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caesarean section; that the appellant was having a Cervical Pregnancy extending to the lower segment of her uterus which is very complicated and rare type of pregnancy which cannot be diagnosed by clinical or vaginal examination particularly in the early weeks of pregnancy; that Hysterectomy is a recommended and established procedure for tackling excessive bleeding in the case of Cervical Pregnancy and in the case of the appellant, Hysterectomy had to be resorted to save her life when excessive bleeding started; that such bleeding was not on account of any negligence in the diagnosis or on account of any faulty procedure adopted in the course of surgery. /p> p>[5] The Commission analysed the pleadings and evidence placed before it with reference to various decisions on the matter that were cited in the course of the arguments. The Commission found that the allegation of the appellant that she had gone to the Lakshmi Hospital, respondent No. 1, only to consult about the suspected pregnancy is false because there were some notings in which it had been found that the appellant had got her pregnancy test done in some other private clinic which showed it was a positive one. The Commission concluded that the appellant must have consulted the second respondent about termination of the pregnancy as her son by the previous pregnancy was only about 8 months old; that she was breast feeding him; and that she had been advised to meet the doctor on 10.2.1990. It was not clear as to why the appellant went to the Hospital on 9.2.1990 but the notings in the documents produced before the Commission indicated that 9.2.1990 was fixed for Tent Insertion. In the notings dated 3.2.1990 facts have been noted that the earlier delivery was by a caesarean section and Medical Termination of Pregnancy (hereinafter abbreviated as MTP] was fixed for 10.2.1990 and there were notings about clinical and per vagina examination made. Therefore, the Commission concluded that the allegation that the second respondent without proper examination presumed that it was a case of termination of pregnancy is incorrect. The appellant had produced certain documents before the Commission which should have been normally in the custody of the respondents and such notings made in the records are not handed over to patients. Therefore, the appellant or her advisors must have managed to remove some of the papers from her case file. The Commission also noticed that respondent Nos. 2 to 4 appeared in the witness box and they were subjected to lengthy severe cross-examination. Neither the appellant nor her husband appeared in the witness box to give any testimony in support of their version put forth in the complaint. The Commission did not attach any importance to the non-examination of Dr. Mohan, respondent No. 5, who was an Anesthesiologist in the case, who had also made notings in the records of the hospital on which reliance was placed by the appellant in support of her case that she had a normal pregnancy. /p> p>[6] After examining the evidence and text books with reference to the details of the operation set out in the additional counter affidavit dated 3.2.1992 submitted by respondent No. 2, the Commission further held that in the circumstances arising at the time of laporotomy, hysterectomy had to be performed upon the appellant and not on account of any negligence in the diagnosis and treatment and in case of emergency the operating doctor has wider discretion about the treatment. On that basis, the Commission came to the conclusion that the respondent acted with due care, circumspection and professional skill and competence and there was no negligence of any kind on their part in any manner. /p> p>[7] Before us, the learned counsel for the appellant addressed two lines of argument firstly, that the appellant had a normal pregnancy and MTP was unnecessary and secondly, without proper diagnosis by ultrasonogram, the respondents conducted MTP, which in fact was done negligently leading to excessive bleeding necessitating hysterectomy but if proper care had been taken this extreme step of removal of uterus could have been avoided. His further complaint is that the products of conception not sent for histopathological examination to confirm the diagnosis and for future follow up. /p> p>[8] On 3.2.1990, the appellant had approached respondent No. 2 with a positive report about her pregnancy and to consult about termination of the same. After having conducted clinical and per vaginal examination respondent No. 2 found that the pregnancy of the appellant was 6 to 8 weeks old. In this context, reference was

also made to article by M.Y.Rawal on Role of USG in MTP and another article about Ultrasonogram in Obstetrics, which indicates that the role of Ultrasonogram is useful in confirming or excluding an intrauterine pregnancy but it was noticed that Ultrasound is associated with significant false positive and false negative data in diagnosing ectopic pregnancy. RW 1, Dr. Rajan had also stated that test of Ultrasonogram is not usually carried out for termination of pregnancy as this test unnecessarily burdens the patient with heavy costs. He also stated that Ultrasound sometimes has harmful effects on the child also. The appellant did not have any symptom to suspect that she was having an ectopic pregnancy and that too in cervix. He deposed that cervical pregnancy in early stages is not easy to be diagnosed. /p> p>[9] The learned counsel for the respondents submitted that what had been done in the case of the appellant by the respondents was the existing practice and, therefore, they cannot be held to be liable being negligent for not doing Ultrasound test; that there was no general practice anywhere in Kerala to do Ultrasound in MTP case; that normal procedure was adopted according to the guidelines issued by the Central Government. He, therefore, submitted that there is absolutely no negligence on the part of the respondents at all and the finding recorded by the Commission is justified and that all the findings recorded by the Commission are completely against the appellant. /p> p>[10] The stand of the respondents is that it is impossible by any kind of test to detect the Cervical Pregnancy caused by the fertilised ovum getting attached to some point in the cervical canal and start growing from there and ectopic pregnancy is at a site that is not designed either to receive the concepts or to permit it to develop. In the Principles and Practice of Ultrasonography in Obstetrics and Gynecology at page 412, it is noticed that the rarest types of ectopic pregnancy are cervical and ovarian and because of their rarity these types of ectopic pregnancy are usually not prospectively diagnosed. In Gynecology by David N. Danforth dealing with this topic, it is stated therein that in about 5 to 10% the diagnosis can be made readily if the uterine cavity is empty and in other cases a cystic or complex mass is noted in one of the adenexal areas or in the culdesac. None of these indications were present in the appellants case. It is stated that in majority of women clinically suspect of having an ectopic pregnancy, however, the only ultrasonic finding is an empty uterine cavity and in such cases, if clinical exigencies permit, additional evaluation is necessary as indicated therein. The recommended use of Ultrasound as an essential adjunct is in certain cases as indicated therein, but it does not include the detection of ectopic pregnancies. In Clinical Obstetrics by Mudaliar and Menon, the authors state that perhaps in certain instances to diagnose ectopic pregnancy and incomplete abortion and Ultrasound is normally applied above the abdomen and it may now be designated as Transabdominal sonography. A different type called Trans Vaginal Sonography is only a recent development, which gives better results in Gynaecology. It is stated by the respondents that this facility was not available anywhere in Kerala not even in medical colleges and this is spoken to by the expert witnesses. /p> p>[11] Following medical authorities were also cited on behalf of the respondents to show the characteristics of a cervical pregnancy: /p> p>(a) Linders Operative Gynaecology, 6th Edition by Richard F Mattingly, it was observed that the treatment of cervical pregnancy is surgical and the condition usually requires an abdominal hysterectomy. (b) Cervical Pregnancy by Macro Antonio Peloci, Vol. IV, it was noticed that most Obstertricians would never see a cervical pregnancy and that those who did would wish that they had not. This statement is nearly as true now as it was then. /p> p>The longer a cervical pregnancy continues, the greater the depth of penetration and the degree of erosion and perforation. The pregnancy itself eventually terminates in one of two ways. Often there is erosion of a large vessel with consequent bleeding, separation and expulsion of the conceptus through the external os. Alternatively, the products of conception will repture into the vagine, the parameterium or the peritonial cavity through the thinning cervical wall. /p> p>The clinical signs of a cervical gestation generally become evident in the first weeks of pregnancy and resemble those of a threatened uterine abortion. However, cervical

pregnancy seldom is diagnosed correctly prior to surgery. This is due in part to the rarity of the condition and to the rather soft clinical features associated with it especially prior to hemorrhage. /p> p>Painless bleeding may be the most reliable way of differentiating a cervical pregnancy from a threatened uterine abortion. This symptom should also sound a warning signal to patients who request voluntary termination of what is thought to be a normal pregnancy. /p> p>Hemorrhage:- cervical pregnancies are some times discovered during voluntary termination of a supposed normal pregnancy. More often spontaneous bloody discharge is what prompts most of these patients to seek medical attention. In about 50% of the cases reviewed by Resnick, blood tinged vaginal discharge or irregular bleeding was present 2 to 4 weeks after the patient missed her first period. Such bleeding often becomes progressively more severe and can result in more or less brisk hemorrhage once the ovum begins to separate from the cervical wall or ruptures through it. Unless the gestation is very early, spontaneous or induced abortion tends to bring on violent hemorrhage. Attempts at removing the placenta, which is usually accreta only augments the hemorrhage potential. Average blood loss is put at 6.4 units. Cervical pregnancies may also involve signs of intra peritonial bleeding if the gestation has ruptured through the cervical wall. However, since the diagnosis is not generally suspected, the origin of the hemorrhage may not be clear until laportomy. /p> p>Finally it was emphasised that the clinical course of patients with cervical pregnancy can vary from a simple, uncomplicated abortion with minimal bleeding to the so-called classic presentation of sudden massive hemorrhage, especially during surgical intervention. Hence, the extent and significance of bleeding remains somewhat controversial particularly with respect to diagnosis. Paalman and Mc Elin suggested that instances of torrential bleeding are probably associated with the cervicoisthmic variety of placentation, which entails greater involvement. /p> p>(c) Gynaecology by Vadid N. Danforth and Orthers therein it is noticed as follows : /p> p>An ectopic pregnancy is a pregnancy implanted outside the uterine cavity, ie., at a site that is not designed either to receive the conceptus or to permit it to develop. The most common site is the fallopean tube. Most cases culminate in disaster of one kind or another, the conceptus is almost invariably lost and the condition may also be fatal to the mother.quot; /p> p>The importance of early surgery has been stressed and it is said that if an operation is to be done it must be done without delay. /p> p>An extremely rare form of ectopic pregnancy, cervical pregnancy produces profuse vaginal bleeding, without associated cramping pain. /p> p>Initial attempts can be made to stop the hamerrhage by local removal of the products of conception, if hemostasis is obtained, this is adequate treatment. Because of the depth of the trophoblastic invasion, however, major blood vessels are often involved, and hysterectomy may be necessary. /p> p>Dr. Rajan in his article Endovaginal Sonography in Infertility, Gynecology and Obstetrics, though acknowledges the usefulness of Trans-Vaginal Sonography until the introduction of this method the diagnosis precision was questionable. Therefore, on that basis, no conclusion can be drawn that if the Ultrasound had not been used in the case of the appellant it can be held that there was negligence on the part of the respondents. Whatever had been done by the respondents was part of general practice available in the State of Kerala. Therefore, the contention advanced on behalf of the appellant to the contrary must be rejected. /p> p>[12] In the present case, the appellant did not have any history from which presence of cervical pregnancy could have been suspected. The appellant had not complained of any significant bleeding or painless bleeding or bleeding with pain at any time. In the circumstances, the doctors could not have found that the appellant had cervical pregnancy and they cannot be held guilty of any negligence either in respect of diagnosis or in the matter of treatment administered. Hysterectomy was the only solution on account of profuse bleeding or severe vaginal or peritoneal bleeding. There was examination and cross-examination on the question whether it was a case of cervical pregnancy or a normal pregnancy where peritoneal bleeding was caused by instrumental perforation. The evidence of Dr. Rajan is that there is clear evidence in the case that the bleeding by an instrumental perforation can be stopped by a

laporotomy and by suturing the site of the bleeding and that would not be the case in a cervical pregnancy. Dr. Balachandran, who is acknowledged to be a very high authority in Kerala and was examined as RW 4, stated that whether perforation was by an instrument or not can be clearly seen after laportomy and if an instrument perforates the uterus, it can be stopped by suturing and it may even stop automatically when the instrument is withdrawn. /p> p>The main dispute between the parties is that it was a normal pregnancy and not a Cervical Pregnancy. The contemporaneous record at the time of operation indicated as follows:- /p> p>Laporotomy (G.A), i.e., General Anesthesia /p> p>While doing the MTP patient started bleeding profusely and signs of internal bleeding was present. So an exploratory laporotomy was done. There was plenty of blood in the peritoneal cavity. The bleeding was from the lateral end of the lower uterine segment. The lower segment was opened and the uterine cavity evacuated. The products were actually in the cervical canal perforating the lower segment. Since the bleeding was not controlled even after evacuation and suturing the lower segment, total hysterectomy was done. Both tubes and ovaries retained. A small rent in the bladder was repaired by Dr. C.B.C. Abdomen closed in layers after perfect haemostasis. 3 units of blood transfused at the time of surgery. Urine drained by folleys Catheter continously. Urine is clear. Output satisfactory. /p> p>The learned counsel submitted that the appellant is admittedly a high risk patient and she had a normal pregnancy at the previous caesarean scar, as noticed by Dr. Mohan, respondent No. 5, and Dr. Mohan not having been examined due weight should have been attached to the notings made by him, particularly when he was one of the persons present in the operation theatre. /p> p>This argument was based upon the notings made by Dr. Mohan. In his notes about diagnosis he had remarked pregnancy at the previous scar and it was noticed that the PPH means Post Partem Hemorrhage which means following a delivery. Dr. Somalatha P. Shenoy, respondent No. 3 stated that when the uterus was open she saw the amniotic sac with a small foetus and Dr. Santha Warriar, respondent No. 2, evacuated this product the site of implantation was noticed at the upper cervical canal and at the isthmic area. RW 4, Dr. C. Balachandran, stated that when the uterus was opened, his attention was drawn by Dr. Santha Warriar showing him the foetus in a sac with cervionic tissue presenting at the opening and when the tissue was removed it was noticed to be attached over the anterior wall of the uterus below the scar extending to the cervix. He also averred that site of implantation of tissue extended from the scar in the uterus to the upper part of the cervix and the scar means the scar opened by Dr. Santha Warriar at the site of the previous scar caused by earlier caesarean section, therefore, notings made by Dr. Mohan cannot be stated to be inconsistent with the evidence placed before the court. His examination would not have improved the matters. Even assuming that the noting of Dr. Mohan is not entirely in accord with other evidence, his noting cannot be given undue weight as against overwhelming evidence of other doctors with contemporaneous record that the pregnancy of the appellant was ectopic. Hence, the finding of the Commission on this aspect cannot be assailed at all. /p> p>[13] If the appellant had ectopic pregnancy in the cervical canal as stated above, the only remedy is Hysterectomy in which event, performance of the test of Ultra sonogram would not have improved the matter at all. At best, Ultra sonogram would have disclosed that uterus was empty and that fact does not establish as to where the pregnancy is located. In this background, we consider, it is futile to indulge in the exercise of study of evidence of doctors and medical literature on the question or the need to conduct Ultra sonogram test or the benefits therefrom. /p> p>[14] The next allegation regarding negligence on the part of the doctors is that lamineria tent for dilating cervix was used instead of dilapan and again on this aspect certain text-books were referred to. In the evidence of Dr. Rajan, RW 1, it was stated that he was using lamineria tent for dilatation of cervical canal. The use of lamineria test in dilatation of cervix is one of the accepted standard procedures and it cannot be stated that the use of that procedure by respondent No. 2 in respect of appellant constituted a negligent act. /p> p>[15] Lengthy arguments have also been advanced before the Commission that after lamineria tent is

inserted on 9.2.1990 the patient was allowed to go away and tent should not be allowed to remain inside the cervix for more than four hours as by that time it causes sufficient dilatation. The allegation made is that respondent No. 2 used Lamineria Tent for dilating cervix instead of dilapan. The evidence tendered before the Commission by Dr. Rajan and respondent No. 2 was that in Kerala the commonly used method is dilatation and evacuation or currettage. Therefore, the Commission concluded that no complaint could be made to characterise the act on the part of respondents to be negligent. Placing reliance on the article of Dr. G.I.Dhall on the subject of Suction Evacuation and Dilatation amp; Currettage in First Trimester MTP it was contended that suction evacuation is a method of choice in dealing with termination of first trimester pregnancy and this method has replaced Dilatation amp; Currettage method. Another article was referred to written by the same author, which indicated that the most commonly used method of first trimester abortion is Dilatation amp; Currettage or more appropriately dilatation, evacuation and currettage. This is the traditional method of procuring first trimester abortion and has been largely replaced by suction evacuation. The author does not say that dilatation and curettage method for purposes of terminating the first trimester pregnancy is a prohibited one. The evidence tendered by Dr. Rajan, RW 1, and respondent No. 2 has weighed with the Commission to come to the conclusion that there is no negligence in the procedure adopted by the respondents. Therefore, even if there is difference of opinion amongst the experts on the procedure adopted by a doctor, but a procedure which is commonly in practice in an area if adopted by a doctor, it cannot be said that there is negligence on his part. /p> p>(16) The learned counsel submitted that the services of Dr. Somalatha P. Shenoy, Assistant Gynecologist, respondent No. 3, was sought for only after complications started and it was only thereafter when the whole procedure was over and bleeding could not be stopped and matters reached at point of no return, as a last resort to save the appellant, Dr. C. Balachandran, Surgeon, respondent No. 4, was called to save her life. These circumstances are thus sufficient to hold that respondent Nos. 3 and 4 were grossly negligent. /p> p>[17] The appellant is a high-risk patient is not in dispute. Respondent No. 2 claimed in her counter affidavit as well as in her statement that she had explained all possible risks and dangers involved to the appellant and her husband when they came to her on 3.2.1990 and 10.2.1990 was fixed for MTP so as to give them sufficient time to reflect over the matter about the dangers of going through for MTP. It is possible for the doctors to have done the MTP or within a short period after 3.2.1990 and the fact that there was sufficient gap between the medical examination of the appellant and MTP which is not less than a week is a circumstance which probalises the respondents version that time was given to the appellant to reflect over the matter. /p> p>[18] Now, we shall turn to the next question raised by the appellant that there has been negligence in failure to take precautions to prevent accidental injury. The argument on this aspect is based on the dictum of the direction given to the jury by McNair J. In Bolam vs. Friem Hospital Management Committee (supra) which is as under : /p> p>I myself would prefer to put it this way : a doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art. Putting it the other way round, a doctor is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view.quot; /p> p>This is the legal position of the standard of care required by a doctor. A doctor will not be guilty of negligence if he has acted in accordance with the practice accepted as proper by a responsible body of medical men skilled in that particular art and if he has acted in accordance with such practice merely because there is a body of opinion that takes a contrary view will not make him liable for negligence. /p> p>[19] In the present case, though large amount of medical literature had been placed and expert evidence had been put forth before the Commission to indicate that Ultra sonography would not have established ectopic pregnancy, some text books indicate that it was possible to identify such problem. But when two views even if possible, the general practice in the area in which the respondents practised such

procedure was not followed and, therefore, no negligence can be attributed to the respondents on that ground. /p> p>[20] The argument advanced on behalf of the appellant is that in pregnancy with vaginal bleeding one must find out a cause of the bleeding before doing any procedure especially Damp;C, which may carry a risk of uterine injury of perforation. There is no material placed before the Court or foundation laid in evidence to show that there was vaginal bleeding in the present case before the proceedings commenced so as to attract the observation made in Atlas on Obstetric Complications by F.H. Falls amp; C.S. Holt. /p> p>[21] The Hospital, respondent No. 1, is alleged to have committed breach of its primary duties, as noticed earlier, for (i) inadequate supervision of physician; (ii) inadequate staffing and (iii) failure to provide ancillary services to the appellant. Regulation 4 of the Medical Termination of Pregnancy Act, 1971 provides that it is incumbent on the part of respondent No. 2 to obtain duly filled consent forms and respondent No. 1 is responsible to keep them in a cover which is mostly secret. So far as this aspect is concerned, we have adverted to the comments made by the Commission that the records had been taken away by the appellant and her advisers on her behalf and zerox copies of the same were available with them, which were produced as exhibits along with the complaint made to the Commission. In those circumstances, the inference has been rightly drawn that the appellant or someone else on her behalf must have caused disappearance of the consent forms and, therefore, the appellant cannot make any grievance in that regard. /p> p>[22] It is alleged that there is no Pathology Department in the Hospital and despite this the removal of the uterus and the products of conception were not sent to outside Pathological Department to confirm the diagnosis and for future follow up actions and that cervix in the uterus, being a seat of cancer it was all the more necessary particularly when the alleged diagnosis is cervical pregnancy which is rarest type of case. The stand of the respondent on this aspect is that in the case of the appellant what was seen was a normal sac with a growing foetus and, therefore, there was no need for any further histopathological examination. Even assuming for a moment that the uterus had not been sent for histopatholigical examination after surgery, it would not have helped the case of the appellant in any manner because that would not have established in any manner negligence on the part of the respondents in the course of the surgical procedure adopted in case of the appellant. If there was a suspicion of cancer, there would have been some manifestation of the same and, in such a circumstance histopathological examination would have been done to rule out the possibility of cancer. However, there was no complaint of any kind of cancer nor was there any such visible proof of the same. The stand of the respondents is that the case of the appellant was one of a normal trophoblast getting implanted in the upper most part of cervix and, in such cases, the question of her having carcinoma could not arise. In these circumstances, we cannot say that the failure to send the uterus and the products of conception after surgery for histopathological examination has resulted in any negligence on the part of the respondents. Therefore, on this aspect also the appellant has failed. /p> p>[23] The other contention under this head addressed by the appellant is that the stand of the doctors that profuse bleeding was on account of tropoblastic invasion or penetration of cells of cervical pregnancy but on this aspect there was no note made. The appellant contended that the defence raised by the respondents was that the profuse bleeding was on account of tropoblastic invasion/penetration but it could be so only if the condition had arisen at cervix of the uterus which is a neopbasic condition and an abnormal form of pregnancy which comes under the head of Molar Pregnancy and Choriocarcinoma which are malignancy pregnancies and to rule out that possibility histopathological examination was required. But, as a fact, there is no such material arising in the present case. Even if such a complication had arisen it would not have helped the appellant in any manner. In any event, cervical pregnancy had to be attended to and appropriate procedure had to be adopted for terminating the same, even if by doing total Hysterectomy. In the light of this fact, all arguments advanced on behalf of the appellant on this aspect pale into insignificance. /p> p>[24] This Court in Achutrao Haribhau Khodwa vs. State

of Maharashtra amp; Ors., 1996 (2) SCC 634, had occasion to examine the test for determining negligence of reasonable skill, knowledge and care in the matter of performing his duties by a medical practitioner. After referring to the decision in Bolam vs. Friern Hospital Management Committee [supra] and Rogers vs. Whitaker, (1992) 109 ALR 625 [though reported in 1993 Australian Law Journal Reports Vol. 67 Part (2) 47], wherein the High Court of Australia has held that the question is not whether the doctors conduct accords with the practice of a medical profession or some part of it, but whether it conforms to the standard of reasonable care demanded by the law and that is the question for the court to decide and the duty of deciding it cannot be delegated to any profession or group in the community. Thus there has been divergence of view between Bolams case (supra) and Rogerss case (supra). In Sidaway vs. Board of Governors of Bethlem Royal Hospital, (1985) 1 All ER 643, the House of Lords examined the principle of Bolams case and had accepted it as applicable to diagnosis and treatment in England. This Court in Laxman Balakrishnan Joshi (Dr.) vs. Dr. Trimbak Bapu Godbole, 1969 (1) SCR 206, has held as under : /p> p>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, namely, 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. /p> p>The aforesaid principle has been reiterated by this Court in A.S. Mittal vs. State of U.P., 1989 (3) SCC 223, wherein it was stated that : /p> p>The approach of the courts is to require that professional men should possess a certain minimum degree of competence and that they should exercise reasonable care in the discharge of their duties. In general, a professional man owes to his client a duty in tort as well as in contract to exercise reasonable care in giving advice or performing services. /p> p>After considering the effect of all these decisions, this Court in Achutrao Haribhau Khodwas case held as follows :- The skill of medical practitioners differs from doctor to doctor. The very nature of the profession is such that there may be more than one course of treatment which may be advisable for treating a patient. Courts would indeed be slow in attributing negligence on the part of a doctor if he has performed his duties to the best of his ability and with due care and caution. Medical opinion may differ with regard to the course of action to be taken by a doctor treating a patient, but as long as a doctor acts in a manner which is acceptable to the medical profession and the court finds that he has attended on the patient with due care, skill and diligence and if the patient still does not survive or suffers a permanent ailment, it would be difficult to hold the doctor to be guilty of negligence. [pp. 645, 646] /p> p>[25] Now, let us test whether the material on record leads us to an inference of negligence on the part of the respondents. /p> p>We have elaborately discussed the question of diagnosis in the decision whether MTP should be done or not; whether non-performance of Ultra sonography has resulted in any negligence; whether there has been any negligence on the part of the concerned doctors in inserting the lamineria tent and allowing it to stand over for more than four hours or whether there has been any damage done to any of the organs of the appellant by the instruments used at the time of Laporotomy and D amp; C. We have drawn conclusions upon the evidence produced on record and after detailed consideration of medical and oral evidence and the evidence recorded by the Commission with respect to contentions urged on behalf of the respondents, that is, there has been no negligence on their part. /p> p>[26] On any one of the aspects upon which the learned counsel for the appellant has addressed us, he has not been able to establish that there has been negligence on the part of the respondents. The case of the appellant was of such a kind that it was difficult even for a doctor to diagnose on the evidence on record as to whether she had ectopic pregnancy or not. /p> p>[27] However, the learned counsel has referred to the decision of the House of Lords in Bolitho (administratrix of the estate of Bolitho (deceased) vs. City and Hackney Health Authority, (1997) 4 AER 771, to contend that the expert evidence tendered though can be accepted as proper

there may be circumstances in which expert evidence cannot be relied upon as establishing proper level of skill and competence. If the record discloses expert evidence both for and against a particular procedure, whether the evidence adduced is reasonable and responsible and whether such evidence is capable of withstanding the logical analysis is for the court to decide. /p> p>[28] Thus in large majority of cases, it has been demonstrated that a doctor will be liable for negligence in respect of diagnosis and treatment in spite of a body of professional opinion approving his conduct where it has not been established to the courts satisfaction that such opinion relied on is reasonable or responsible. If it can be demonstrated that the professional opinion is not capable of withstanding the logical analysis, the court would be entitled to hold that the body of opinion is not reasonable or responsible. But the present case does not warrant such a conclusion since it is implicit in the courts view that the course adopted by Dr. Santha Warriar, respondent No. 2, as reasonable and although the risk involved might have called for further investigation, we cannot dismiss the doctors view to the contrary as being illogical. On that basis, we find that this decision is not of much help to the appellant. /p> p>Clark vs. Maclennan amp; Anr., [1983] 1 All ER 416, was a case where a procedure had been adopted which was a departure from the orthodox course of treatment. However, there has neither been such an allegation nor proved as a fact in the present case. Therefore, that decision has no application in the instant case. /p> p>The learned counsel for the appellant adverted to the decision in Cassidy vs. Ministry of Health, (1951) 2 KB 343, to contend that a hospital authority is responsible for the negligence of its medical staff. But, as we have found, in the present case, no negligence has been established on the part of the medical staff of respondent No. 1. Therefore, we find this decision also to be of no relevance. /p> p>Though there was reference to certain other decisions by the learned counsel for the appellant, we consider it unnecessary to advert to them since they do not lay down any different or new principles apart from what we have stated in the course of this judgment. /p> p>[29] In the light of the discussion made above, we find that the appellant has not been able to establish the case of negligence on the part of the respondents and, therefore, this appeal stands dismissed. However, in the circumstances of the case, the parties shall have to bear their respective costs./p> /div> /body> /html>