SUPREME COURT OF INDIA

Laxman Balkrishna Joshi, Dr.

Vs.

Dr. Trimbak Bapu Godbole

C.A.No.547 of 1965

(R. S. Bachawat, J. M. Shelat and A. N. Grover, JJ.)

02.05.1968

JUDGEMENT

SHELAT, J.:-

1. This appeal by special leave raises the question of the liability of a surgeon for alleged neglect towards his patient. It arises from the following facts.

2. At about sunset on May 6, 1953, Ananda, the son of respondent 1, aged about twenty years, met with an accident on the sea beach at Palshet, a village in Ratnagiri District, which resulted in the fracture of the femur of his left leg. Since the sea beach was at a distance of 1-1/4 miles from the place where he and his mother lived at the time it took some time to bring a cot and remove him to the house. Dr. Risbud, a local physician, was called at about 8.80 or 8.45 p. m. the only treatment he gave was to tie wooden planks on the boy's leg,with a view to immobilise it and give rest. Next day, he visited the boy and though he found him, in good condition, he advised his removal to Poona for treatment. On May 8, 1953, Dr. Risbud procured Mac Intyres splints and substituted them for the said wooden planks. A taxi was thereafter called in which the boy Ananda was placed in a

reclining position and he along with respondent 2 and Dr. Risbud, started for Poona at about 1 a. m. They reached the city after a journey of about 200 miles at about 11.30 a. m, on May 9, 1953. By that time respondent 1 had come to Poona from Dhond where he was practising as a medical practitioner.They took the boy first to Tarachand Hospital where his injured leg was screened. It was found that he had an overlapping fracture of the femur which required pin-traction. The respondents thereafter took the boy to the appellant's hospital where, in his absence, his assistant, Dr. Irani, admitted him at 2.15 p. m. Sometime thereafter the appellant arrived and after a preliminary examination directed Dr. Irani to give two injections of 1/8th grain of morphia and 1/200 th grain of Hyoscine H. B. at an hour's interval. Dr. Irani, however, gave only one injection. Ananda was thereafter removed to the x-ray room on the ground floor of the hospital where two x-ray photos of the injured leg were taken. He was then removed to the operation theatre on the upper floor where the injured leg was put into plaster splints. The boy was kept in the operation theatre for a little more than an hour and at about 5.30 p. m., after the treatment was over, he was removed to the room assigned to him. On an assurance given to respondent 1 that Ananda would be out of the effect of morphia by 7 p. m., respondent 1 left for Dhond. Respondent 2 however, remained with Ananda in the said room. At about 6.30 p. m. she noticed that, he was finding difficulty in breathing and was having cough. Thereupon Dr. Irani called the appellant who, finding that the boy's condition was deteriorating, started giving emergency treatment which continued right until 9 p. m. when the boy expired. The appellant thereupon issued a certificate Ext. 138, stating therein that the cause of death was fat embolism.

3. The case of the respondents, as stated in para 4 of the plaint, was that the appellant did not perform the essential preliminary examination of the boy before starting his treatment that without such preliminary examination a morphia injection was given to him that the boy soon after went 'under morphia'; that while he was 'under morphia' the appellant took him to the x-ray room, took x-ray plates of the injured leg and removed him to the operation theatre. Their case further was that

"While putting the leg in plaster the defendant used manual traction and used excessive force for this purpose, with the help of three men although such traction is never done under morphia alone, but done under proper general anaesthesia. This kind of rough manipulation is calculated to cause conditions favourable for embolism or shock and prove fatal to the patient. The plaintiff No. 1 was given to understand that the patient would be completely out of morphia by 7 p. m. and that he had nothing to worry about Plaintiff No. 1 therefore left for Dhond at about 6 p. m. the same evening."

In his written statement the appellant denied these allegations and stated that the boy was only under the analgesic effect of the morphia injection when he was taken to the x-ray room and his limb was put in plaster in the operation theatre. Sometime after the morphia injection the patient was taken to the x-ray room where x-ray plates were taken. The boy was co-operating satisfactorily. He was thereafter remove to the operation theatre and put on the operation table. The written statement then proceeds to state:

"Taking into consideration the history of the patient and his exhausted condition, the defendant did not find it desirable to give a general anaesthetic. The defendant, therefore, decided to immobilise

the fractured femur by plaster of paris bandages. The defendant accordingly reduced the rotational deformity and held the limb in proper position with slight traction and immobilised it in plaster spica. The hospital staff was in attendance. The patient was cooperating satisfactorily. The allegation that the defendant used excessive force with the help of three men for the purpose of manual traction is altogether false and mischievous and the defendant does not admit it."

The appellant further averred that

"the defendant put the patient's limb in plaster as an immediate preliminary treatment on that day with a view to ameliorate the patient's condition."

4. His case further was that at about 6.30 p. m. it was found that the boy's breathing had become abnormal whereupon the appellant immediately went to attend on him and found that his condition had suddenly deteriorated, his temperature had gone high, he was in coma, was having difficulty in breathing and was showing signs of cerebral embolism and that notwithstanding the emergency treatment be gave, he died at about 9 p. m. The parties led considerable evidence, both oral and documentary, which included the correspondence that had ensued between them following the death of Ananda, the appellants letter dated July, 17, 1958 to respondent 1, the complaint lodged by respondent 1 to the Bombay Medical Council , the appellant's explanation thereto and such of the records of the case as were produced by the appellant. The oral testimony consisted of the evidence of the two respondents, Dr. Gharpure and certain other doctors of Poona on the one side and of the appellant and his assistant, Dr. Irani, on the other. The nurse who attended on the boy was not examined. At the time of the arguments the parties used extensively well-known works on surgery, particularly with reference to treatment of fractures of long bones such as the femur.

5. On this evidence, the trial court came to the following findings: (a) The accident resulting in the fracture of femur in the left leg of Ananda occurred at about 7 p. m. on May 6, 1958 at the sea beach of village Palshet. That place was about one and a quarter mile away from the place where he and respondent 2 had put up. Arrangement had to be made for the cot to remove him and the boy was brought home between 8.30 and 9 p. m. (b) Dr. Risbud was called within ten minutes but except for tying three planks to immobilise the leg he gave no other treatment. This was not enough because the fracture was in the middle third of the femur and, therefore, the hip joint and the knee joint ought to have been immobilised. (c) On May 8, 1953, Dr. Risbud removed the planks and put the leg in Mac Intyres splints. There was on that day swelling in the thigh and that part of the thigh had become red. The Mac Intyres protruded a little beyond the foot. (d) At about midnight on 8/9 May 1953, a taxi was brought to Palshet. Ananda was lifted into it and made to lie down in a reclining position. The party left at 1 a. m. and reached Poona at about 11.30 a.m. The journey took nearly eleven hours.The boy was first taken to Tarachand hospital and from there to the appellant's hospital where he was admitted by Dr. Irani at about 2.15 p. m. (e) After the appellant was summoned to the hospital by Dr. Irani, he first examined his heart and lungs, took temperature, pulse and respiration and the boy was thereafter taken to the x-ray room where two x-ray plates

were taken. The appellant then directed Dr. Irani to give two morphia injections at an hour's interval but Dr. Irani gave only one injection instead of two ordered by the appellant. The trial court found that the appellant had carried out the preliminary examination before he started the boy's treatment. (f) The morphia injection was given at 3 p. m. The boy was remove to the x-ray room at about 3.20 p. m. He remained in that room for about 45 minutes and was then removed to the operation theatre at about 4 p. m. and was there till about 5 p. m. when he was taken to the room assigned to him. The boy was kept in the operation theatre for a little over an hour. (g) Respondent 1 was all throughout with Ananda and saw the treatment given to the boy and left the hospital for Dhond at about 6 p. m. on the assurance given to him that the boy would come out of the morphia by about 7 p. m. (h) At about 6.30 p. m. respondent 2 complained to Dr. Irani that the boy was having cough and was finding difficulty in breathing. The appellant, on being called, examined the boy and found his condition deteriorating and, therefore, gave emergency treatment from 6.30 p. m. until the boy died at 9 p.m.

6. On the crucial question of treatment given to Ananda, the trial Court accepted the eye-witness account given by respondent 1 and came to the conclusion at notwithstanding the denial by the appellant, the appellant had performed reduction of the fracture; that in doing so he applied with the help of three of his attendants excessive force, that such reduction was done without giving anaesthetic, that the said treatment resulted in cerebral embolism or shock which was the proximate cause of the boy's death. The trial court disbelieved the appellants case that he had decided to postpone reduction of the fracture or that his treatment consisted of immobilisation with only light traction with plaster splints. The trial Judge was of the view that this defence was an afterthought and was contrary to the evidence and the circumstances of the case. On these findings he held the appellant guilty of negligence and wrongful acts which resulted in the death of Ananda and awarded general damages in the man of Rs. 3,000.

7. In appeal the High Court came to the conclusion that though the appellants case was that a thorough preliminary examination was made by him before he started the treatment, that did not appear to be true. The reason for this conclusion was that though Dr. Irani swore that the patients temperature, pulse and respiration were taken, the clinical chart, Ext. 213, showed only two dots, one indicating that pulse was 90 and the other that respiration was 24. But the chart did not record the temperature. If that was taken, it was hardly likely that it would not be recorded along with pulse and respiration.

8. As regards the appellants case that be had decided to delay the reduction of the fracture and that he would merely immobilise the patient's leg for the time being with light traction, the High Court agreed with the trial court that that case also was not true. The injury was a simple fracture. The reasons given by the appellant for his decision to delay the reduction were that (1) there was swelling on the thigh, (2) that two days had elapsed since the accident, (3) that there was no urgency for reduction and (4) that the boy was exhausted on account of the long journey. The High Court observed that there could not have been swelling at that time for neither the clinical notes, Ext. 213, nor the case paper, Ext. 262, mentioned swelling or any other symptom which called for delayed reduction. Ext. 262 merely mentioned one morphia injection, one x-ray photograph and putting the

leg in plaster of paris. The reference to one x-ray photo was obviously incorrect as actually two such photos were taken. This error crept in because the case paper, Ext. 262 was prepared by Dr. Irani some days after the boy's death after the x-ray plates had been handed over on demand to respondent 1 and, therefore, were not before her when she prepared Ext. 262. Her evidence that she had prepared that exhibit that very night was held unreliable. Exhibit. 262, besides, was a loose sheet which did not even contain either the name of the appellant or his hospital. It was impossible that a hospital of that standing would not have printed forms for clinical diagnosis.

9. The next conclusion that the High Court reached was that if the appellant had come to a decision to postpone reduction of the fracture on account of the reasons given by him in his evidence he would have noted in the clinical chart Ext. 213 or the clinical paper, Ext. 262 the symptoms which impelled him to that decision. The High Court agreed that the medical text books produced before it seemed to suggest that where time has elapsed since the occurrence of the fracture and the patient has arrived after a long journey, deferred reduction is advisable. But the High Court observed, the question was whether the appellant did defer the reduction and performed only immobilisation to give rest to the injured leg. After analysing the evidence, it came to the conclusion that what the appellant actually did was to reduce the fracture, that in doing so he did not care to give anaesthetic to the patient, that he contented himself with a single morphia injection, that he used excessive force in going through this treatment, using three of his attendants for pulling the injured leg of the patient, that he put that leg in plaster of paris splints, that it was this treatment which resulted in shock causing the patient's death, and lastly, that the appellant's case that the boy died of cerebral embolism was merely a cloak used for suppressing the real cause of death, viz. shock.

10. These findings being concurrent, this Court, according to its well established practice, would not ordinarily interfere with them. But Mr. Purshottam urged that this was a case when we should reopen the findings, concurrent though they were, and reappraise the evidence as the courts below have arrived at them on a misunderstanding of the evidence and on mere conjectures and surmises. In order to persuade us to do so, he took us through the important parts of the evidence. Having considered that evidence and the submissions urged by him, we have come to the conclusion that no grounds are made out which could call for our interference with those findings.

11. 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: (of. Halsbury's Laws of England, 3rd ed. vol. 26 p. 17). 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. But the question is not whether the judgment or discretion in choosing the treatment he exercised was right or wrong, for, as Mr. Purshottam

rightly agreed, no such question arises in the present case because if we come to the same conclusion as the High Court, viz., that what the appellant did was to reduce the fracture without giving anaesthetic to the boy, there could be no manner of doubt of his being guilty of negligence and carelessness. He also said that he was not pressing the question whether in this action filed under the Fatal Accidents Act (XIII of 1855) the respondents would be entitled to get damages. The question, therefore, is within a small compass, namely, whether the concurrent findings of the trial court and the High Court that what the appellant did was reduction of the fracture without giving anaesthetic to the boy and not mere immobilisation with light traction as was his case, is based on evidence or is the result of mere conjectures or surmises or of misunderstanding of that evidence.

12. While considering the rival cases of the parties, it is necessary to bear in mind that respondent 1 is a medical practitioner of considerable standing and though not an expert in surgery, he is not a layman who would not understand the treatment which the appellant gave to the boy. It is not in dispute that he was present all throughout and saw what was being done, first in the X-ray room and later in the operation theatre. The trial court and the High Court had before them his version on the one hand and that of the appellant on the other and if they both found that his version was more acceptable and consistent with the facts and circumstances of the case than that of the appellant, it would scarcely be legitimate to say that they acted on sheer conjecture or surmise.

13. It is not in dispute that the appellant had directed Dr. Irani to administer two morphia injections. Admittedly only one was given. Dr. Irani said that it was not that she omitted to give the second injection on the appellant's instructions but that she forgot to give the other one. That part of her evidence hardly inspires confidence for, in such a case as the present it is impossible to believe that she would forget the appellant's instructions. The second one was probably not given because the one that was given had a deeper effect on the boy than was anticipated. The evidence of respondent 1 was that after the boy was brought from the operation theatre to the room assigned to him he was assured by the appellant that the boy was alright and would come out of the morphia effect by about 7 p. m. and that thereupon he decided to return to Dhond and did in fact leave at 6 p. m. Both the courts accepted this part of his evidence and we see no reason to find any fault with it. What follows from this part of his evidence, however, is somewhat important. If respondent 1 was assured that the boy would come out of the effect of morphia by about 7 p. m., it must mean that the appellant's version that the boy was co-operating all throughout in the operation theatre and was even lifting his and as directed by him cannot be true. Though the morphia injection of the quantity said to have been administered to the boy would ordinarily bring about drowsiness and relief from pain, the evidence, was that the boy was unconscious. It seems that it was because of that fact that Dr. Irani had refrained from giving the second injection. The second result that follows from this part of the evidence of respondent 1 is that if the fracture had not been reduced but that the appellant had only used lift traction for immobilising the injured leg and had postponed reduction of the fracture, it was hardly likely that he would not communicate that fact to respondent 1. In that event, it is not possible that respondent 1 would decide to leave for Dhond at 6 p.m. There would also be no question of the appellant in that case giving the assurance that it was alright with the boy. That such an assurance must have been given is borne out by the fact that respondent 1 did in fact leave Poona for Dhond that very evening. That would not have happened if reduction of the fracture had been postponed and only immobilisation had been done. The assurance given by the appellant upon which respondent 1 left Poona for Dhond implies, on the contrary, that whatever was to be done had

been done and that the presence of respondent 1 was no longer necessary as the boy's condition thereafter was satisfactory and he would come out of the morphia effect in an hour or so. This conclusion is fortified by the fact that it was never put to respondent 1 that the appellant had at any time told him that he had postponed reduction of the fracture and that the only thing he had done was immobilisation by way of preliminary treatment.

14. The letter of the appellant to respondent 1 dated July 17, 1953, was, in our view, rightly highlighted by both the courts while considering the rival versions of the parties. In our view, it was not written only to express sympathy towards respondent 1 for the death of his son but was the result of remorse on the appellants part. If the only treatment he had given was to immobilise the boy's leg and he had postponed putting the fractured ends of the one right at a later date, it is impossible that he would write the letter in the manner in which he did. If he was certain that fat embolism had set in and the boy's death was due to cerebral embolism, it is impossible that he would write in that letter that it was difficult for him even after one and a half months to piece together the information which could explain the reasons why the boy died. If his version as to the treatment given to the boy were to be correct, there was hardly any need for him in that letter to as forgiveness for my mistake, either of commission or omission which he might have committed. It is significant that until he filed his written statement, he did not at any stage come out in a forthright manner that what he had done on that day was only to immobilise the boy's leg by way only of preliminary treatment and that he had postponed to perform reduction of the fracture at a later date. In the complaint which respondent l filed before the Medical Council he had categorically alleged that while putting the boy's leg in plaster splints the appellant had used excessive manual force for about an hour, that what he did was reduction of the fracture without administering anaesthetic and that was the cause of the boy's death. It is strange that in his explanation to the Council, the appellant did not answer specifically to those allegations and did not come out with the version that there was no question of his having used excessive force and that too for about an hour as he had postponed reduction and had only given rest to the boy's leg by immobilising it in plaster splints.

15. As we have already stated, both sides used a number of medical works both at the stage of evidence and the arguments in trial court. Certain passages from these books were shown to the appellant in cross-examination which pointed out that plaster casts are used after and not before reduction of the fracture. The following passage from Magnuson's Fractures (5th ed.) P. 71, was pointed out to him:

"It is important to reduce a fracture as promptly as possible after it occurs before there is induration, delusion of blood and distension of fascia".

The appellant disagreed with this view and relied on an article by Moore, Ext. 295, where the author advocates delayed reduction. But in that very article the author further on points out that "if teams which provide well trained supervision are available for immediate reduction" it should be made. The author also states that where plaster cast is used for immobilisation before reduction a

cylindrical section 3" to 4" in width at the site of the fracture should be removed leaving the rest of the cast intact. The appellant did not follow these instructions though he placed considerable reliance on the above passage for his theory of delayed reduction. Counsel for the appellant complained that the High Court perused several medical works, drew inspiration and raised inferences therefrom instead of relying on Dr. Gharpure's evidence, an expert examined by the respondents. We do not see anything wrong in the High Court relying on medical works and deriving assistance from diem. His criticism that the High Court did not consider Dr. Gharpure's evidence is also not correct. There was nothing wrong in the High Court emphasising the opinions of authors of these works instead of basing its conclusions on Dr. Gharpure's evidence as it was alleged that that doctor was a professional rival of the appellant and was, therefore, unsympathetic towards him. From the elaborate analysis of the evidence by both the trial court and the High Court, it is impossible to say that they did not consider the evidence before them or that their findings were the result of conjectures or surmises, or inferences unwarranted by that evidence. We would not, therefore, be justified in reopening those concurrent findings or reappraising the evidence.

16. As regards the cause of death, the respondents' case was that the boys' condition was satisfactory at the time he was admitted in the appellant's hospital; that if fat embolism was the cause of death, it was due to the heavy traction and excessive force resorted to by the appellant without administering anaesthetic to the boy. The appellants case, on the other hand, was that fat embolism must have set in right from the time of the accident or must have been caused on account of improper or inadequate immobilisation of the leg at Palshet and the hazards of the long journey in the taxi and that the boy died, therefore, of cerebral embolism. In the death certificate issued by him, the appellant no doubt had stated that the cause of death was cerebral embolism. It is true that some medical authors have mentioned that fat embolism is seldom recognised clinically and is the cause of death in over twenty per cent of fatal fracture cases. But these authors have also stated that diagnosis of fat embolism can be made if certain physical signs are deliberately sought by the doctor. Mental disturbance and alteration of coma with full consciousness occurring some hours after a major bone injury should put the surgeon on guard. He should examine the neck and upper trunk for petechial haemorrhages. He should turn down the lower lid of the eye to see petechiae; very occasionally there would be fat in the sputum or in the urine, though these are not reliable signs. In British Surgical Practice, Vol. 3, (1948 ed). p. 378, it is stated,

"a fracture of a long bone is the most important cause of fat embolism, and there is an interval usually of 12 - 48 hours between the injury and onset of symptoms during which the fat passes from the contused and lacerated marrow to the lungs in sufficient quantity to produce effects."

* * * * *

"The characteristic and bizarre behaviour noted in association with multiple cerebral fatty emboli usually begins within 2 or 3 days of the injury. The preceding pulmonary symptoms may be overlooked, especially in a seriously injured patient. The patient is apathetic and confused,

answering simple questions with difficulty; soon he becomes completely incoherent. Some hours later delirium sets in, often alternating with stupor and progressing to coma. During the delirious phase the patient may be violent."

In an article in the Journal of Bone Joint Surgery by Newman, (Ext 291), the author observes that the typical clinical picture is that of a man in the third or fourth decade who in consequence of a road accident has sustained fracture of the femur and is admitted to hospital perhaps after a long and rough journey with the limb improperly immobilised. suffering a considerable shock. None of the symptoms noted above were found by the appellant. The appellant is a surgeon of long experience. Knowing that two days had elapsed since the accident, that the leg of the patient had not been fully or properly immobilised and that the patient had journeyed 200 miles in a taxi before coming to him, if he had felt that there was a possibility of fat embolism having set in, he would surely have looked for the signs. At any rate, if he had thought that there was some such possibility, he would surely have warned respondent 1, especially as he happened to be a doctor also of long standing. The evidence shows that the symptoms suggested in the aforesaid passages were not noticed by the appellant or respondent 1. The assurance that the appellant gave to respondent 1 which induced the latter to return to Dhond, the appellants apologetic letter of July 17, 1953 in which he confessed that he had even then not been able to gauge the reasons for the boy's death, the fact that while giving treatment to the boy after 6-30 P. M. he did not look for the symptoms above-mentioned, all go to indicate that in order to screen the real cause of death, namely, shock resulting from his treatment, he had hit upon the theory of cerebral embolism and tried to bolster it up by stating that it must have set in right from the time the accident occurred. The aforesaid letter furnishes a clear indication that he was not definite even at that stage that death was the result of embolism or that even if it was so, it was due to the reasons which he later put forward.

17. In our view, there is no reason to think that the High Court was wrong in its conclusion that death was due to shock resulting from reduction of the fracture attempted by the appellant without taking the elementary caution of giving anaesthetic to the patient. The trial court and the High Court were, therefore, right in holding at the appellant was guilty of negligence and wrongful acts towards the patient and was liable for damages.

18. The appeal is dismissed with costs.

Appeal dismissed.