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Review Research Paper

Medico-legal Aspect of Pregnancy and Delivery: A Critical Case Review

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Abstract

For all parents and grandparents, birth is a joy, a wonder and a renewal of hope. But, one of the most devastating, life-changing events for parents is finding out their child suffered cerebral palsy. NCDRC while awarding compensation observed that human life is most precious; it is extremely difficult to decide the **quantum of compensation in the medical negligence cases.** NCDRC pointed out the difficulty in calculation of compensation and further observed that the multiplier method which typically used in motor accident cases not often conclusive for **'just and adequate compensation'**. Hon'ble Supreme Court has held that there is no restriction that courts can award compensation only up to what is demanded by the complainant. NCDRC cautioned that the corporate hospitals and Specialists, as might be expected, must perform at a higher level than other hospitals/ general practitioners.

This paper deals with critical analysis of NCDRC Judgment dated 24th April 2015 to understand the reasons for medical negligence, factors and methods for calculation of compensation in medical negligence cases and accordingly recommend for prevention of such cases in future.

Key Words: Antenatal Care, LSCS, Cerebral Palsy, Compensation, Deficiency in Service, Complications, Damage

Introduction:

This is perhaps 3rd case [1] of medical negligence in India in which more than one crore compensation has been awarded. First case of medical negligence was in 1990, twenty-year old Prasant S. Dhananka, a student of engineering, was operated upon at the Nizam Institute of Medical Sciences, Hyderabad. Due to medical negligence of the hospital, he was completely paralysed. Compensation was claimed, and the matter finally reached the Supreme Court.

The court did not apply the multiplier method and awarded a compensation of Rs. 1 crore plus interest. [2] Second case was of Dr. Kunal Saha [3] in which Rs. 6.8 Crore along with interest at the rate of 6%, highest compensation is awarded for medical negligence in India till date. NCDRC in its judgment dated 24th April 2015 [1] observed that the corporate hospitals and Specialists, as might be expected, must perform at a higher level than other hospitals/ general practitioners.

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They, after all, represent themselves as possessing highest standard facilities, care superior skill and additional training. The hospital charges and the doctor's fees normally reflect this. No doubt that the compensation in medical negligence cases has to be just and adequate, that the medical professionals need to be accountable to a certain degree. [1]

Joy of Birth of a Child: Patient Perspective

"The most important and emotional event in the life of a couple is the birth of a child and it's always a joyous occasion in the family when a newborn arrives. Most parents have a niggling fear that the nine months of pregnancy is comparable to walking through a minefield. Things can go wrong at any time. They only breathe a sigh of relief when they've counted all ten toes and fingers of their newborn. It's no wonder they feel that way because it can be the most devastating thing if your baby is born with a birth defect". **-Dr. S. M. Kantikar, Member, NCDRC, Judgment dated 24th April 2015**

Grief to Parents after Death of Child:

For all parents and grandparents, birth is a joy, a wonder and a renewal of hope. But, one of the most devastating, life-changing events for parents is finding out their child suffered cerebral palsy. Parents often go through stages of grief similar to those they would have if they had lost the child. Caring for a child with a Cerebral Palsy

can negatively impact the physical and mental health of parents and caregivers.

Many parents experience significant depression, fear and anxiety, which may have a devastating effect on the whole family.

These feelings are often suppressed due to embarrassment, shame or guilt. Many families suffer a financial burden when they have a child who has a birth defect due to a variety of factors. In some cases, the financial burden on families gets so great that families must change residences and adjust their standard of living, which can cause stress for all involved.

If the child needs regular physical, occupational, or speech therapy, this can create debilitating financial strain which can stigmatize the child who has a birth defect.

Many parents live with a sense of isolation, particularly if the birth defect of their child is rare and there is little support. This can cause significant anxiety in social settings and distressed parents further isolate themselves. [1]

Facts of the Case:

The complainant patient, (Dr. Indu Sharma, B.A.M.S.), during her first pregnancy, was under observation and follow-up of Dr. Sohni Verma, at Indraprastha Apollo Hospital, New Delhi. Previously, she took treatment from Dr. Sohni Verma, for infertility, thereafter, spontaneously; she conceived, after 4½ years.

On 10.6.1999, after midnight, due to rupture of membranes, she got admitted in Apollo hospital for her delivery. No senior doctor was available at that time, the resident doctor examined her. In the morning, Dr. Sohini Verma examined her and advised her medicines, started IV fluid with 1 ampule of Syntocinon for speeding up the process of delivery.

But, the patient noticed that the dose was maximum, and the Cardiotopographic Tracings (CTG) machine showed that the heart rate of the child began to sink (80/min.), during the midnight of 11/12-6-1999. It was alleged that none attended the patient, immediately.

Thereafter, the patient was shifted to operation theatre at 2.00 a.m. for emergency caesarean (LSCS), and at 3.36 a.m. a female baby was delivered by LSCS, weighing 3.7 kg.

The baby did not cry immediately after birth and it took almost five minutes. The baby was kept on ventilator in NICU. The OP assured that all the reports were normal. The condition of baby deteriorated further, till 29.6.1999. The baby was unable to suck milk. Meanwhile, the patient was discharged on 16.6.1999, while the baby was discharged from Apollo Hospital, on 30.6.1999. [1]

Complications or Damage occurred due to Birth Asphyxia:

After 2½ months of birth, the baby suffered, loose motions and strong clonic seizures and was admitted to Holy Family Hospital. After doing EEG and C.T. Scan, it was revealed that the baby was severally affected by the atrophy of brain, which may lead to severally mental retardation.

The complainant observed that, at age of 1 year 8 months, the milestones were delayed, and the episodes of seizures persisted. Baby was unable to hold her neck and unable to suck milk. Therefore, the complainant had to appoint a special nurse for her care.

Expert Opinion:

The child was treated at AIIMS, from 21.09.1999 to 03.12.2002, where, the Paediatric Neurologist, Dr. Veena Kalra, opined that, a full term baby having such problems were because of the negligence during the delivery.

The child was further investigated by CT scan and x-ray, but the Hospital declared reports as normal. In this regard, the complainant sought opinion of doctors in USA and from her brother, who is a paediatric surgeon, in USA.

The opinion was that severe atrophy of baby's brain cortex due to birth asphyxia and the child might remain severally mentally retarded for as long as she lives.

The Disability Board of AIIMS, New Delhi certified the baby as '95% disability'. Baby survived for 12 years with disabilities and with mental retardation. Unfortunately, baby Nistha died on 15.1.2012. [1]

Allegations of Medical Negligence:

Allegations are mainly related to protocol failure, manipulation in medical record and not supplying the medical record to patient which is an unethical practice and amount to professional misconduct.

It was further alleged that false assurance about the condition of the baby and prognosis, and not able to attend baby immediately. Specific allegations are as follows:

- The complainant alleged that doctor failed to perform LSCS within 12 to 18 hours after rupture of membrane. It was abnormally delayed for about 27 hours. [1]
- The doctor advised excessive dose of Syntocinon, which caused foetal distress and cerebral anoxia- palsy. [1]
- None attended the patient, immediately. Therefore, it was alleged that, baby suffered birth asphyxia and seizures. [1]
- The hospital assured that all the reports were normal.

- The doctors/hospital made number of corrections/interpolations on the case sheets. The neo-natal record was also tempered. The hospital purposely concealed Cardiotocograms (CTG) tracings, which was the vital document in this case.
- The doctor failed to take proper care during delivery, which resulted in birth of an asphyxiated baby.
- The hospital did not issue entire medical record, CTG graphs etc. [Para 1]

Compensation Claimed:

The complainant filed this complaint of medical negligence and has prayed total compensation of Rs. 2.5 crores plus Rs.5 lacs for the mental agony and Rs.25000/- as costs of litigation. The complainant paid approximately 2.5 lakhs towards hospitalisation. [1]

Compensation Awarded and Factors considered:

Considering the peculiarity of this case [1], NCDRC partly allowed this Complaint and pass the following order:

- The opposite parties were held responsible for medical negligence in this case, NCDRC, therefore fixed total compensation of Rs. One Crore; out of which, Indraprastha Apollo Hospital, will pay Rs.80 lacs and, Dr. (Mrs.) Sohini Verma will pay Rs.20 lacs to the patient/complaint within 90 days from the date of receipt of this order.
- The insurance company shall indemnify the respective OPs, as per law.
- Further, NCDRC imposed Rs.10 lacs as punitive cost which Apollo Hospital shall deposit in the Consumer Legal Aid Account, NCDRC within 90 days from the date of receipt of this order.
- If the order is not compiled within 90 days, the OPs are liable to pay interest @ 9% per annum, till its realization.

What went wrong: Legal Perspective?

The patient had pregnancy after 4½ years of infertility, thus it was a precious pregnancy. She was under regular observation during ANC period. Thus, the OP-3 should have taken prudent approach to deliver baby with utmost care and caution. After spontaneous rupture of membranes and administration of Syntocinon she should not have waited for more than 8 hours to take decision of C-section.

The Nurses chart speaks volumes of negligent act of OP-3. The nursing notes clearly establish hypertonic contractions foetal distress; which OP-3 failed to take proper decision for emergency C-section. It was act of omission, thus negligence.

After going through several OBG and Paediatric text books, we are of considered view that, it was the case of excessive use of Syntocinon and delay in decision to perform C-section, which caused birth asphyxia to baby.

In addition there is unflappable evidence that, the medical record of baby and mother are tampered in several places, noted interpolation, pinholes, overwriting the doses of Syntocinon.

Therefore, the doctor and it's nursing staff failed in a duty of care to accord the obstetric and paediatric care with the reasonable skill and diligence prevailing in the medical profession in order to the safe delivery of the baby. [1] NCDR concluded that thus, in this instant case, the patient with precious pregnancy was unnecessarily suffered during prolonged labour; there was administration of excessive Syntocinon which caused birth asphyxia to the baby Nishtha, who further suffered Cerebral Palsy and 95% disability. She survived in such pathetic condition for 12 years.

Keeping in the view that during this period certainly her parents were whole time engaged in care of Nishtha, incurred heavy expenditure for care, medical assistance, regular medication and physiotherapy etc. from several hospitals in Delhi. Also, the parents sustained distress and suffered metal agony, further embracement in the society for 12 years.

They sustained a loss of their baby forever. In case of precious full term pregnancy, no prudent Obstetrician/ Gynecologist will wait for more than 24 hours after rupture of membranes and allow induction by Oxytocin stimulation.

Thus, the complainant had established a prima facie case of negligence against the OPs. The complainant's evidence stood uncontroverted, and that there was no cogent evidence adduced by the OP. [1]

Case Law on Duties of Doctors:

In two decisions rendered by Hon'ble Supreme Court [4, 5], it was laid down that when a Doctor is consulted by a patient, the Doctor owes to his patient certain duties which are (a) a duty of care in deciding whether to undertake the case; (b) a duty of care in deciding what treatment to give; and (c) a duty of care in the administration of that treatment.

A breach of any of the above duties may amounts for negligence and the patient may on that basis recover damages from his Doctor. [1]

Duty of Obstetricians and Nurses /Team Members:

Obstetricians and nurses must carefully monitor a baby during labour and delivery in order to make sure that the baby is getting

enough oxygen and is not in foetal distress. The primary way to detect whether a baby is in distress is through **electronic foetal monitoring (EFM),** which records both the mother's contractions and the baby's heart beat in response to contractions.

Despite its standard use in hospitals today, sometimes doctors and nurses still fail to monitor their patients or improperly interpret monitor **CTG tracings.** This can lead to debilitating birth injuries for the baby.

When the CTG tracings show that the baby's heart rate pattern is non-reassuring, it means she is in distress and is being deprived of oxygen and must be delivered very soon.

Often, a C-section delivery is the safest and fastest way to do this. Delaying the delivery of such a baby can cause permanent brain damage due to a prolonged lack of oxygen rich blood in the baby's brain. Indeed, it is important for obstetrician and the medical team to pay close attention to the foetal heart tracings.

Medical personnel should be **skilled enough in heart tracing interpretation** that they notice even subtle changes in the tracings. Not only is it crucial for the medical team to recognize non-reassuring heart tracings, but the staff must be prepared to act on these findings. It is the responsibility of the medical team to pay very close attention to the heart tracings. [1]

Standard Protocol for Delivery:

As per **standard of practice**, after rupture of membrane (PROM or spontaneous) the obstetrician shall wait for maximum up to 12 hours; and then supposed to proceed for C-section or alternatives. In this case, **what was the need for OP-3 to conduct emergency LSCS at 2 a.m. if CTG was normal?**

The OP-3 visited the patient every 2-3 hours, thus, the foetal heart rate taken to waver at night which was unnoticed by the OP or by its staff. There is no cogent evidence that the nursing staff or labour room staff managed the FHR properly. Unfortunately the CTG tracings were not available to prove the reality. [1]

Issue of Informed Consent /Informed Refusal Consent and Medical Records:

The statement of OP that, the patient was informed about emergency LSCS which was rejected by the patient or by her husband, but, there is no evidence as such, the OP failed to take written consent or signature of the complainant or her husband about refusal of C-section. The progress sheet clearly showed some insertion made by OP/staff to show that patient was informed. Thus, the entry was also tampered one.

When to Declare Non-Progress of Labour? And to decide about LSCS?

NCDRC members concluded that we can clearly infer in this case that, after rupture of membranes, within 12 to 18 hours OP should have declared the non-progress of labour.

It is also obvious that if oxytocin did not cause effective dilation of the cervix even after 18-20 hours of rupture of membranes, the decision of LSCS should have been taken much earlier. Thus, the delay and heavy doses of Syntocinon resulted into foetal distress and brain damage of new born in this case. [1]

Delayed Decision for Emergency C-Section:

A delayed decision of emergency C-section delivery was finally ordered by OP-3. Foetal scalp pH should be checked if augmented labour is prolonged and higher dosages are given. However, the same was not done by the OP-3; it was the act of omission.

The baby was born with very low Apgar scores, wasn't breathing. Resuscitation manoeuvres were initiated right after birth, by mask ventilation and further intubation.

The umbilical cord showed blood pH 7.12; indicate baby had acidosis during delivery i.e. she was deprived of oxygen for a significant period of time. She began having seizures, which is also an indication that she experienced an oxygen depriving insult.

In fact, **hypoxic ischemic encephalopathy (HIE)** is the most common cause of seizures in the newborn period. HIE is caused by oxygen deprivation/ asphyxia. The **CT scan/ head imaging** of the baby showed oedema which is also sign of asphyxia. [1]

In the instant case, the cervical dilation never took place more than 2 cm, thus it was unfavourable cervix; and not a Cervical Dystocia as declared by OP-3 after 27 hrs. It was not an absolute indication for emergency LSCS as stated by OP-3, but certainly there would have been foetal distress noticed on CTG which OP-3 decided for emergency c-section. In our view, the OP-3 should have done LSCS after 8 hrs of Oxytocin infusion when there was no response/ no cervical effacement of cervix. [1]

As per the Complainant, she never received the CTG graphs from the OP but, the OP stated that all CTG graphs were handed over to the Complainant at the time of discharge, which was kept in separate brown folder.

The CTG tracings are vital evidence in the case of HIE which caused damage to Baby

Nistha at the time of her birth. OPs should have kept standby records of CTG tracings. [1]

NCDRC also rejected the contention of OP that, the patient was reluctant to undergo c-section, but preferred to wait for vaginal delivery. In this context, it was the bounden duty of the doctor to decide, the correct line of treatment; doctor wouldn't just blindly obey the wishes of the patient., which itself it would be unethical as discussed by the Hon'ble Supreme Court in the case of Malay Kumar Ganguly vs. Dr. Sukumar Mukherjee & Ors. 2009. [6]

Inappropriate Action with Suspicious or Pathological CTG:

Once a diagnosis of suspicious or pathological FHR trace is made action must be taken depending on the severity of CTG abnormality.Thus may mean continued observation, change in maternal position, administration of tocolytic, hydration, omission of oxytocin infusion in cases with suspicious traces and in addition fetal blood sampling/immediate operative delivery in cases with pathological traces. Accurate documentation of the time of observation and any other actions taken is very important from a medico-legal view point.

In the presence of an abruption, cord prolapse or scar rupture intervention should be taken immediately as they warrant immediate delivery (within 15-30 min).

In these situations a CTG may suddenly present with acute bradycardia. In cases of bradycardia <80bpm, the pH can decline by 0.01 every min and with prolonged decelerations that have transient recovery to the baseline rate the pH can decline by 0.01 every 2-3 min. Fetal scalp blood sampling (FBS) is an inappropriate action in such situations and is likely to compromise the baby.

Special arrangements should be in place in each unit to deliver these cases as category 1 caesarean section.

Storage of CTG:

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

Need for Teamwork and Role of Communication:

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

We have gone through the medical text, medical literature and **WHO manuals.** In the instant case, it was due to a **breakdown in communication amongst the team of doctor and nursing staff during delivery of patient.**

The resident and nurses failed to appreciate the signs of distress on the foetal heart monitor, and they failed to inform the attending OP-3 of the non-reassuring heart tracings. The Nurses chart clearly revealed that there were hypertonic contractions and the Syntocinon was decreased to 80ml/hr, again at 10.30am it was increased to Synto 100/hr, pt was getting moderate contraction and at 1130 am FHS decreased below120/min. Also, at 5 PM FHR dipped below 100/min.

Those findings were brought to notice of OP-3, but the OP-3 failed to take decision for emergency C-section. Thus at that time, the uterus was in a hypertonic state, or a state of almost constant contraction.

Contraction causes the vessels in the placenta to be compressed, which means they cannot easily refill with fresh, oxygen-rich blood to be transported to the baby through the umbilical cord. This can lead to be severely deprivation of oxygen to the baby and can result in permanent brain damage, as was the case with baby Nistha.

Therefore, it was against the standard of care for a hospital to quickly deliver a baby by emergency C-section when necessary. [1]

Standard of care allow obstetricians two options to ensure that the continuation of labour is safe for the baby. One option is to perform a test to make sure that the baby is not acidotic. (If a baby is acidotic, it means that the baby is being deprived of oxygen.)

If that test is not performed, the Oxytocin must be stopped. However, if stopping the Oxytocin did not improve the heart tracing, the standard of care required C-section delivery.

Even if the foetal acidosis test is not familiar to some obstetricians, all obstetricians are familiar with the necessity of calling a stat C-section when a foetal heart tracing does not improve despite resuscitative measures.

A good trial on fetal resuscitation would require randomization based on fetal distress diagnosed using the "gold standard" of fetal scalp blood pH < 7.2, testing the methods used for resuscitation, and accounting for the variables. [1]

In the instant case, there was the long labour process brought about by poor and negligent medical management caused the birth of asphyxiated child with cerebral palsy and seizures/ fits. As per medical literature, we

confirm that the long hours in labour caused pressure on the umbilical cord and placenta; that the oxygen supply to the foetus and very importantly to the brain was reduced and or off completely, and this caused hypoxia.

In addition the liquor was completely drained out due to prolonged period, which in turn exerted direct compression of placenta, because of pressure from contacting uterine wall. This was happened because the labour process was poorly handled. A lot of time was wasted and critical warning signs were missed by OP-3.

The cause of the baby's traumatic birth resulting in her being a cerebral-spastic quadriplegic was attributable to the fact that during the long labour process from the rupture of the membranes to the time she was delivered after 27 hours. There were stages when his brain had insufficient amounts of oxygenated blood, and as a consequence, hypoxia and peri-natal asphyxia occurred. The birth record voluminously speaks about the asphyxia. [1]

Substandard Care during Labour:

NCDRC are of considered view that, in this case due to substandard care to the patient during labour resulted poor outcome despite using modern technology of cardiography (CTG). Inability to interpret the CTG trace, not taking into consideration the clinical situation suggesting foetal distress and delay in taking appropriate action due to poor communication and team work were the reasons for the poor outcome. [1]

Issue of Unethical Practices and Medical Record:

The OPs were indulged in the unethical medical practices and professional misconduct like tampering of medical records to the maximum extent. They had not issued entire medical record to the patient and made false submission before NCDRC on 27.10.2007, that "whatever record of treatment was available with hospital has already been filed and hospital is not having other records", but produced original records of child at belated stage of proceedings in this case i.e. on 20.11.2014.

The conduct of OP was to mislead the commission on the pretext of one and other.

It is not acceptable to us, that OP issued CTG to the patient, but it was the duty of hospital to preserve CTG tracings. Thus OP did not follow the standard of medical practice, not maintained medical records. Therefore, NCDRC further imposed punitive cost of Rs.10 lacs on the OP-1. [1]

Discussion and Reasons:

A person may lie, but the documents will speak the truth. NCDRC perused the original medical records of patient maintained by the Hospital. [1]

Clinical Findings in Patient (Mother) after hospitalization:

It is most relevant to mention about the sequence of events after admission to OP-1 as stated in **medical record**:

At the time of admission uterus was 36 weeks' in size. There was Cephalic presentation, 2/5 fixed, FHR 144/minute and the PV findings are leaking ++. Cervix was long, with uneffacement, OS was closed and the head was at Station 2. The OP advised for "start 5 units Syntocinon, 40 ml/minute, and (10 drops per minute) ↑ every 30 minutes by 10 drops till desired contractions, 3/10 minutes".

Continuous CTG Monitoring:

The note at 08:10 a.m. at 11.06.1999 revealed cervix was uneffaced totally, OS was 1 cm. **CTG-FH** 130 per minute and there was "Poor beat to beat variability otherwise regular"

The OP continued the same treatment

- At 11.50 a.m. the cervix gel (prostaglandin) was instilled in posterior fornix and injection Pethedin was advised stat, but not available hence, not given, but injection Drotin was given.
- At 03.00 p.m. there were mild contractions and Syntocinon ↑ to 100 ml per minute, at 05.50 p.m. Syntocinon ↑ to 150 ml per minute and at that time CTG showed beat up to 100 beats per minute and the same was informed to OP-3.
- At 06.00 p.m. the OP-3 mentioned that FHS satisfactory and the OS was 1.25 cm, syntocinon 10 units induction continued @ 200 ml/min.
- At 09.00 p.m.: cervical OS admits one finger, cervix was 60-70% effaced; findings explained to the patient and her husband, they wish to continue labour requesting USG to confirm presentation (Pt. obese)-Agreed.
- The USG was conducted and the findings were informed to the patient and her husband and they wish to continue labour. At 00.00 hours on 12.06.1999, the notes are that "explained poor prognosis LSCS advised, but the patient and her husband refused and wished to wait for 2 more hours as FH satisfactory agreed to wait for only 2 more hours.
- Thereafter, at 02.00 a.m. the OP examined the patient and there were same findings

and the Syntocinon was stopped and performed the LSCS.

- The clinical note at 02.40 hrs: "Patient feeling unhappy and very bitter about being taken for LSCS. Says, "Brought to OT against her wishes", although consent signed! Explained the reasons for C-Section again. Foetal Heart heard-Regular-120/ml."

On careful perusal of **clinical notes** revealed that; at the first instance, OP-3 examined the patient at 7.00 am; the CTG findings taken at 08.00 a.m. clearly establish that there was poor beat to beat variability.

The subsequent findings and nursing notes on 11.6.1999 at 9.00 am, Hypertonic contractions were noticed, thereafter at, 11.30 am revealed the FHS decreased <120, informed Dr. Geeta, again at 5 pm, FHR was dipped below 100/min. Thus, the danger signals were noted thrice, and brought to the notice of OP-3, but, OP-3 did not take any prompt action or decision for emergency C-Section.

Also, it was quite obvious that, due to continuous leaking of liquor, the uterine contractions went on unnoticed. Under these circumstances, in addition to Syntocinon, administration of Cervigel caused further stimulation to the uterus.

Therefore, OP-3 should have taken the decision for urgent C- Section at least at 5pm. It was the duty of Obstetrician to counsel the patient properly about the progression of labour for every 2 hours. NCDRC do not find any such counseling was done by OP-3 or by her staff.

The OP-3 was aware that it was a precious pregnancy. Thus, NCDRC was surprised that why the OP-3 delayed the decision to perform C-section. It is apparent from the medical record that there was poor Bishop's score. [1-**Cervical Favorability**]

Neonatal Record:

Baby delivered at 3.07 on 12.6.1999, did not cry at birth even after stimulation. Bag mask ventilation was done for 1 min; at 4 am- tonic convulsions- bag mask ventilation. [1]]

Suspected? Metabolic Acidosis:

Arterial Blood Gas (ABG)= at 3.30 am pH 7.12, PCO2-50, PaO2-38, HCO3-16, BE-12 On the basis of medical text books and literature, NCDRC are of considered view, that all these findings are of **asphyxia that baby suffered during birth process**. [1]

Summary and Conclusions:

NCDRC observed that thus, accordingly, the complaint deserves for just and proper compensation. The higher the level of hospital had specialised facilities and specialist doctors available and also the cost of treatment will be higher, thus the level of expectation of the patient certainly will be high. NCDRC further added that most of the hospitals either government or private sector who treat a large number of patients and must be held accountable in cases of negligence.

It is very disappointing that, the sky-rocketing costs in health care spurred public and private reform.

There is need to debate on the issue of reasons for high cost of healthcare in India. Is there any relation with high cost of medical education in private medical colleges, excessive commercialization of healthcare, less spending by government in healthcare, etc?

There is need for awareness among medical fraternity about the changing perception of public and judicial bodies in this respect.

Following of Medical ethics and Etiquettes in letter and spirit will go a long way in improving the situation as most of the high compensation cases of medical negligence in India are filed by doctors or their relatives.

There is a strong need for developing protocol, creation of awareness about these protocols, regular CMEs, and strengthening of regulatory mechanism on healthcare providers. State Medical Councils /Medical Council of India should play their much awaited role of regulating medical profession. Professional organization and IMA should come forward to intervene in timely manner to fill the gap in such scenario.

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