her condition began to deteriorate. A team of doctors came from Rewa and there was joint consultation. Urine test revealed granular cast with sugar traces and albumin. Dr. Shrikhande also noticed icteric tinge in the conjunctiva. That indicated extensive damage to the kidneys. Quoting Lord Denning in Roe v. Minister of Health (1954) 2 QB 66 : (1954) 2 All ER 131 that we would be doing a disservice to the community at large if we were to impose liability on hospitals and doctors for everything that happens to go wrong. Doctors would be led to think more of their own safety than of the good of their patients. Initiative would be stifled and confidence shaken. Medical science has conferred great benefits on mankind, but those benefits are attended by considerable risk. He further quoted Lord Denning in Hatcher v. Black and others (The Times. 2nd July 1954) that every surgical operation involves risks. It would be wrong and indeed bad law to say that simply because a misadventure or mishap occurred, the hospital and the doctors are thereby liable. It would be disastrous to the community if it were so. It would mean that a doctor examining a patient, or a surgeon operating at a table, instead of getting on with his work, would be for ever looking over his shoulder to see if someone was coming up with a dagger for an action for negligence against the doctor. The learned District Judge did not hear in mind the difference in approach on the question of negligence relating to motor car accident and the negligence against doctors because an accident on road can be averted if everyone uses proper care but when a person who goes for treatment in a hospital there is always some risk, by referring to the aforesaid case. Mistaken diagnosis is not necessarily a negligent diagnosis. No human being is infallible. A practitioner can only be held liable if his diagnosis is so palpably wrong as to prove negligence. In the present case, the clinical symptoms present could be mistaken or appendicitis. There is absolutely no negligence in the diagnosis. It was not imperative to obtain the husband's consent when the operation was being performed on a lady who was sui juris. The gall bladder was gangrenous and its immediate removal was necessary otherwise her life was in danger. She was a yound lady with good nutrition, without any anaemia or jaundice with normal blood pressure, her pulse having normal volume and tension with no history of diabetes or nephritis. Therefore, she could very well sustain the operation. Relying on Challand v. Bell, 1954 (18) DLR 2-D 150 it was held that the general practitioner should not be criticised just because experts disagree. No fault has been found with the surgery performed by the defendant. The deceased gall bladder has been preserved in a jar and has been produced in Court and it has not been shown that it was normal and contained no stones. It was in a highly pathological condition which could not be doubted. In order to save her life, the defendant felt that Cholecystectomy was immenent. Therefore, no neglignece can be attributed to the surgeon. If the chloroform had any adverse effect for reason of personal idiosyncrasy of the patient which could not be anticipated and which the clinical tests performed

before the operation did not forewarn, that will not amount to negligence. It was Dr. Mrs. Janki who was responsible if there was any fault in giving the anaesthesia. The condition of the deceased remained good throughout the operation. Since the surgeon did not anticipate the deceased gall bladder, so the pre-operative preparations were made for appendictomy. It cannot be definitely said that it was the chloroform which was responsible for hepatorenal failure. That was only a probability since no post-mortem was done. The operation was performed in 1958 when chloroform was probably in vogue. We should not judge the matter with 1980 glasses.

As no urine could be obtained, so no urine test was carried out. The urine test carried on 2-10-1958 would not necessarily indicate chronic urine disease from before the operation. Some kind of toxemia, especially by bacterial toxins transported through the blood stream from a focus of infection, could readily damage the kidney. Moreover, the report of the Technician cannot be relied upon. The hospital being a Government hospital, it was difficult to say that it was kept ill-equipped. All that could possibly be done was done for the patient. The deceased died 3 days after the operation not because the offending organ was not successfully removed but because the lady could not withstand the trauma of surgery or because of some type of toxemia developed. The surgeon had followed a recognised practice and had shown reasonable carefulness and skill in the performance of the operation. He could not, therefore, be made liable in damages for negligence. Relying on Marshall v. Curry (1933) 3 DLR 260 it was held that as it was a case of emergency, the question of taking consent for the second operation was not very relevant.

7. Shri D. N. Pathak learned counsel for the appellant contended that the learned single Judge has reversed the findings of the learned District Judge without discussing the evidence and on the basis of certain set notions and established principles by assuming certain fact*. He has relied on certain decisions which have no relevance to the facts of the present case and are clearly distinguishable. The learned single Judge without reversing the finding of the District Judge that the case-sheet was tempered with held that he has no reason to believe that the same has been fabricated or manipulated. Not only there are alterations and manipulations in the case-sheet but the case-sheet was actually prepared on 2-10-1958 in order to assist Dr. Mrs. Ganpathy who was coming from Rewa to see the patient. In the case-sheet originally it was mentioned to be a case of chronic appendicitis, then as acute chronic appendicitis and then as chronic Cholecystitis. Although the deceased was under the treatment of the respondent right from the night of 28-9-58 till 30-9-58 when she was operated, the respondent was negligent in not carrying out the necessary tests before the operation. If he had taken urine test, total blood count and X-ray, it would have been disclosed that the kidney of the deceased was affected and that it was not a case of appendicitis though other symptoms for the two diseases may be common. Presence of Murphy's sign was a sure indication of affected gall bladder. The deceased was under starvation for 3 days and no adequate preparation was made for carrying out any major operation. The hospital was ill-equipped, trained anaesthetist was not available, there was no oxygen, blood transfusion was not available, nor blood matching was possible. Even the operation theatre was under repairs and in spite of all these facts the respondent rashly and negligently proceeded with the operation. The deceased was respoding to the treatment and since 48 hours had passed, there was no case for operation of the appendix. This was so adviced by the D.M.O. but the respondent paid no heed and proceeded with the operation. He created a situation when the plaintiff No. 1 and the patient had no option but to agree for the operation. No

preventive steps were taken before administering chloroform which anaesthesia had long been discarded. Anesthesia was given to the deceased by inducting Ethyl Chloride and then sustaining by chloroform for two hours. If due care was taken by the respondent, operation for apendicitis could have been. avoided and the respondent could have proceeded with the operation of the gall bladder immediately and the patient would not have been required to remain under chloroform for such a long time. The hazards of chloroform were not explained to the appellant No. 1 nor any fresh consent was taken for the second operation for removing gall bladder. The appellant No, 1 was waiting outside in the verandah and there was a team of doctors and other persons attending the patient and the respondent should have taken his consent before removing the gall bladder even if the consent of the patient was not possible because she was under chloroform. The respondent ought to have kept the patient under Glucose and given vitamin B complex and vitamin K to counteract delerious effects of the chloroform. Nothing was done. In great haste and without ascertaining the true nature of the ailment the respondent removed the gall bladder. Even if there were stones in the gall bladder, that was not a case for emergent operation. In fact, in the written statement the respondent has not pleaded that it was a case of emergency but the case has been improved and in evidence it has been iniroduced that it was a case of emergency. The learned single Judge accepted the bare statement of the respondent that the gall bladder was a pathological case and of enormous size. He also assumed that the gall bladder which has been produced is the gall bladder of the deceased. Firstly, her gall bladder was not sealed nor marked nor shown to the visiting doctors immediately after the operation. It was only when the respondent handed over charge on his transfer that he handed over the gall bladder which has been produced in Court. Even his own expert witnesses have not stated that this gall bladder is gangrenous or there is puss formation. The learned Judge wrongly held that the chloroform anaesthsia has no adverse effect during the course of the operation without considering that it starts reacting much after the operation and the condition of the deceased started deteriorating right from the night of the operation. The urine test and the detection of icteroid tinge in the conjunctiva by Dr. Shrikhande confirmed that there was extensive damage to the kidneys and liver. The learned Judge erred in holding that this was not a case of negligence but of mistaken diagnosis and there was only misadventure. He also did not consider the findings of the District Judge by observing that the trial Judge did not bear in mind the difference in approach on the question of negligence relating to motor car accident and negligence by a driver. It is true that some kind of risk is always involved in a surgical operation and the result may be otherwise than for which it was intended but still much greater care and caution is required of the doctor carrying out the operation. The learned Judge also assumed that it was a case of emergency and so it was not necessary to make preparation for the operation of Cholecystitis when she was already prepared for the operation of appendicitis. The learned Judge has wrongly placed the blame on Dr. Mrs. Janki for administering chloroform when it was at the instance of the respondent and he being the operating surgeon, he cannot escape his responsibility for administration of anaesthesia during the operation. Even in case of gall bladder, operation is not a must and medicinal treatment should have been pursued. Even if there has to be an operation, he should have first tried to drain out the gall bladder stone instead of straightway removing the gall bladder. The learned Judge has made out a new case for the respondent by saying that the death was induced by trauma of surgery and not due to administration of chloroform which may not be the real cause for hepato-renal failure. The learned Judge also wrongly observed that it is difficult to say that the Government hospital was not well-equipped and all that could possibly be

done was done for the patient. He also wrongly opined that it was inadvisable to pass an arm chair judgment particularly when thesurgeon required a quick decision. Therefore, the findings are contrary to evidence on record and are liable to be set aside and those of the trial Judge restored.

8. Shri T. C. Naik learned counsel for the respondent submitted that the respondent possessed necessary knowledge, skill and experience in carrying out the operation. He did not force the appellant No. 1 or his wife for the operation. In fact, the pleaded case of the appellants that the respondent gave two such injections which made the operation imperative has been found to be false even by the District Judge. It was of their own volition and due to their confidence in him that they wanted the respondent to operate the deceased. All necessary tests were carried out and it confirmed the diagnosis of appendicitis and so he proceeded with the operation. When the incision was made, then it was detected that the appendix was normal but the gall bladder was a pathological case and required immediate removal. It being an emergent case, he could not have left the operation table for taking the consent of the appellant No. 1 who was waiting outside. Chloroform is mainly the anaesthesia which is supplied to the Government hospitals and a large number of operations are carried out under Chloroform without any side-effects. The deceased was a healthy lady and the respondent was their personal physician and fully knew the history of the patient. Her urine test was taken about 41/2 months back and fresh urine test was not necessary. Total blood-count was also not necessary as differential blood-count was taken which indicated inflammation in the body of the deceased. The gall bladder has been produced in the Court but the appellants had no courage to get it opened in order to show that it is not a pathological case. The experts examined by the appellants have avoided to opine about this gall bladder. If the operation was not carried out immediately, the life of the patient would have been in danger. The team of doctors who came from Rewa unnecessarily interelered with the treatment and kept the respondent out of consultation and so he cannot be held responsible for the complications. The gall bladder was taken out and shown to the other persons who were present there and they could feel the presence of gall bladder stones inside. There are two schools of opinion about the line of treatment for appendicitis or Cholecystitis, one is in favour of waiting treatment i.e. medicinal while the other prefers surgery immediately. The respondent followed the latter treatment. The appellant No. 1 being the Collector was a highly influential person and he made Dr. Mrs. Janki speak against him. The learned single Judge has considered all relevant evidence and has given his findings after considering the same. It was not necessary to consider other irrelevant evidence. There is no case for interference with the findings given by the learned single Judge.

9. First of all we have to see what are the liabilities of medical practitioners for neglignece and what duties they own to patients. In Halsbury's Laws of England, Fourth Edition, volume 30 in paragraphs 34 & 35 it has been mentioned that a person who holds himself out as ready to give medical advice or treatment impliedly undertakes that he is possessed of skill and knowledge for the purpose. Whether or not he is a registered medical practitioner, such a person who is consulted by a patient owes him certain duties, namely a duty of care in deciding whether to undertake the case; a duty of care in deciding what treatment to give, a duty of care in his administration of that treatment and a duty of care in answering a question put to him by a patient in circumstances in which he knows that the patient intends to rely on his answer. A breach of any of these duties will support an action for neglignece by the patient. The practitioner must bring to his task a reasonable degree of

skill and knowledge, and must exercise a reasonable degree of care. Neither the very highest nor a very low degree of care and competence, judged in the tight of the particular circumstances of each case, iswhat the law requires, and a person is not liable in negligence because someone else of greater skill and knowledge would have prescribed different treatment or operated in a different way nor is he guilty of neglignece if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art, even though a body of adverse opinion also existed among medical men. Deviation from normal practice is not necessarily evidence of neglignece. To establish liablity on that basis it must be shown (1) that there is a usual and normal practice;

(2) that the defendant has not adopted it; and (3) that the course in fact adotped is one no professional man of ordinary skill would have taken had he been acting with ordinary care. It is a defence to a practitioner that he acted on the specific instructions of a consultant who had taken over responsiblity for the case. Failure to use due skill in diagnosis with the result that wrong treatment is given is negligence. The Supreme Court relying on this commentary in Laxman v. Trimbak, AIR 1969 SC 128 has held as under :-

"The duties which a doctor owes to his patient are clear. A person who holds himself out ready to give medical advice and treatment impliedly undertakes that he is possessed of skill and knowledge for the purpose. Such a person when consulted by a patient owes him certain duties, viz,, a duty of care in deciding whether to undertake the case, a duty of care in deciding what treatment to give or a duty of care in the administration of that treatment. A breach of any of those duties gives a right of action for negligence to the patient. The practitioner must bring to his task a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. Neither the very highest nor a very low degree of care and competence judged in the light of the particular circumstances of each case is what the law requires; The doctor no doubt has a discretion in choosing treatment which he proposes to give to the patient and such discretion is relatively ampler in cases of emergency.

Held, High Court was right in its conclusions that death of patient was due to shock resulting from reduction of the fracture attempted by the doctor without taking the elementary caution of giving anaesthetic to the patient and that he was guilty of negligence and wrongful acts towards his patient and was liable for damages."

Lord Denning M. R. in Hucks v. Cole (1968) 118 New LJ 469 said "A charge of professional negligence against a medical man was serious. It stood on a different footing to a charge of negligence against the driver of a motor car. The consequences were far more serious. It affected his professional status and reputatioa The burden of proof was correspondingly greater. As the charge was so grave, so should the proof be clear. With the best will in the world, things sometimes went amiss in surgical operations or medical treatment. A doctor was not to be held negligent simply because something went wrong. He was not liable for mischance or misadventure; or for an error of judgment. He was not liable for taking one choice out of two or for favouring one school rather than another. He was only liable when he fell below the standard of a reasonably competent practitioner in his field so much so that his conduct might be deserving of censure or inexcusable.

10. In Encyclopaedia Britannica, 1970 Edition, IInd volume at page 135 Appendicitis is the inflammation of the vermiform appendix, which is a vestigial worm like structure attached to the caecum. The caecum is the pouchlike beginning of the large intestine; into the caecum empties the small intestine. The appendix does not serve any useful purpose as a digestive organ in man. It is essentially a "blind alley" kind of organ with a channel that is two inches or more in length, closed at one end and communicating at the other with the caecum. Intestinal contents may work their way into the appendix and then be expelled by the muscular activity (peristalsis) of the walls of the appendix. Any factors that prevent the appendix from propelling its contents into the caecum may lead to appendicitis, as pointed out by O.H. Wangensteen. Intestinal material in the appendix may be prevented from escaping into the caecum by a failure of peristalsis or by a blocking of the opening into the caecum. The blocking can be caused by faecal concretions (fecaliths), undigested food particles such as seeds or by swelling of the lining of the appendix. When the appendix is prevented from emptying itself a chain of events develops. Increasing pressure within the appendix leads to edema, swelling and distention of the appendix; the swelling is further increased by mucoid secretions from the lining of the appendix. As the distention increases the blood vessels of the appendix may become closed off, leading to gangrene. Meanwhile, the bacteria normally found in this part of the intestine (colon bacillus especially) proceed to propagate in this closed-off pocket. The combination of increasing tension from within and weakeningof the wall by gangrene may lead to a rupture or perforation of the appendix. If this intestinal pus pocket spills into the peritoneal cavity, peritonitis, a very serious and often fatal condition, develops. Fortunately, peritonitis is usually prevented by the protective mechanisms of the body. The omentum, a sheet of fatty tissue, often wraps itself bout the inflammed appendix. Exudate that has the clot-forming properties of fibrin normally develops in the areas of inflammation, behaving like paste or glue and sealing off the appendix from the surrounding peritoneal cavity with the help of the omentum. This prevents, in many instances, the direct spread of pus or intestinal contents into the peritoneal cavity. By this localizing process a ruptured appendix may lead to an abscess instead of a generalized peritonitis.

Occurrence and symptoms.-- Appendicitis is most common in the second and third decade of life but may occur in the very young or old. Males are afflicted in somewhat greater numbers than famales. The symptoms of appendicitis are varied. In the so-called typical case the pain may first be noticed all over the abdomen, or only in the upper abdomen, or about the navel. It is often described as a "gas pain". It is usually not as severe as the excruciating colic of gall bladder or kidney stones. After one to six hours or more the pain may become localized to the right lower abdomen. Nausea and vomiting may develop some time after the onset of the pain. Fever is usually present but is seldom high in the early phase of the disease. The leucocytes (white blood cells) are usually increased from a normal count of 5,000-10,000 in an adult to 12,000-20,000. Tenderness develops in the right lower abdomen, and the sudden release of pressure of the palpating hand may cause pain (rebound tenderness), Diagnosis.-- When there is some variation in the anatomical location of the appendix the pain and tenderness may be misleading. If the appendix is lateral to or behind the caecum the tenderness may be in the right flank. If the appendix lies deep in pelvis one may detect tenderness only on rectal or pelvic examination and even then it may not be easily demonstrated. When the appendix lies on the left side due to transposition of viscera or failure of normal bowel rotation during embryonic life, the symptoms occur on the left. In the youngster and the elderly person the sympioms are more difficult to evaluate. Appendicitis is one of many causes of

abdominal pain. Various diseases produce symptoms that closely resemble appendicitis; these diseases include acute inflammation of the gall bladder, perforating ulcer of the stomach or duodenum, diverticulitis (inflammation of a small pouch) of the sigmoid colon, intestinal obstructions, inflammation of the uterine tubes (salpingitis), rupture of a tubal pregnancy, twisted ovarian cyst, bleeding from a ruptured corpus luteum of the ovary and perforating cancer of intestine. In addition, appendicitis-like symptoms may be produced by pneumonia, heart disease, herpes zoster (shingles) and kidney infection or stones. Many abdominal pains are due to digestive disturbances related to food and have no serious significance. Diarrhea is generally a symptom that goes with digestive disturbances, but its presence does not necessarily exclude the possibility of an infected appendix. Removal of a Diseased Appendix.-- Once a diagnosis of acute appendicitis has been made the appendix should be removed by surgery as soon as the patient's condition permits. In the early phase of the disease, i.e. up to 12-20 hours after the onset of symptoms, the mortality and disability rates arising from an appendectomy performed by a qualified surgeon in a well-equipped hospital are extremely low. On the other hand the mortality rate after an abscess has formed may be 3% --5%, and if spreading peritonitis has set in the death rate may be 10% -- 15% or even higher.

Non-surgical treatment,-- There is evidence that the use of antibacterial drugs instead of surgery for the treatment of appendicitis is hazardous because important symptoms may become masked. The antibacteriaLdrugs are, of course, of tremendous value in postoperative management and in preventing some of the complicated problems for surgery. Many patients will survive an attack of appendicitis without developing a serious complication, such as abscess or peritonitis. However, it is much safer to have the acute appendix removed early in an attack than to resort to any type of non-surgical treatment except where medical facilities or personnel are not available or adequate for safe surgical treatment.

11. In Encyclopaedia Britannica, Volume 9 at page 1097 Gall Bladder is described as a thin, pear-shaped structure, with the capacity if one to two ounces, situated oh the under-surface of the right lobe of the liver. Its principal activities are to store the bile excreted by the liver for digestive purpose, and to regulate the pressure in the biliary system, preventing backpressure on the liver in its continuous production of bile. The gall bladder is not an essential organ, and its removal by operation does not deprive the body of any vital function; nor does removal of the gall bladder decrease the quantity of the bile entering the digestive tract. Bile is of value in aiding the digestion of fat, and as a means of excreting certain toxins and poisons removed from the body by the liver.

Acute Cholecystitis.- This is an inflammation of the gall bladder caused usually by the following sequence of events; constriction of the cystic duct (leading from the gall bladder to the common bile duct) by gallstones, stasis of bile and chemical inflammation, induced by constituents of bile. Bacterial infection may or may not be present. There is a sudden onset of pain in the right upper quadrant of the abdomen, often radiating to the back of shoulder, fever, nausea, vomiting and occasionally jaundice. Symptoms may continue for several hours to several weeks depending upon the severity of attack. The disease may be complicated by softening or gangrene of the gall bladder with rupture and peritonitis, or by inflammation of adjacent portions of the liver. Treatment compiles bed rest, relief of pain, avoidance of liquid and food by mouth, glucose and salt solutions intravenously, and the use of sulfonamides and antibiotics. In cholecystitis without jaundice, the

flow of bile into the intestine is unimpeded; hence there is no need for bile salts or laxatives. Surgical removal of the gail bladder may be performed promptly or deferred until the inflammation subsides.

The gall bladder, although it is absent in many lower species, is rarely lacking in man. Congenital abnormalities of the gall bladder, such as double gall bladder and bilobed gall bladder, also are rare. Anomalies of the bile duct, however, are fairly common and may be of considerable technical importance to the surgeon in the performance of operations on the biliary tract. Other serious congenital anomalies, which may be corrected by surgery, are congenital obliteration of the bile duct and congenital cystic dilatation. By far the commonest operations performed on the gall bladder are complete removal (cholecystectomy) and drainage of the gall bladder (cholecystectomy); the latter may be done as a temporary expedient. These operations are usually performed for inflammatory disease associated with gall stones. In case of obstruction to the common bile duct produced by tumour, the gall bladder may be joined to the duodenum or small bowel to relieve the pressure in the biliary tract. The common indication for exploration of the common bile duct is the presence of obstructing gall stones. After the stones are removed from the bile ducts, a drainage tube is frequently left in place for a time. Occasionally, obstruction to the outflow of bile from the liver follows damage to the bile ducts during an operation. Operations for correction of these postoperative structures of the common bile duct are serious procedures but usually are successful. Cancer is found in about 1% of all gall bladders removed at operation and is usually associated with gallstones. The outlook for patients with cancer of the bile duct is poor. An exception is the cancer that occurs in the terminal portion of the common bile duct, or ampulla of Vater, which may produce symptoms early enough for a radical operation to be curative.

12. Now it may be useful to refer to certain medical text books about Appendectomy and Cholecystectomy of editions pertaining to the period of the present case in question. There are two schools of thought, one preferring immediate operation and the other preferring first cure by conventional treatment and surgery as a last resort. Hamilton Bailey on Emergency Surgery, 1958 Edition, at page 233 recommends Ochsner Sherren or Delayed treatment of Appendicitis because after a large experience of the aforesaid treatment the author had nothing but praise for it. Several hundred cases have resolved uneventfully. As in surgical practice one always seems to get ill fortune in batches, it sometimes happens that several cases in a short period of time fail to resolve. If the delayed treatment fails and the patient has been starved for some days, the urine should be examined for acetone, before giving the anaesthetic, but if the patient has been receiving dextrose-saline, acetonuria is most unlikely. The author further commend at page 310 that after a wave of enthusiasm for early cholecystectomy, some surgeons of experience in Great Britain, the U.S.A., Europe and Soviet Russia are returning to the Ochsner-Sherren treatment, or to early cholecystectomy. Their reasons for this change are reviewed at some length in Chapter XCIV. In this chapter the opinion is expressed that when the surgeon is inexperienced in performing cholecystectomy, it is unwise to undertake this operation as an emergency measure if an alternative procedure is available. As a rule, when urgent operation on the gall bladder is imperative, cholecystectomy will save life. There are. however, a few instances where urgent cholecystectomy is the method of choice. Romanis and Mitchiner on the Science and Practice of Surgery, 1941 Edition, have observed at page 713 that many different views have been expressed on this subject, for whereas there is little doubt that it is quite impossible in the first stages of the disease to foretell

which cases are going to recover spontaneously, which are going to perforate, which are going to become gangrenous, and which are going to lead to an abscess, it is equally true that an ill-timed operation, performed when localisation is just occurring and the infection is beginning to settle down, is likely to spread the infection, set up peritonitis, and possibly even lead to the patient's death. When a patient is seen who has been ill for more than fortyeight hours, i.e. during the third, fourth and fifth days of the disease, considerably more judgment is required. A lump is then probably forming, which may be beginning to contain pus, and localisation is occurring. Operation, therefore, should be avoided at this period if possible. We advise, therefore, during the third, fourth and fifth day that if the patient's condition is improving or remaining stationary operation should be deferred; if, however, the condition is in any way progressing as shown by increase of pulse rate, vomiting, pain, tenderness, distension or spreading of the area of tenderness, pain or rigidity, immediate operation should be performed. Rise of pulse rate is especially important in this connection. Price on Practice of Medicine, 1956 Edition, at page 657 opined that some surgeons are of opinion that when the patient is seen later than 48 hours from the onset and is tending to improve, medical treatment should be undertaken until the attack has subsided and the appendix removed during the quiescent period. Since operation in such cases is, with competent surgery, very little more difficult or dangerous than in early cases, such a view has little to recommend it, since it condemns the patient to two tedious periods of sickness instead of one, and there is in addition the risk of the patient's natural objection to an operation, when he feels perfectly well, overcoming the advice he has been given and leaving him exposed to all the risks of a further attack. When peritonitis or localised abscess formation has occurred, there arc no two opinions as to the necessity of operation. Rodney Maingot on the Management of Abdominal Operations, 1953 Edition, has observed at page 711 that the manifestations after the first 48 hours are most variable, and at times even misleading. It is by no means uncommon to find that serious complications, such as those mentioned above, are present in the absence of significant signs and symptoms which would point to a grave pathological condition of the gall bladder. The diagnosis of acute cholecystosis may be difficult, but the assessment of the degree of pathological damage is incalculable by clinical methods, haematological studies, or X-ray investigations. However, he further recommends at page 712 that all patients suffering from acute cholecystosis should be admitted to hospital as soon as the diagnosis is made or suspected, and be regarded as abdominal emergencies. When the diagnosis is established, the patient's general condition should be evaluated, and the chemical and fluid balance restored. The writer believes that the majority of these patients should be subjected to immediate or early operation rather than to delayed or late operation. Early operation is advised after a brief course of preparatory treatment, and more especially in those cases which are seen within 48 hours of the onset of the acute attack. There should be no undue haste, and no item in the investigation or in the pre-operative treatment should be omitted. It may require a few hours to prepare these patients for operation, and in some cases it may be well to wait a day or two until they are deemed fit for surgery. But this preparation does not constitute "conservative treatment". As soon as the patient is prepared, the operation should be performed, the nature and the extent of which is determined by the findings and the general condition of the patient. Though the authorities differ regarding the type of treatment to be given initially but they agree that if gall bladder is distensional or gangrenous or has perforated, then immediate operation is a must but that has to be done as an emergent operation after preparing the patient for the same. The operation may be postponed for a day or two and can be done when the patient becomes fit for surgery.

13. Encyclopaedia Britannica in Volume 15 on Medicine and Surgery at page 105 mentions that of the parasurgical methods that revolutionized surgery between the wars, two of the most important at any rate as regards abdominal surgery were intravenous alimentation and gastro-intestinal decompression. The introduction of continuous intravenous infusion in 1926 enabled surgeons to do something that had never been done before; i.e. to keep the body supplied with all its needs of fluid and nutriment while leaving the alimentary canal at rest. Continuous gastrointestinal suction through an indwelling tube enabled them to relieve distension when present, to remove pathological accumulations and to keep the alimentary canal rested and empty. These methods brought the most dramatic improvement in the treatment of intestinal obstruction, peritonitis and the acute abdominal emergencies generally, but every branch of abdominal surgery was made safer and more successful. Operations for peptic ulcer, yearly becoming more frequent, were increasingly undertaken with growing success. Operations for cancer of the stomach, colon and rectum become more radical and, at the same time safer and more curative. K. Das on the Handbook of Operative Surgery, 1966 Edition, at page 183 has commented that in the absence of jaundice, no intensive preparation is required for the good-risk of Cholecystectomy. The routine preparation with plenty of glucose in order to ensure adequate stores of liver glycogen is usually enough. But since there are (1) liver insufficiency, (2) biliary infection and (3) risk of haemorrhage in these cases, great care should be taken to prepare the patient for the operation. To make good the liver insufficiency, plenty of glucose should be injected intravenously and a sufficient quantity of fluid given per mouth. Administration of hexamine cylotropin and antibiotics will be required to control the biliary infection. To diminish the risk of haemorrhage the following measures should be adopted; (a) intravenous injection of 5 ml. of 10% calcium chloride or 10 ml. of a 10% solution of calcium gluconate, given daily for 3 consecutive days; (b) blood transfusion in small doses e.g. 250 ml. on one or t'.vo occasions; (c) vitamin K (intravenously) which is necessary for maintaining the normal prothrombin level in the blood and which is not absorbed in the absence of bile salts and (d) 30 ml. of 30% sodium citrate injected intramuscularly immediately before the operation.

14. John Glaister on Medical Jurisprudence & Toxicology, 1915 Edition at page 715 has observed that various views have been expressed by different individual writers and by commissions regarding the intimate cause of death by chloroform during anaesthesia. All of these, however, agree upon two facts viz. (a) that the drug has a paralysing effect upon respiration, and (b) that it causes a fall of blood pressure. Several hold the view that respiratory failure is the cause of circulatory failure, but acknowledge that in some cases circulation ceases before respiration. It is also generally agreed that the drug exercises a direct toxic action on the myocardium. Experimental observation has also shown that safety or danger lies in the percentage amount of chloroform vapour which is exhibited during administration. Even a small quantity will kill when exhibited in a concentrated form, while a comparatively large amount will be safe if exhibited in a vapour below 2 per cent, because it is the amount which circulates through the heart and not the length of time of administration which is the important factor. The author further observed at page 718 that during the last 15 years of the post-mortem examination of the bodies of at least 120 persons who have died while under the influence of anaesthetic, 91 were by use of chloroform. In the 1957 Edition of the same author there is no mention of chloroform being used for anaesthesia but there is mention of its being used for committing suicide or for committing crimes which means that by 1957 chloroform was no longer used as anaesthetic in the western countries due to its toxic effect. Taylor on Principles & Practice of

Medical Jurisprudence Volume II at page (sic) has opined that the vapour when inhaled in a concentrated form is highly dangerous. If diluted with air, it produces insensibility, with entire loss of muscuar power in from 2 to 10 minutes, but the patient recovers after the vapour is withdrawn. Fourth -- plane anaesthesia is achieved with blood levels of 15-25 mg./100 ml It is very rapidly eliminated from the blood, some 30 to 50 per cent in 15 to 20 minutes and 90 per cent within 1 hour. The sudden administration of anything over 2 per cent of chloroform vapour in the air breathed may lead to inhibition of the heart by its action on the vagal centre, or to fatal fibrillation. Halothance has the same danger attaching to it. Frequent intermittent chloroform administration constitutes a later danger, the liver being particularly susceptible to damage. Delayed chloroform poisoning is featured by symptoms of vomitting, frequent feeble pulse, acetonuria, and apathy deepening into coma. The time in which these symptoms appear is variable; cases have been recorded in which these symptoms occurred in as 12 or as much as 80 hours. Fatty degeneration of the heart, liver, and kidneys is commonly found. Wylie and Churchill Davidson on Practice of Anaesthesia, 1966 Edition, at page 283 have made following comments on chloroform: "Delayed chloroform poisoning was originally described by Casper in 1850. The first symptoms occur as early as six hours after the operation although more commonly they present themselves twenty-four to forty-eight hours later. Nausea and vomiting start early and progressively increase in severity. The diagnosis becomes certain with the development of jaundice, and death, preceded by coma, may occur at any time during the first ten days. Delayed chloroform poisoning is not restricted in its symtomatology to the liver; the heart and kidneys also being affected. Fatty degeneration of the heart and necrosis of the tubular epithelium of the kidneys take place and result in incipient cardiac and renal failure. A poor nutritional state increases the risk of this complication, whereas the pre-operative use of carbohydrates, proteins and amino-acids helps to protect the liver. Moreover, the avoidance of hypoxia and carbon dioxide retention is of practical help. Wators (1951) has shown that if chloroform is given in the presence of a high percentage of oxygen, and if steps are taken to avoid carbon dioxide accumulation, hepatic and renal function tests in a group of patients show no significant difference from those of controls. The treatment of delayed chloroform poisoning consists primarily of the dministration of intravenous fluids, together with carbohydrates, protein and amino-acids. of the various amino-acids methionine is the most useful because it plays an important part in building up the reserves of glycogen in the liver.

Action on the Kidneys.-- The toxic effects of chloroform are mainly on the renal tubules, which at microscopy can be seen to be swollen with the lumina filled with fat globules and coagulated serum. After chloroform anaesthesia transient albuminuria is a common occurrence, while prolonged administration often leads to glycosuia. In cases of delayed poisoning as described above ketonuria also occurs.

15. In Medical Negligence by Nathan, 1957 Edition, it has been observed at page 156 as follows : The intentional interference with the person of another without legal justification amounts to an actionable assault and battery for which damages may be recoverable by the injured person. Such damages will of course include compensation for actual injuries suffered as the result of the assault, but in addition a Judge or jury is at liberty, in a proper case, to award the plaintiff exemplary damages in respect of an assault or battery as a means of punishing the defendant for reprehensible conduct in invading the plaintiffs personal rights without justification. Bodily interference which

would otherwise amount to an assault and battery may, however, be justified by showing that the "patient" voluntarily submitted to the conduct in question. No action lies, therefore, against a medical man who interferes with the person of a patient if the patient's consent to the interference has been obtained. But for a medical man to administer treatment to or perform an operation upon a patient without the latter's consent amounts, subject to some exceptions which will be noticed in due course, to an actionable assault. Glanville Williams in his textbook on Criminal Law, 78 Edition, at page 568 has discussed this topic as under :

"Although English authority is lacking, the operation is clearly lawful. This was stated by an eminent member of the United States Supreme Court, Cardozo J. Every human being of adult years and sound mind has a right to determine what shall be done with his own body..... This is true except in cases of emergency where the patient is unconscious and where it is necessary to operate before consent can be obtained.

We have here a kind of hybrid between the defences of necessity and consent. It is not an ordinary case of consent, because consent is not in fact given; so from that point of view the justification must be one of necessity. On the other hand, the justification would clearly not avail if the surgeon ascertained, before the patient fell unconscious, that the patient withheld his consent. So it is not a case where social necessity overrides a refusal of consent. American writers have called the defence, with more punch than accuracy, "future consent". The surgeon is entitled in the circumstances to suppose that what he does will be ratified by a grateful patient, having nothing to cause him to suppose the contrary; and he will be protected in law even though the patient turns out to be ungrateful. His defence must, to repeat, be grounded on necessity; the only distinctive feature is that the defence is curtailed when it conflicts with the patient's express exercise of his right of self-determination.

It would be an illegitimate application of the doctrine of future consent to subject a depressed and protesting patient to a brain operation on the ground that the operation will change the patient's personality and he will then be pleased he had it. That is a bootstrap argument, and ought to be rejected. The general question of operations on the mentally disordered will be briefly considered in 11 (sic).

Sometimes, in the course of an operation, a surgeon sees a need for some other operation. He is generally protected in performing this by the consent form signed by the patient, which authorises such further or alternative operative measures as may be found to be necessary. But sometimes a consent form has not been offered to the patient, as when a maternity patient is under anaesthetic when it is discovered that delivery by caesarean section is necessary. In such circumstances, the Medical Defence Union encourages its members to do what is required, the justification being either implied consent or necessity. The surgeon would of course be ill advised to perform an unexpected operation having serious consequences if there is no great urgency for it.

16. Deceased Kantidevi was aged 32 years. Obsymultipare came out of her 7th confinement 41/2 months prior to her present operation. She was on her second day of menstruation period. She had an abdominal pain about 10 months prior to her death and was then treated by Dr. L. K. Mishra,

D.M.O. (P.W. 7). She got abdominal pain on the night intervening 27 and 28 September 1958. The defendant was called at her residence at about 1.30 a.m. on 28-9-1958 who gave her one tablet of Largactyl of 25 mg. The defendant was then posted at Shahdol as Assistant Surgeon since 3-4-1955 but he had no previous occasion to examine her. This was his first posting after his return from England where he could not qualify for the F.R.C.S. though he had experience of working in the hospitals there for 9 years. He was distantly related to the deceased. Since they were relation and the deceased was the wife of the Collector, the defence expected no monetary gain by treating or operating her. In the morning of 28-9-1958 the deceased experienced Nausea, vomited twice or thrice and had 99° temperature with diffused pain in the abdomen. At about 9 a.m. the defendant attended on her and gave one injection of Streptopenicilin and one tablet Largactyl of 25 mg. She had no further vomiting sensation. She slept well in the night and on the next day morning i.e. on 29-9-1958 she was somewhat better though temperature subsisting at 99°. The defendant saw her in the morning and gave one injection pf Streptopenicilin and advised giving one Largactyl tablet in case she felt uncomfortable. As her condition improved, her husband Rambiharilal went on urgent tour and returned in the night. The defendant was not required to attend on her in the evening or in the night as she slept well and she had no nausea. She woke up at about 7 a.m. According to Dr. Shrivastava, the defendant, (D.W. 2) he saw heron the morning of 30-9-1958, she had 100° temperature and her pulse rate was 84 to 86 per minute, there was localised tenderness over the right iliac-fosa and also rebound tenderness and she also complained some type of pain. He also suggested that the Murphy's sign which is present in the gall bladder pathology was not present though looked for it everyday right from the beginning. The defendant did not keep any record of the treatment during this period before her operation. It may be mentioned that in his reply to the query of Dr. Mishra (Ex. P. 16) the defendant mentioned the temperature to be 99.6° on the morning of 30-9-1958. There was extreme tenderness on the right iliac fosa but nothing was mentioned about the pulse rate or about Murphy's sign or about rebound tenderness or about her complaint that she was having some type of pain. In fact, the word 'pain' has not been mentioned. But in his report Ex. P. 10 he mentioned that the temperature was 99.4° : She walked down up to the car for going to the hospital and there also she walked down from the car to the hospital. Therefore, the evidence shows that she had stabilised herself and it was not a case for emergent operation. D.M.O. Dr. Mishra was contacted on phone and when told about the progress he advised against operation and told that since she was responding to the treatment, the treatment must continue. Defendant's witness Dr. C. B. Singh (D.W. 2) stated that under these conditons he would not have operated the deceased for acute appendicitis. In the written statement it is denied that the defendant had told the plaintiff 1 that delay in operation would endanger her life. He only advised that there was acute inflammation and the operation was advisable. Though the defendant has denied that he was so advised by Dr. Mishra but his own witness Rajendra Bahadur Singh (Lalji) (D.W. 8) stated that the defendant was insisting on immediate operation but the plaintiff 1 and his wife were against the operation. The defendant has admitted this fact in his evidence. Dr. Mishra was contacted on phone and he advised against the operation. When told, the defendant opined that there was no response to the treatment and she has to be operated. Her differential blood count was taken by Dr. Dutta (D.W. 1) and found 84% polymarphose. Dr. Mrs. Janki (P.W. 8) on examining her found per-vagine and per-rectum to be normal but in view of the report of the differential blood count the defendant insisted that his diagnosis of acute appendicitis is correct and she has to be operated immediately.

17. As mentioned earlier, the district hospital was at Umaria and the defendant was in charge of the 28 bedded hospital at Shahdol. There was fully equipped with specialists Medical College at Rewa not far away from Shahdol. According to the defendant, there was no trained pathologist nor any trained Anaesthetist in the hospital. The compounder who was doing the work of Anaesthetist was on leave, there were only two staff nurses. Dr. Datta (D. W. 1) admit'ted that there was no pipette for doing total blood count. The defendant admitted that blood-bank was empty and there was no facility for blood grouping and transfusion. Dr. J, P. Tiwari (P. W. 6) and Dr. Mrs. Ganpathy (P. W. 2) stated that there was defect in the saline apparatus and according to Ramdas Gupta (P. W. 12) such an apparatus was fetched from the missing (sic) hospital. According to Rambeharilal (P. W. 1). there was Oxygen and he had to procure the same from the market. According to the defendant's own witnesses, the operation was conducted in sterilisation room as the operation theatre was under repairs, There was no shadowless lamp in the improvised operation theatre and in the absence of Arc lamp, a battery torch was used for focussing light. According to the defendant, only anaesthesia in stock was chloroform. The defendant admitted that between ether and chloroform he would prefer ether but no attempt was made to get ether from the market. Dr. C. B. Singh (D. W. 2) has opined that he would avoid an operation if chloroform was the only medium and if no trained anaesthetist is there to give it. He would shun chloroform as well as ether. He further opined that total blood count and urine examination are prerequisite for all acute emergencies. He stated that prolonged use of chloroform as anaesthesia has delirious effect on liver and kidney. According to Dr. Shrikhande (P. W. 3) and Dr. S. C. Pande (P. W. 16) chloroform is unsuitable for major operations. Therefore, it is clear that the hospital in the charge of the defendant was ill-equipped and it was not advisable to carry on any major operation.

18. As has been mentioned earlier, the deceased was under the treatment of the defendant since the morning of 28-9-1958 till morning of 30-9-1958 when she was removed to the hospital for operation. The defendant diagnoised her ailment to be acute appendicitis requiring emergency operation. He did not carry out necessary clinical tests during this period for confirming his diagnosis. Only on the day of the operation her differential blood count was taken which showed 84% Polymorphose, blood pressure was found normal and fluid was aspirated through Ryles tube from the stomach of the deceased but nothing abnormal was found. The defendant was treating the deceased for the first time. According to the text books and also experts, Murphy's sign would have been an indication that her ailment was with the gall bladder. This was not done. In the case history Ex. P. 1 Murphy's sign was shown + + --.This could not be if it was a case of pathological gall bladder. He did not take her total blood count or carried out urine test which are very necessary for carrying out any major operation. Urine test is also necessary before applying chloroform anaesthesia because it has toxic effects. The defendant explained that no urine could be got even by Catheterization but this attempt was made just before the operation. The deceased was under his treatment for the last 3 days and he could have done urine test earlier. Moreover, not getting urine should have put the defendant on the guard that there was something wrong with the kidney of the deceased. In any case the patient has also to be prepared to counteract the toxic effects of chloroform by giving. Glucose, Vitamin B Complex and Vitamin K. This was not done. No X-ray was taken which may have shown that the ailment was with the gall bladder and not with the appendix. The defendant was giving Largactyl tablet which is a dangerous drug according to Dr. J. P. Tiwari (P.W. 6) and according to Dr. C. B. Singh (DW. 2). As has been found by the learned District Judge

and as opined by the experts, her kidney was already affected before the operation, so giving of Largactyl tablet and applying chloroform anaesthesia further aggravated the kidney. As a surgeon, he was expected to take these preliminary precautions before proceeding with the operation. The hospital was ill-equipped and having only two staff nurses, Anaesthetist and other basic facilities like Oxygen, blood transfusion were not available and the operation should not have been undertaken. But it appears that the defendant had the bona fide intention to cure the deceased and he perhaps wanted to impress the Collector about his efficiency. His over-confidence made him act in great haste without realising the consequences. All these tests were necessary because there are similarities in the symptoms of appendicitis and cholecystosis, such as abdominal pain, nausea, temperature. We have the advantage in this case of the evidence of Experts. Dr. Mrs. Ganpathy (P. W. 2) was Medical Specialist in the Gandhi Memorial Hospital, Rewa, Dr. K. Y. Shrikhande was Surgical Specialist, Dr. J. P. Tiwari (P. W. 6) was Pathologist in the said hospital Dr. L. K. Mishra was D. M. O. (P. W. 7) and Dr. Mrs. Janki (P. W. 8) was Medical Officer. All these doctors had attended on the deceased after the operation. The plaintiffs have also examined Dr. S. C. Pandey (P. W. 16) who was then Assitant Professor of Surgery in Jabalpur Medical College. The defendant has examined himself as D. W. 2 and also Dr. A. K. Dutta (DW. 1) who assisted him in the operation and an expert Dr. R. B. Singh (DW. 8) who was Principal and Professor of Surgery in Kanpur Medical College. Dr. Pandey and Dr. Singh did not have the advantage of attending on the deceased. It appears that the defendant had worked under Dr. Singh as a Demonstrator earlier and naturally he had a soft corner for him. It may be said that Dr. Mishra was under the influence of the plaintiff 1 who was then Collector but that cannot be said about Dr. Mrs. Ganpathy, Dr. Tiwari and Dr. Shrikhande who were in Medical College at Rewa. These 3 doctors were independent witnesses and there is no reason why they would speak against their colleague in the profession for nothing. The defendant has admitted in his cross-examination that his relations with Dr. Mishra were not inimical and were the same as a junior has with his senior. Therefore, there is nothing why he should speak against the defendant. Dr. Dutta had mentioned in the history-sheet before the operation that it was a case of chronic cholecystosis. It appears that the defendant himself was not sure. He first wrote chronic appendicitis and then as acute appendicitis. In the history-sheet the consent of the plaintiff 1 was taken for the operation in chloroform and the ailment was mentioned to be appendicitis, neither acute nor chronic. The defendant and Dr. Dutta both admitted that they did not explain to the plaintiff 1 the hazards of chloroform anaesthesia before taking his consent. Therefore, it was a clear case of carelessness and negligence in taking the deceased to the operation theatre although it was not a case of emergency.

19. On making grid iron incision, the defendant-found the appendix to be normal, he should have then closed the incision and should have made further investigation before deciding the future course of treatment. But instead of doing that, he straightway made Kocher's incision because, according to him, from the earlier incision he palpated the gall bladder and found it inflammed with gall stones. Therefore, he removed the gall bladder without taking any consent of the Plaintiff 1. According to Dr. Singh (D. W. 2) stones cannot be felt by any surgeon however a capable he may be. If he had been careful in his diagnosis, he would not have operated for the appendix and would have curtailed time for keeping her under chloroform anaesthesia. According to Dr. Shrikhande (P. W. 3) before a major abdominal operation including appendicitis is done we do the complete blood examination of the patient, the urine examination, the chest is examined for the condition of the

lung and heart, blood pressure is also taken. These investigations are common to all the major abdominal operations. In case of special operations oh organs like gall-bladder, the special investigations have to be done. For an operation of gall-bladder the special investigations would be blood cholesterol, level blood icterix index, then serum bilirubin, vandenbarg reaction, bleeding time, clotting time, prothrombin time. Some more investigations may be done depending on the availability of the facilities in the laboratory. Gall-Bladder is a major operation. The rate of mortality of cholecystectomy is 2 to 10 per cent. Compared to an operation like appendectomy the mortality of cholecystectomy is higher. Out of 100 persons operated for cholecystectomy the chances are that 2 to 10 per cent may die. I cannot say what is the percentage of mortality in other abdominal operations unless the particular type of operation is indicated. In the case of appendectomy it is about Order 5 per cent. In a cold case of gall-bladder disease it is advisable to prepare the patient before hand for operation. The patient is prepared by admitting in the hospital at least a week before hand. All the investigations are completed. Then the patient is given intravenous glucose injections, calcium gluconate intravenous with Vitamin C. then vitamin B complex by mouth, then vitamin K. He is put on a high carbohydrate and low fat diet and then he is operated. In a case having a gall bladder disease the liver is usually damaged to some extent and carbohydrates are known to protect the liver against toxic agents. Hence the necessity of giving glucose injections arises. The operation of gall bladder as such has not delirious effect on kidney and liver. The ideal anaesthetic for gal! bladder operation is gas, oxygen ether. By gas, I mean Nitrous Oxide. If in case this is not available it is also possible to do this operation under high spinal and intercostal block. With the discovery of newer and safer anaesthetic agents and depending on their availability, it is not advisable to use chloroform as an anaesthetic in gall-bladder operation because chloroform is a toxic agent for liver. From what I was told at Shahdol it seemed that the condition of the patient was improving, and it is generally agreed that if 48 hours have elapsed after the onset of the attack and if the condition of the patient is not deteriorating then it is advisable to wait and not to go ahead with the operation." The defendant himself did cross-examination of this witness but he has not challenged this part of his statement According to Dr. Mishra (P. W. 7), the defendant was negligent. According to Dr. Singh (DW. 2), blood examination and urine examination are the pre-requisites for all acute emergency. For planned abdominal operations there are different things to be done for each system. Urine, blood, stooe and gestric secretion are necessary and some X-ray examinations are recommended. Satisfaction about urine examination should relate back about a week. Pathalogical examination should not be ignored. According to Dr. Pande (PW 16) operation is indicated in appendicitis if in spite of adequate treatment the pulse rate continues to rise, pain continues to increase, temperature continues to rise and the patient continues to vomit. All these indications were missing so far as the deceased was concerned. Urine and blood tests were necessary before carrying the operation. Therefore, it was a rash act on the part of the defendant in proceeding to remove gall bladder without taking necessary precautions and without preparing the patient for such a major operation. She was on restricted diet for 3 days and was under her menses during which period there is weakness in the patient as has been admitted by the witness.

20. It has been tried to be shown subsequently by the defendant that the gall bladder was a pathological case and after its removal it was preserved. While handing over charge in December 1958, the defendant had handed over this gall bladder to Dr. Mrs. Janki (P. W. 8), but it is difficult to say whether it is the same gall bladder. Normal size of a gall bladder is 3" to 4". This gall bladder

which was produced in Court was actually measured by Dr. Dutta and it was found to be 41/2" in length. The defendant asserted that the gall bladder was of 7" length and it has contracted while kept in formalin in jar, but this does not appear to be correct. According to Dr. Dutta, the gall bladder did not contract because it was tied with strings at two ends and if it had contracted, strings would have become loose but this was not so. According to Dr. Dutta, no record was kept in the hospital about the specimens. He had preserved the gall bladder but not at the instance of the defendant, scales and the labels on the jar containing the gall bladder were not put by him. Sealing of the jar with the adhesive plaster was also not done by him. The label bears the signatures of the defendant. In his reply Ex. P. 16 to the D. M. O. dated 1-11-1958 there is a mention about preservation of the gall bladder. History-sheet dated 30-9-1958 Ex. P. 1 is the earliest document and it mentions about a big inflamed gall bladder. There is no mention that it is gangrenous. In his statement Exp. 12 recorded by Dr. Shrikhande, Dr. Dutta mentioned the gall bladder to be redish in colour. This shows that the gall bladder was not gangrenous nor there was any pus formation. The gall bladder which was produced in Court was shown to Dr. C. B. Singh and he deposed that it was bigger than normal size and appears to be probably full of stones or pus. There are 1 or 2 darkish patches at the end of fundus, but this gall bladder was not put to the plaintiffs' witnesses. It was for the defendant to prove that the gall bladder was in a pathalogical condition requiring immediate removal. Even if there were some stones in the gall bladder, that was not a case of emergency. According to Dr. Dutta (D W. 1), the colour of the gall bladder changes when kept in formalin. According to Dr. Singh, stones inside the gall bladder could not be felt by a doctor, so the evidence of Rajendra Bahadur Singh (D. W. 8) that he could hear the noise of stones while shaking it is unbelievable. If there was pus formation, the defendant would have detected the same in the fluid aspirated from the stomach. Therefore, it has to be held that it was not a case of emergency for removal of the gall bladder as neither it was gangrenous nor there was pus formation. Even if there were gall stones, the operation could have been postponed. According to Dr. Pande, the operation should have been after thorough preparation and that too for cholecystestomy and not for cholecystectomy i.e. by drainage of stones which is a sure process though may not be a permanent cure. In the absence of basic facilities in the hospital, the defendant should not have taken the risk of carrying out such a major operation without any preparation. Perhaps it appears that the defendant was in dilemma after having found his diagnosis of appendicitis to be wholly wrong, but he jumped to a conclusion that there must be something wrong with the gall bladder and he then proceeded to remove the same without getting it confirmed and without realising the consequences. He ought to have advised the plaintiff No. I to take his wife to the Medical College. Rewa which was not far off and there was no difficulty for the plaintiff No. 1, who was then Collector, to get best possible treatment in that college. However, the defendant wanted to impress the Collector about his ability and so in great haste performed the second operation.

21. The condition of the deceased started deteriorating a few hours after the operation because the toxic effect of the chloroform shows reaction after sometime. On the night of 1-10-1958 she became quite serious, her pulse rate was 140 per minute, respiration was 50 per minute, temperature was 103° blood-pressure was 90-70 and there was slight diminished air entry in the right lung base. On the night of 2-10-1958 her temperature was at 105°, her pulse rate gradually becoming imperceptible, Blood pressure plummeted down to 60-40 and thereafter she collapsed. The defendant tried to show that he was kept out from attending the deceased from 2-10-1958 but in his

reply Ex. P. 16 to the D. M. O. he did not complain that he was ever kept out from attending the deceased, on the other hand he submitted that he has been giving the treatment in consultation with the Rewa doctors. After condition of the deceased started deteriorating, she was not able to withstand the sight of the defendant and so he was advised to remain at a distance. According to Dr. Mishra, the defendant had suggested Methadrine at 3 p.m. which he himself fetched from the market and administered to the deceased. According to the plaint allegation, the deceased died due to renal failure. The defendant in his written explanation to the D. M. O. dated 29-11-1958 Ex. P. 12 admitted that immediate cause of her death was due to renal failure. This is reiterated by the defendant in his deposition but in his written statement he tried to plead that her death was caused due to mishandling and panic created by the crowd surrounding the deceased after the operation. The experts examined by the plaintiffs also opined that her death was due to renal failure. The defendant tried to clarify that renal failure was probably brought about by post-operative and not pre-operative bacterial infection but this was not mentioned in his reply Ex. P. 12. There is no basis for his guess that bacterial infection was of the post operative period as infection may have been conveyed from the gall-bladder to the right kidney after the operation. No question has been put to Dr. Singh (PW. 2) to elicit such an opinion. According to Dr. Shrikhande (P. W. 3) and Tiwari (P. W. 6). the cause of death was hepatorenal failure. Dr. Pande (P. W. 16) stated that in the case of a patient dying within 2 to days of the operation done for appendicitis and gall bladder and under chloroform as anaesthetic agent and developing jaundice and cast and albumin found in urine, the case of death would be hepatorenal damage. On seeing the history sheet of the deceased. Dr. Singh opined that the condition showed peripheral vescular failure and failure of heart and if there is presence of albumin casts and recurrence of icteroid tinge in Conjunctiva, that indicates hepato-renal failure. The defendant us D. W. 2 admitted that rapid and thready pulse, rise of temperature, distension of the abdomen, sub-normal temperature and signs of peripheral vescular failure and jaundice which are symptoms of hepatic failure. Urine test of the deceased was done by Technician Goswami (P. W. 4) who found as per his report Ex. P. 8, Albumin + + + cast + + + and traces of pus. There was no cross-examination about the test carried out by him. Urine lest was done by Goswami at the instance of Pathologist Dr. Tiwari (PW. 6). So it cannot be said that Goswami did not carry out necessary tests. Dr. Singh did say that he would not prefer to rely on the report of the Technician if he had not carried out microscopic test but then his report gets confirmed from the observations of Dr. Shrikhande (PW. 3) who found icteroid tinge in the Conjunctiva. This proves that the deceased had an attack of jaundice and her kidney was affected even before the operation, the liver was also damaged in the process.

22. Under the circumstances, the defendant should not have put the deceased under chloroform anaesthesia without carrying out proper tests and without preparing her for taking this anaesthesia. The toxic effect of this anaesthesia has already been explained earlier. The defendant did not realise that it was not advisable to keep the deceased under chloroform as anaesthesia for two hours in view of its toxic effects. Since her kidney was already damaged and the liver was also damaged in the process, the anaesthesia caused further damage resulting in renal failure. Dr. Singh (DW. 2) admitted in cross-examination that he would not like to be put in an embarrassed position of operating on a patient where chloroform is the only anaesthesia available and there is no expert to give it, he would like to avoid it. He would say it is not safe. Chloroformis a more toxic drug as compared to other anaesthetic agents. He would avoid using ether or chloroform but given a choice

he would start with chloroform to give the anaesthesia and follow it with the mixture of chloroform and ether. Here in the present case, as per history-sheet Ex. P. 1 the induction was by Ethyl Chloride and maintenance was by chloroform. Dr. Dutta (D. W. 1) stated that he would prefer Ether to Chloroform for gall bladder operation. According to him. Ether and spinal anaesthesia was also supplied to Shahdol hospital. The defendant himself as D. W. 2 admits that in England such a major operation would not have been carried out under chloroform. Therefore, he was well aware of the hazards of chloroform but yet he put the deceased under chloroform for 2 hours. Dr. Mrs. Janki (P. W. 8) states that it was the defendant who insisted on her putting the deceased under chloroform anaesthesia in spite of her protest. She suggested some local anaesthesia. If no other anaesthesia except chloroform was available in the hospital, the defendant should have procured ether from the market or from other hospital if he thought that emergency operation was to be carried out, even if he did not prefer to use local anaesthesia. Neither hazards of chloroform were explained to the plaintiff No. 1 before taking his signature nor his second consent was taken for the second operation. This act of the defendant is an actionable wrong by itself and makes him liable for damages.

23. In view of the aforesaid discussions, we beg to differ with the findings given by the learned single Judge. He proceeded to decide the case by making several assumptions when the evidence on record was otherwise. The findings of the trial Judge have been brushed aside by saying that the District Judge did not bear in mind the difference in approach on the question of negligence relating to motorcar accidents and negligence against the doctors, the District Judge overlooked the oft-quoted observations of Lord Denning that every surgical operation is attended by risk and we cannot take the benefit without taking the risk. In Roe v. Minister (1954 (2) QB 66) (supra) where the plaintiff emerged from the hospital paralysed after receiving spinal injection of anaesthetic into which phenol had unforeseably seeped through invisible crack in the phial, was denied remedy as it was mishap and not a case of negligence. Lord Denning in Watt v. Hertfordshire County Council ((1954) 1 WLR 835) held that in measuring due care you must balance the risk against measures to eliminate the risk. What he has been saying was that we must not condemn as negligence that which is only a misadventure but he also has been reiterating that the doctor is liable when he fell below the standard of a reasonably competent practitioner in his field so much so that his conduct might be deserving of censure or inexecusable. Learned Judge assumed that the deceased was prepared for operation after preliminary tests were done. As has been found it was not a case of emergency, without doing all the necessary tests and preparing the patient, the defendant suddenly decided to apply his knife when the condition of the deceased was getting stabilished. The learned Judge relied on the bare statement of the defendant without considering the evidence to the contrary. So it had been held that gall bladder was of enormous size, inflamed, black and full of stones, so it was a case of emergent operation and the defendant skilfully removed the gall bladder without considering the consequences of the ill-timed and hasty second operation of removal of gall bladder. He wrongly opined that the defendant was not responsible for administering chloroform anaesthesia and the patient regained consciousness within an hour without considering that toxic effects of chloroform take sometime to set in. In fact, the patient regained consciousness after 3 hours at 7. p.m. or so though one witness said that she asked for water at 5 p.m.. e also erred in saying that there was mistake and no negligence in wrong diagnosis of acute appendicitis and did not imply absence of reasonable skill and care. He failed to consider that due to negligence other tests were not carried out, which would have eliminated the case of appendicitis. Learned Judge erred in holding that it

was not imperative to obtain the husband's consent when the operation was being performed on a lady who was sub-juris. The case of Marshall v. Curry (1933 (3) DLR 260) (supra) is clearly distinguishable. There the patient had many complications and he was operated number of times for various ailments by the same doctor. In July 1929, while curing hernia, the doctor had to remove the testicle as the same was grossly diseased with multiple abcesses in it without taking patient's consent who was in anaesthesia. But there was no complication and, in fact, the patient was operated again in August and September to remove stone from kidney and penis. Here the husband of the patient was very much present outside for taking his consent. The learned Judge has observed that the patient was young healthy lady of 32 years and assuming that she was without jaundice or nephritis. It was otherwise and the defendant did not carry out any investigation for finding out such ailments. He wrongly held that if chloroform had any adverse effect for reason of personal idiosyncrasy of the patient which could not be anticipated and which the clinical tests performed before the operation did not forewaru, that will not amount to negligence. There was no question of any idiosyncrasy of the patient, the toxic effects of the chloroform are well known and it has now been discarded as an anaesthesia and no investigations were made to find out whether the patient had any liver or kidney trouble. He also erred in saying that since the operation contemplated was appendectomy, no preparations were necessary for removal of gall bladder. The learned Judge has made out a new case not pleaded by parties by holding that renal failure may have been induced by trauma of surgery by relying on some text book about such possibility. He also assumed that removal of gall bladder which was gangrenous at places, could be a seat of some bacterial organisms causing toxomia when undisputedly it was a case of renal failure and experts opined it was caused due to toxic effects of chloroform. The Judge also assumed thai it being a Government hospital, it would be difficult to say that it was kept ill-equipped and all that was possible was done for the patient and it is unadvisable to pass arm chair judgment, contrary to evidence on record. We feel that due consideration ought to have been given to the well-reasoned findings based on evidence of the learned District Judge and which deserved to be affirmed.

24. We have, therefore, to hold that Smt. Kanti Devi died of hepato-renal failure due to rash and negligent act of the defendant. He wrongly diagnoised the ailment to be acute appendicitis without proper investigation and without preparing the patient for the operation. She was in her menses and was on restricted diet for 3 days. She'had history of abdominal pain. On doing necessary blood and urine tests it could have been found that ailment was in her kidney, but hastily he proceeded to operate her. It may not be questioned that the defendant possessed the necessary skill and knowledge to undertake the operation but his over-confidence and hurry failed him. He paid no heed to the advice of his superior that since the patient had stabilized herself, it was not an emergent case. He should have been put on guard when he could not get urine even by catheterization. Before applying the knife he did not find out Murphy's sign, which would have shown that the ailment was in gal! bladder which he removed subsequently. Finding appendix to be normal, he proceeded to remove the gall bladder without further investigation and without preparing the patient for the second operation. He acted rashly in removing the gall bladder and without caring for the ill-effects of keeping the patient under chloroform for 2 hours especially when her kidney was affected. No preventive steps were taken to counteract the toxic effects of chloroform on the kidney and liver by giving glucose and vitamins. No consent of the husband, who was present outside, was taken for removal of the gall bladder. He should not have undertaken such a major operation in a hospital

which was lacking in basic facilities. The operation theatre was under repairs, there was no facility for Oxygen and blood transfusion, no anaesthesist was there, even some life saving drugs were not available, pipatte, for blood test was broken, the saline apparatus was not in order and there were only two staff nurses for 28 bedded hospital. He should have advised the plaintiff No. 1 after he found that it was a case of emergant operation, to take his wife to Rewa Medical College, which was not far off and all facilities including Specialists were available there. The plaintiff No. 1, who was then the Collector, had no problem in taking his wife to Rewa for emergent operation. Nothing would have happened if the operation was to be postponed for a day or two. Presence of stones in gall bladder is not a case of emergent operation and it could be postponed for days together. The defendant failed in his duty of care in undertaking the operation and in doing the operation without taking necessary precautions. His act of removing the gall bladder was highly hazardous which resulted in the death of the patient. So the defendant is liable to pay damages for his wrongful acts. However, the plaintiffs are only claiming symbolical damages. The award of Rs. 3000/-for loss of service at the rate of Rs. 25/- per month for 10 years on the death of young mother of 7 minor children, youngest being aged 41/2 months, is hardly adequate. Award of Rs. 1,000/- for mental agony and physical suffering is also too low. But there is no claim for enhancement. There is no merit in the contention that the suit is barred by limitation. The deceased died on 3-10-1958 and the suit has been filed on 3-10-1959, notice under Section 80 C.P.C. was served on 31-8-1959, two months notice period has to be excluded, and the suit is, therefore, well within the period of one year's limitation.

25. With the result, the appeal is allowed, the judgment and decree of the Single Bench are set aside and that of the trial court restored with costs throughout. Counsel's fee as per schedule, if certified.