THE WEST BENGAL CLINICAL ESTABLISHMENT REGULATORY COMMISSION.

Present: Justice Ashim Kumar Roy, Chairperson.

Dr. Sukumar Mukherjee, Member.

Dr. Makhan Lal Saha, Member.

Dr. Madhusudan Banerjee, Member.

COMPLAINT ID: SPG/2017/000243.

Mr. Akash Raj .....Complainant.

-versus-

Apollo Gleneagles Hospital Ltd. & others.....Respondents.

Date of judgment: 16th February, 2018.

J U D G M E N T.

1. The complainant Akash Raj with an allegation of overbilling,approached this Commission against the Clinical Establishment, Apollo Gleneagles Hospitals Ltd (hereinafter referred to as "*Apollo*").

2. The case of the complainant, as narrated in his letter of complaint, is reproduced herein below in verbatim:-

On October 17, 2017, in the evening, the complainant started feeling pain in the lower middle of his abdomen, slowly the pain increased and by night, the pain became severe. The whole middle part of the stomach was paining. On the advice of a local doctor, he got admitted at *"Apollo"*. At the time of admission, he was told that he had symptoms of appendicitis and performed several tests including CT Scan to confirm the diagnosis. After CT Scan the complainant was told that he had appendicitis and needed to be operated. Owing to high cost of operation, he took discharge on the next day evening and by that time, the pain in the middle of the stomach was subsided and he decided to get his appendix operated at some other place. On the second day after discharge, he went to Dr. Udipta Roy for getting his appendix operated when DrUdipta Roy after examining him and CT report, told that he had no symptom of appendicitis and pain was due to his irregular food habits and constipation. He did not prescribe any medicine and advised him to drink lot of water and now he is normal. However, the "Apollo" making a false claim of appendicitis charged him Rs.47,403/- in one day and pressurized him to get his appendix operated there.

3. Immediately upon receipt of the complaint, notice was issued against the clinical establishment seeking their response against the allegations and also directed to submit the entire medical file of the service recipient.

4. In response to that that clinical establishment appeared and submitted their written reply and produced the bed head ticket.

5. According to the Apollo, the service recipient presented himself in its emergency department on October 18, 2017 at around 12.10am with acute periumbilical and right iliac fossa pain with an episode of vomiting about one and half hours back (as per the Clinical Information noted in the Accident & Emergency Record, UHID: 1275542 dated 18.10.2017 and in the Brief History of Presenting Complaints). As per the patient's own admission and reported clinical history, there were two similar episodes in past, which were undiagnosed (also noted in the medical file in B.H.T.). One was four years and another, six months back. On evaluation, there was Mc Burney's point tenderness. Clinical features raised possibility of acute appendicitis. Initial investigations showed leucocytosis (TLC 15000/cumm). In view of a recent USG investigation done outside Apollo Gleneagles Hospitals, which was inconclusive, CECT Scan of whole abdomen was done to confirm the diagnosis of acute appendicitis after informing the patient and his relatives and with due consent. CECT Scan of abdomen was suggestive of acute appendicitis as documented in the report as "Appendix is dilated and thickened with absence of intraluminal contrast. There was periapendical inflammation and multiple enlarged discrete mesenteric nodes in right iliac fossa. No evidence of any periappendical collection."

On the basis of all these evidences a diagnosis of acute appendicitis was made and appendectomy was offered as mode of treatment. Non-surgical treatment options were also discussed with the patient and family.

According to the complainant his condition subsequently improved without surgery, that neither surprising nor disprove that diagnosis of appendicitis was wrong.

The patient was offered the surgical option of treatment in presence of his relatives. It had been mentioned that in view of definite evidence (Clinical features, Blood results, CECT findings) it was better to have appendectomy, which is the preferred treatment for acute appendicitis. At the time of counseling for operation it was also mentioned that in view of no periappendical collection on CECT, if patient did not want operation, antibiotics might be continued but the patient would need monitoring. This was clearly documented in the patient's hospital record (BHT) as well as in the discharge summary given to the patient. The patient and his family were given all options of treatment and were counseled extensively.

It was categorically denied that the patient party was pressurized to get the surgical operation done at the Apollo. The allegation of overbilling was also refuted. It was added that the patient was presented in the Emergency Department of Apollo Gleneagles Hospitals, Kolkata with acute pain in abdomen at around midnight which itself was suggestive of the medical emergency. As such the relevant initial assessment investigations were essential for diagnosis and hence done. He needed a CECT to confirm the diagnosis and to plan for definitive management. Intravenous antibiotics were initiated and administered. The Investigations were billed as per standard tariff of the hospital.

6. The parties were heard at length. Perused the complaint and the reply of the "Apollo" as also the medical file of the service recipient and the medical literature relied upon.

7. We have carefully gone through the materials placed before us. Now considering the allegations in the petition of complaint together with the prescription of DrUdipta Roy (dated 20/10/2017 and 23/10/2017), it is not disputed by the service recipient/complainant that he was admitted atApollo on October 18, 2017 (around 12.10 a.m. at midnight) and according to the contemporaneous record, that is, the clinical notes in the admission sheet, the patient presented with manifestation of symptoms suggestive of acute appendicitis and CECT Scan was done, which also confirmed the clinical diagnosis. The medical condition of the Gastro Intestinal Tract (GIT) as noted in the CECT Scan Report, *"Appendix is dilated and thickened with absence of intraluminal contrast. There is periappendical inflammation and multiple enlarged discrete mesenteric nodes in right iliac fossa. No evidence of any periappendical collection"* (AGHLIP60508, DRN: 317021812). It was also categorically documented that while advising for appendectomy the patient relatives were explained non-surgical options as well, but the patient party agreed either for surgery or for non-surgical treatment and opted for discharge against medical advice and was discharged with the advice of medicines' intake including antibiotics. It is claimed by the complainant on October 20, 2017 when he visited DrUdipta Roy, after examining him and the CT Scanreport, he was told by Dr. Roy that he had no symptom of appendicitis and that the pain was mainly due to irregular food habit and constipation. We, however, going through the prescriptions dated October 20,

2017, referred by the complainant, as also the prescription dated 23rd October, 2017, do not find that even remotely Dr Roy opined that the CT Scan Report did not reveal that he had no appendicitis at the time when the procedure was done and that the service recipient has not suffered pain due to appendicitis. It be noted that the service recipient, first felt pain on 17.10.2017 in the evening, he got admitted at Apollo on 18.10.2017 at 12.10. a.m., and took discharge against medical advice at 3 p.m., and examined by Dr. Roy on 20.10.2017 at 8p.m. and 23.10.2017.

8. On further perusal of the prescriptions of Dr. Roy, on the first day (20.10.2017), his clinicalnotes was to the effect,

"Started acute
Pain around navel
On 17/10/2017 evening
↓↓
T/t by local doctor
Oral medicines
↓
Had dinner, vomited once
Pain ↑ in intensity
& went to Apollo
same night
No H/o Fever
Took D on 18/10/2017
C/E

Pain ® groin

Radiating to testis

A-O-J-C-Cl/K-

NG-NV"

Likewise on perusal of the prescriptions of Dr. Roy, on the second day (23.10.2017 i.e., on the fourth day from the first day of examination), his clinical notes was to the effect

"F/U C/O

Pain ® IF

+ ® groin

USG lower abdomen: N study

B1 picture

TLC : 5800

N : 61%

CRP : 5.6

Urine R/E, C/S : D"

In his last prescription (23/10/2017), Dr. Udipta Roy noted that no clinical finding suggestive of acute appendicitis at present i.e. obviously on 23.10.2017. Such opinion never ruled out the diagnosis, that the service recipient was suffering from acute appendicitis when he was examined at Apollo on 17/ 18.10.2017 around midnight and finding of the CECT Scan was wrong.It will not be out of place to refer from the medical file that during his treatment at Apollo, the

complainant received medicines including antibiotics, vizINJ. PIPERACILIN, TAZOBACTUM + INJ. METRONODAZOLE and INJ. TRAMADOL, INJ. Paracetamol. After intake of those medicines, more particularly, the antibiotics, the acuteness of symptom of appendicitis might have been subdued,consequently on 23/10/2017 when Dr. Roy opined *"no clinical finding suggestive of acute appendix at present"* (pain started on 17.10.2017 and Dr. Roy opined on 23.10.2017, i.e. after a gap of 6 days). It is pertinent to note that Dr. Roy when examined the service recipient on 23/10/2017, never opined *"the clinical findings was not suggestive of appendicitis"*. Therefore the claim of the complainant that the Apollo falsely claimed he was having appendicitis is far-fetched.

9. The next question arises for decision as to whether the manifestations ofsymptoms and past episode, with which the complainant was presented at Apollo on 18.10.2017 at around 12:10a.m. at midnight and on clinical examination having found that he was suffering from appendicitis the consultant was wrong in advising CECT Scan.

10. In this regard it would be quite relevant to refer an article titled *"Appendicitis Imaging"* published in *Medscape* issue dated *July 3, 2017 Editor Eugene C Lin, MD (which is one of the leading online global destinations for physicians and healthcare professionals worldwide, offering the latest medical news and expert perspectives).* The said article was authored by LutfiIncesu, MD and Professor, Department of Radiology, OndokuzMayis University School of Medicine; Chief, Neuroradiology, Department of Radiology, OndokuzMayis University Hospital, Turkey and co-authored by Caroline R Taylor, MD Associate

Professor, Department of Diagnostic Radiology, Yale University School of Medicine; Chief, Diagnostic Imaging Service, Veterans Affairs Connecticut Health Care System. In the said article *"Appendicitis Imaging"* under the sub-title *"Preferred Examination"* the Author referred a passage from a paper titled *'ACR Appropriateness Criteria: Right Lower Quadrant Pain--Suspected Appendicitis'*, published *in the November, 2011 issue of the Journal of American College of Radiology, Vol. 8, Issue 11, p.-749*. The same is reproduced in verbatim:

"Controversy exists as to whether imaging is required in patients with the classic history and physical findings of acute appendicitis. Opinion varies as to whether these modalities should be performed in all patients with suggested appendicitis or if radiology should be reserved for select patients with atypical or confusing clinical presentations.

Appropriateness criteria have been published by the American College of Radiology (ACR) for right lower quadrant pain suggestive of appendicitis. In the appropriateness criteria, ratings of 7 to 9 are considered "usually appropriate". Computed tomography of the abdomen and pelvis with intravenous contrast is rated 8, and CT of the abdomen and pelvis without contrast is rated 7. Ratings of 4 to 6 indicate that studies "may be appropriate." Right lower quadrant ultrasound with graded compression is rated 6, and abdominal radiographs (for excluding free air or obstruction) are rated 5. Magnetic resonance imaging is rated 4. Ratings of 1 to 3 indicate that studies "are usually not appropriate." Barium enema and technetium-99m white cell scanning are rated 3."

In the said article the author also referred a Guideline of *Smith M P, Katz D S, Lalani T, Carucci L R, Cash B D, Kim D H et. al. ACR Appropriateness Criteria ®*

Right Lower Quadrant Pain – Suspected Appendicitis Ultrasound Q. 2015 June 31(2):85-91and the relevant portion of the said articleis reproduced below:

"...Computed tomography is the most accurate imaging study for evaluating suspected acute appendicitis and alternative etiologies of right lower quadrant pain...."

Reference was also made from a joint study on Radiology by Carpenter J L, Orth R C, Zhang W, Lopez M E, Mangona K L, Guillerman R P- A Prospective Cohort Study. Radiology. 2017 Mar. 282(3) : 835 – 841 (Medline) which revealed *"Contrast-enhanced, thin-section (0.5 mm) CT scanning has become the preferred imaging technique in the diagnosis of acute appendicitis and its complications, with a high diagnostic accuracy of 95-98%. The literature suggests that limited helical CT scanning with rectal contrast is a highly accurate, time-efficient, cost-effective way to evaluate adult patients with equivocal presentations for appendicitis. CT scanning is particularly preferred in patients in whom appendiceal perforation is suspected, because the diagnostic accuracy remains high and because CT scanning is useful for characterizing periappendiceal inflammatory masses. Ultrasonography has been found to be highly specific but nonsensitive for perforated appendicitis"*

11. In addition to the above referred article another article titled *"Acute appendicitis in adults: Diagnostic Evaluation"*authored by Ronald F Martin, MD and Stella K Kang, MS will also be apposite to refer on this issue. The relevant portion of the said article is quoted below:

"....Abdominopelvic CT is recommended as the preferred test in the imaging evaluation of suspected appendicitis in adults ..... If available, low radiation dose

image acquisition protocols should be used as they do not compromise diagnostic accuracy..... Intravenous contrast is recommended, although CT without contrast is an acceptable alternative when intravenous contrast is contraindicated..... CT demonstrates higher diagnostic accuracy than ultrasound or MRI..."

12. In view of the above medical authorities, the decision on the part of the doctor of the clinical establishment to make the service recipient undergo a CT Scan in order to determine whether he was indeed suffering from a medical condition of acute appendicitis or not, cannot, under any circumstances, be held to be an unnecessary advice. Further, contemporaneous clinical notes reveals that the service recipient had been suffering from pain in his lower abdomen for one and a half days prior to his admission with one episode of vomiting and he had two similar episodes in the past, which were undiagnosed will also justify the decision of the clinical establishment.

13. It is pertinent to note that the CT Scan report dated 18.10.2017, in fact, confirmed the preliminary diagnosis that the service recipient indeed was suffering from a condition of acute appendicitis. Nowhere in his two prescriptions, more particularly in the last prescription dated 23/10/2017 the Dr. Udipta Roy in his findings noted that diagnosis by the Doctors of Apollo that the service recipient was suffering from acute appendicitis was wrong. By mere recording a finding "*No C/F suggestive of acute appendicitis at present*" in his prescription dated 23/10/2017, when he examined the service recipient, 6 days after when he was hospitalized by no stretch of imagination can be said to have ruled out the conclusion of the consultant of Apollo at the relevant time (on 17

/18-10-2017 midnight). It is pertinent to note that on and from 17/18-10-2017 midnight the service recipient along with pain killer and other medicines was also receiving antibiotics and thereforewhen he was examined by Dr. Roy on 23.10.2017, the symptom of appendicitis might have,in all likelihood, subsided due to the regular use of antibiotics in the intervening period. In his two prescriptionsDr. Roy neither noted that the CECT Scan was not necessary nor did the CECT Scan report reveal that the patient was not suffering from acute appendicitis, as claimed by the service recipient.

Although not established still as a matter of abundant caution it be noted no allegations of deficiency of serviceis forthcoming from the side of the complainant.

14. For the reasons stated above, the case of the complainant/ service recipient that he was not suffering from acute appendicitis on 17/18-10-2017 midnight, when he was examined at Apollo, and the clinical establishment unnecessarily made him to undergo CECT Scan and on a false claim that he had acute appendicitis charged him Rs.47, 304/- (Rupees Forty Seven Thousand Three Hundred and Four) do not stand established.No materials have been brought on record to substantiate such charges against the Clinical Establishment.

15. The only other complaint is left for consideration is of overbilling. It is claimed, that the service recipient had to pay a sum of Rs.47, 304/- (Rupees Forty Seven Thousand Three Hundred and Four) for one day stay at the Hospital. We find from the Bill that he was charged on account of consultation, invasive procedures, investigations, non-invasive procedure, profile, room rent and ward

pharmacy, which were actual. It is not disputed those were according to the standard tariff of Apollo. It is never the case of the complainant either the Apollo charged him in excess from their standard tariff and levied a charge without actually conducting any particular procedure or investigation, etc.On the mere allegation in a particular premium hospital the rates for invasive and non-invasive procedure, investigation, room rent, doctor's consultation fees are high, that does not make out a case of overbilling. It is one case that rates are high and it is completely different there was overbilling. A case of overbilling can very well be made out against any clinical establishment even where charges are quite moderate or low, when it is established they are charging for a service exceeding the prescribed rate or charging for a service which has actually not been rendered.

This case has got no merit and stands dismissed.

Sd/-
Justice Ashim Kumar Roy
Chairperson.

Sd/-
Dr. Sukumar Mukherjee, Member.

Sd/-

Dr. Makhan Lal Saha, Member.

Sd/-

Dr. Madhusudan Banerjee, Member.

Authenticated
16/11/2018
Secretary
W.B.C.E.R.C.
Kolkata-1