THE WEST BENGAL CLINICAL ESTABLISHMENT REGULATORY COMMISSION.

Present: Justice Ashim Kumar Roy, Chairperson.

Smt. Sanghamitra Ghosh, IAS, Vice-Chairperson.

Dr. Sukumar Mukherjee, Member.

Dr. Gopal Krishna Dhali, Member.

Dr. Makhan Lal Saha, Member.

Dr. Madhusudan Banerjee, Member.

Dr. Maitrayee Banerjee, Member.

Dr. Debasis Bhattacharyya, Member.

COMPLAINT ID: NPG/2017/000191.

Manoj Kumar Jain .....Complainant.

-versus-

Charnock Hospital & others.....Respondents.

Date of judgment: 20th April, 2018.

J U D G M E N T.

It is the case of the complainant, after the pregnancy of his wife Deepa Thapa, was detected by positive urine test of pregnancy, on July 19, 2017, she attended Dr. Jayanta Kumar Gupta at Apollo Clinic, who advised both medicines and USG for pregnancy. Since the medicines advised by Dr. Gupta gave no relief, on 26.07.2017, the patient visited Dr. S.B. Mahapatra at Millennium Clinic with pain in abdomen and 6 weeks amenorrhea and Dr. Mahapatra advised her for USG of abdomen for fetal profile. According to his advice, on August 1, 2017 such USG was done at Charnock Hospital by Dr. Nilanjana Dutta Chowdhury and impression was *"features suggestive of incomplete abortion"*. It is alleged at the time of USG, the patient tried to tell her

problem to the Sonologist but she was busy with her colleagues and did not pay any heed to her complaints. After obtaining the USG report, the complainant personally met Dr. Mahapatra with the report since his wife was unable to visit the doctor due to abdominal pain and bleeding per vagina. Dr. Mahapatra advised some blood tests and asked the complainant to come for review with the reports. However, at the same night, her abdominal pain aggravated and at about 1:19am on 02.08.2017, the wife of the complainant was admitted at Charnock Hospital under Dr. S.D. Mahapatra. At the emergency, the doctor, who attended her and advised only analgesics, the complainant although tried to contact Dr. Mahapatra but could not succeed. Thereafter, as per the advice of the emergency doctor the complainant backed home and returned to the hospital again at 9am. At the hospital, he found his wife was in severe distress but he was not allowed to remain in the ward by the duty sister since that was a female ward. He tried to contact the doctor but could not. In the meantime, he came to learn that Dr. Mahapatra attended the patient at 8am in the morning and advised for USG abdomen, however, such advice was not followed. Then again around 11am, the concerned Registrar visited her and also advised for urgent USG. After about 3 hours from the second advice, finally at around 1:45pm, USG was done by the sonologist, Dr. Nilanjana Dutta Chowdhury, and according to the report, *"features suggestive of ruptured ectopic"*. After obtaining the report, the complainant was told by the hospital authority that immediate surgical intervention is needed and he was asked to collect 4 units of blood and a requisition slip was handed over to him. In the blood requisition slip, the blood group of the patient was wrongly noted A+ve, but when the blood sample was tested at the blood bank it was found to be B+ve and due to that mistake, there was a delay of about half an hour in delivery of the blood and, the operation was delayed. Thereafter around 3pm exploratory laporatomy was done and 1-3 litre of blood was found collected in peritoneal cavity with corneal ectopic rupture and blood was evacuated hemostatsis secured and patient was shifted to the ward. According the complainant, all this untoward events happened and the patient suffered unnecessary pain and distress due to the wrong USG report, treatment and delayed surgery. Perhaps she may not be able to conceive in future. Finally, the complainant took discharge of his wife on 5.8.2017.

As per the affidavit and the statement made in Paragraph 10 thereof, the clinical establishment gave a discount of Rs.15,000/- but it was not clear therefrom how much was the final bill.

The complainant in addition to his letter of complaint filed his complaint in the form of affidavit. It is his categorical case of deficiency in patient care service and over billing against the Clinical Establishment and prays for adequate compensation.

2. The Clinical Establishment duly represented by its Medical Superintendent and both Dr. Shankar Das Mahapatra and Dr. Nilanjana Dutta Chowdhury were present before the Commission.

3. The Clinical Establishment as well as Dr. Shankar Das Mahapatra used affidavits in response to the case of the complainant. In the affidavit the Clinical Establishment denied the allegation of deficiency in service and over billing and it is claimed a sum of Rs. 15,000/- was discounted against a total bill of Rs. 75,000/-.

4. In course of hearing Dr. Utpal Chatterjee, the Medical Superintendent of the Clinical Establishment and Dr. Nilanjana Dutta Chowdhury, Sonologist, examined on oath.

5. Dr. Utpal Chatterjee, when was examined with reference to the medical file of the patient viz Bed Head Ticket admitted that USG was advised first by Dr. Mahapatra at 8 am on August 2, 2017 to rule out ectopic pregnancy and the same has been noted in the BHT and then by another doctor at 12.10 pm but actually USG was done 6 hours after the first advice. He further admitted that the test should have been done within an hour from the time of advice and he has no explanation as to why there has been such delay. He admitted that the patient was admitted in their hospital with abdominal pain and bleeding per vagina and diagnosis was incomplete abortion based on earlier USG done at their on 01.08.2017. He further stated that he did not dispute that it was the duty of the Clinical Establishment to carry out the advice of Dr. Das Mahapatra at once and when their Registrar at 12 noon after attending the patient not only ratified such advice but also asked for urgent USG (TVS). The witness volunteered that Dr Das Mahapatra is their regular consultant and on that day, he had only one patient in their

hospital and Dr Das Mahapatra should have apprised the nursing home authority about the urgency of the procedure. The patient was admitted in the hospital on the advice of Dr Das Mahapatra.

6. Dr. Nilanjan Dutta Chowdhury, Sonologist, in her evidence stated that she is in the pay roll of the nursing home and on 2.8.2017, she came to the hospital at around 8.30am. She further admitted that she received the requisition of doing the USG at 1.30pm and if such requisition received earlier, it could have done much before. She admitted that between 8.30am to 1.30pm, she had time to do the USG, if informed earlier.

7. Heard the parties. Considered their respective submissions. Perused the letter of complaint and the complaint in the form of affidavit as also the affidavit in reply filed by Dr. Sankar Das Mahapatra, treating doctor and that of the clinical establishment filed by their Medical Superintendent, Dr Utpal Chatterjee. The deposition of both Dr Utpal Chatterjee and Dr Nilanjana Dutta Chowdhury were also considered.

8. From perusal of the affidavit in reply of Dr S. D. Mahapatra, the treating doctor, we find that on considering the ultrasound study done on 1.8.2017 revealing *"features suggestive of incomplete abortion along with mixed ecogenic SOL in the mid endometrial cavity"* he gave his advice. Thereafter, on 2.8.2017, at 8am he physically attended the patient thoroughly examined her and advised for a repeat USG and Adnexa to exclude the possibility of an Ectopic Pregnancy. Then again after he was informed at around 12.10pm on that day, that the patient complaining abdominal pain, he insisted for getting USG done urgently. Finally, TVS was done at 2pm by the same Sonologist, who reported, *"features suggestive of ruptured ectopic"* over phone. Having come to learn about the report of USG, he rushed to the hospital at 2.10pm and then after arranging for blood and other things, operated the patient at 3.30pm. Exporatory Laparotomy was done, Ruptured Cornual (Left Side) Ectopic was confirmed and all necessary surgical management was completed methodically within an optimal time frame.

9. Now from perusal of above materials on record, it is an admitted position that on the advice of Dr S.D. Mahapatra, the first USG of the service recipient, Ms Deepa Thapa, was done

on 1.8.2017 at Charnock Hospital by Dr Nilanjana Dutta Chowdhury and it was reported ... *"features suggestive of incomplete abortion"*. The said Dr Nilanjana Dutta Chowdhuy is admittedly in the pay roll of the Charnock Hospital and under their employment. On the next day i.e. on 2.8.2017, the said Dr Nilanjana Dutta Chowdhury once again done second USG of the patient and this time reported *"features suggestive of ruptured ectopic"*. This variance of interpretation how occasion was never explained by the clinical establishment far less by Dr Nilanjana Dutta Chowdhury, who was examined during the hearing. Rupture Ectopic Pregnancy is life threatening emergency. At 7 weeks of pregnancy, abdominal pain associated with bleeding per vagina is one of the presentations of Rupture Ectopic Pregnancy. The wrong USG report led to wrong diagnosis and surgical intervention has been considerably delayed resulted in causing extreme pain, agony and distress to the patient. Even if, such variance be accepted as error in judgment on the part of the sonologist still certain other manifest deficiency cannot be overlooked. Admittedly, the patient was admitted at midnight around 1:19am and until 8am no specialized gynecologist attended her. According to Dr. Mahapatra, he thoroughly examined the patient at 8am and advised for a repeat USG and Adnexa to exclude the possibility of an ectopic pregnancy. Thereafter, he was again at 12:10am informed by the hospital authority that the patient was complaining about acute abdominal pain and till then no USG was done as advised. When at that time i.e. around 12:10pm he insisted for getting the USG done urgently. Finally the USG was done at 2pm and the report was "features suggestive of ruptured ectopic". According to Dr. Mahapatra, having come to know about the USG report he rushed to the hospital and after all arrangements are complete the patient was operated at around 3:30pm and exploratory laporatomy was done and ruptured cornual ectopic was confirmed. We find from the response of the clinical establishment that their RMO on duty at midnight contacted Dr. Mahapatra but he only attended the patient after about 7 hours. It is well-known that ruptured ectopic pregnancy is a life threatening emergency but luckily, in the case at hand, such disaster has not occasioned but the patient has to suffer acute pain, agony and distress without any fault of her. If anybody is to be made responsible for this immense suffering of the patient it is none else but the Clinical Establishment. In this regard, it be added that according to Dr. Nilanajana Dutta Chowdhury, Sonologist, on that day she came to the hospital at 8.30am and

got the requisition for USG at 1.30pm. It is also her categorical evidence that if she would have received the requisition for USG earlier which could have been done much before. Dr. Utpal Chatterjee, Medical Superintendent also admitted that USG should have been done within an hour from advice and he had no explanation why there was such inordinate delay in carrying out the doctor's advice. We further find, not only that at 8am Dr. Mahapatra advised for USG but that was not done, even after another doctor advised for urgent USG at around 12.10pm still requisition was sent at 1.30pm and procedure was done around 2 pm. This is undoubtedly a clear deficiency on the part of the Clinical Establishment.

Secondly we find that for surgical operation 4 unit blood was requisitioned. However, in the requisition slip the blood group of the patient was A+ve but fortunately when the sample was tested at blood bank it was found that actual blood group was B+ve. This is another gross lapse and deficiency on the part of the hospital authority. If the wrong blood was transfused the patient, it would have led her death.

10. For the reasons stated above, we are of the opinion that the clinical establishment is guilty for deficiency in patient care service.

11. Thus the only question left for our consideration to fix the quantum of compensation. Now, considering the nature of pain and agony suffered by the patient and the period during which she has to bear such pain and agony due to the lapse and negligence on the part of the clinical establishment and the fact the possible consequences of such lapse and negligence and taking into account that already a discount has been given to the patient party to the tune of Rs.15,000/-, we are of the opinion that it would be adequate if a sum of Rs.100,000/- be fixed as compensation.

The compensation amount must be paid to the complainant through an account payee banker's cheque, drawn in favour of Mr. Manoj Kumar Jain within 15 days from the date of release of this order.

12. Before parting we make it clear that we have not gone into the issue that whether there was any negligence on the part of Dr. Sankar Das Mahapatra, on the face of the content of the

affidavit of clinical establishment that from the midnight and as soon as the patient was admitted, the on-duty RMO contacted him and he was intimated the condition of the patient still he did not visit the patient until 8am on 02.08.2017, since in view of prohibition contained in first proviso to Section 38 (iii) of the West Bengal Clinical Establishment (Registration, Regulation & Transparency) Act, 2017 adjudication as regards to the same by this Commission is not permissible.

Sd/-

Justice Ashim Kumar Roy,
Chairperson.

Sd/-

Smt. Sanghamitra Ghosh, IAS, Vice-Chairperson.

Sd/-

Dr. Sukumar Mukherjee, Member.

Sd/-

Dr. Gopal Krishna Dhali, Member.

Sd/-

Dr. Makhan Lal Saha, Member.

Sd/-

Dr. Madhusudan Banerjee, Member.

Sd/-

Dr. Maitrayee Banerjee, Member.

Sd/-

Dr. Debasis Bhattacharyya, Member.

Authenticated

20/4/2018

Secretary
West Bengal Clinical Establishment
Regulatory Commission

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COMPLAINT ID: NPG/2017/000191