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.

Dr. Maitrayee Banerjee, Member.

COMPLAINT ID: EMID/2018/000278.

Mr. Goutam Maiti.....Complainant.

-versus-

R.N. Tagore International Institute of Cardiac Sciences.....Respondents.

Date of judgment: 18th December, 2018.

J U D G M E N T.

The complainant, Gautam Maiti in his letter of complaint, alleged as follows,

His wife, Sumana Maiti who was suffering from diabetes and as a result developed renal dysfunction for last 3/4 years was under treatment of Dr. Pratik Das, one of the best empanelled doctors of R N Tagore International Institute of Cardiac Sciences (for the sake of brevity hereinafter referred to as *'RTIICS'*) in it Nephrology Department. On August 18, 2017, since her condition became very serious, she was immediately taken to RTIICS and reached there around 6.30p.m. However, at around 9.30p.m, she was admitted and the staffs at emergency, took the history and her present difficulties and complications. Even after

admission, she was not allotted bed and was left on a stretcher only with an oxygen mask. At around 10.30p.m, his wife started suffering from respiratory disorder and acute chest pain. But no doctor attended her. After repeated insistence and lapse of about 25/30 minutes, she was attended and her proper treatment started but by that time severe damage already caused. At around 12.30a.m, the complainant was informed that his wife had suffered a cardiac arrest. But no Cardiologist examined her on 19.8.17 and 20.8.17. Ultimately, on August 27, 2017, during visiting hour at around 4.25p.m, he was informed by the hospital authority that his wife had expired.

In the light of aforesaid allegations, the complainant posed following questions,

a) Why his wife was not admitted soon after they reached at the hospital?
b) After officially admitted, at around 9.30, why not the proper treatment started at once?
c) Why there was a delay in allotment of bed?
d) Why at 10.30p.m when his wife had chest pain, no doctor was available at that moment?
e) Why no Cardiologist was consulted after she suffered cardiac arrest on 19.8.2017 and 20.8.2017?
f) Why USG of eye ball/ orbit was done on 25.8.2017, when hospital authority was fully aware that she was completely blind of two eyes?
g) Why the ventilator and apparatus were removed before he entered the cabin to see his wife dead?
h) No pattern was maintained while billing and dates are haphazard
i) The complainant was charged twice for blood glucose strip test on 2.4.17 and 6.4.17

2. Immediately, after receipt of the complaint, a notice was sent to the RTIICS calling for its reply. The Clinical Establishment submitted its reply in the form of affidavit denying all the allegations and contending as follows,

a) The patient was brought in the emergency ward of RTIICS on August 18, 2017 with chief complaints of 'shortness of breath', Altered Sensorium, History of Tongue Bite, Lower Limb Weakness and Restlessness and already having dialysis elsewhere in the backdrop of Chronic

Kidney Disease, Stage 5, Type II Diabetes Mellitus and Hypertension. The patient and the kin of the patient were duly informed about immediate unavailability of any beds in the Emergency Department and its uncertainty. Despite the unavailability of any beds, the said patient was put on a trolley bed, in between two beds in the Emergency Ward and immediately was attended by the on duty Emergency doctor.

b) Although the kin of the said patient were duly informed about unavailability of beds in the Emergency Ward of RTIICS still they intended to continue her medical management in the Emergency Ward of RTIICS. The medical management of the said patient commenced immediately upon her arrival and before commencement and completion of the admission procedure and the subsequent to availability of bed, the completion of Emergency medical record sheet by the on-duty Emergency doctor of RTIICS and other documentations being completed thereof, the procedure of admission of said patient was competed at 9.03p.m.

c) The on duty Emergency doctor commenced immediate supplemental oxygen therapy and nebuliztion, to stabilize the condition of the said patient and that undertook further medical management, which includes injecting Furosemide. The on Duty Emergency doctor of the RTIICS further undertook 'blood-gas analysis' and 'ECG'. The said patient was also attended to by the Nephrology on call doctor, on behalf of the admitting consultant. Up until the time the condition of the said patient deteriorated at around 12.15a.m on the morning of August 19, 2017, the said patient had no complaints of any chest pain or aggravation of symptoms. It is further submitted that said patient was catered to diligently and with utmost care and was continuously monitored, in accordance to the set protocol.

d) The said patient, from the time of being brought into the Emergency Ward of RTIICS, was with utmost care continuously monitored by the on duty staff, in accordance to the set protocol and that at no point was the said patient left unmonitored. The condition of the patient was stable and continued to be stable, until complaints of generalized discomfort at around 12.15 a.m of August 19, 2017.

e) The Emergency Ward, is at all times, manned by highly trained and professional security personnel, wherein such personnel is at all times sensitized about the condition of the patients and the kin of the patient thereof. Therefore, the security personnel or other staff allow at least

one member of the family, relative or friend, as the case may be, to accompany the said patient, unless the presence of such person is an hindrances to the treatment or causes disturbance or annoyance to other patients.

f) Subsequent to the commencement of medical management, the said patient was hemodynamically stable and was saturating at one-hundred per cent (100%) on supplemental oxygen at two liters per minute (2liters/minute) and that the said patient did not require, at any stage, non-invasive ventilator support, prior to her clinical deterioration at around 12.15a.m on the morning of August 19, 2017. However, the said patient complained of generalized discomfort, with no chest pain, at around 12.16a.m in the morning of August 19, 2017, it is to be noted that up until such time, the said patient had no complaints of any chest pain. The said patient became unresponsive and bradycardiac for which the said patient received immediate intervention i.e. 'atropine' was give. However, the condition of the said patient continued to deteriorate and progressed to a cardiac arrest. Resuscitation was started according to Advanced Cardiovascular Life Support Protocol ('ACLS Protocol') and the said patient had to be immediately intubated and eventually due to the joint diligent efforts of the on duty Emergency doctor and para-medical and nursing staff, Return of Spontaneous Circulation ('ROSC') was achieved with a blood pressure of 190/100mmHg. During this time, the admitting consultant, Dr. Pratik Das was consulted, immediately and that Dr. Pratik Das visited and examined the said patient in the Emergency Ward of RTIICS, the said patient was further evaluated by the on call doctor from the Cardiology Department, at around 3a.m in the morning of August 19, 2017 and that he performed an 'ECHO Screening'. The condition of the said patient continued to deteriorate, the patient become hemodynamically unstable and that inotropes was started. The said patient was also assessed by consultant Neurologist of RTIICS, Dr. Haseeb Hassan. The said patient continued to be diligently monitored by the medical practitioners, para-medical staff and nursing staff of RTIICS and was subsequently shifted to the Intensive Treatment Unit of RTIICS at 4p.m on August 19, 2017. In the meanwhile, the kin of the said patient was duly informed about the sudden deterioration and the cardiac arrest thereof and that the same is matter of record.

g) The patient from the time deterioration of condition was accessed by the on call doctor from the Cardiology Department in the Emergency Ward of RTIICS, who further conducted an ECHO Screening of the said patient. The said patient continued to be under the observation of, among others, the consultant Cardiologist of RTIICS, Dr. Kuntal Bhattacharya and that the advice of Dr. Kuntal Bhattacharya was duly followed.

h) The said patient on August 27, 2017 at 4.25p.m unfortunately passed away due to 'Septic Shock' in a case of chronic kidney disease stage 5 on hemodialysis.

i) As is the standard practice and protocol of answering RTIICS, the kin of the patient is shown the flatline on the ECG monitor while declaring the death of a patient. Subsequent to which the decannulation commences, after 'Authenticity Declaration of Patient Details by the Patient Relative (After Expiry)'.

j) There was no negligence in the treatment of the said patient and on multiple occasions, she was admitted and successfully treated at RTIICS, prior to her sad demise.

k) It is incorrect to suggest that the USG of eye ball was performed to derive 'more profit'. The said patient was known to be blind and was accordingly evaluated by the Neurologist for history of tongue-bite and altered sensorium. The examination by the Neurologist revealed 'Right Eye Corneal Opacity', with bilateral pupils dilated. In order to evaluate any ophthalmic etiology, a referral was given to the Ophthalmologist. On the examination by the Ophthalmologist, the learned Ophthalmologist was unable to evaluate the right eye fully due to the opacity and requested a USG of both eyes to rule our Endophthalmitis, Retinal Detachment or Vitreous Hemorrhage. The USG was therefore necessary and therefore the allegation levied is wholly an afterthought. The treatment rendered is in line with the comprehensive care provided to all the patients of RTIICS.

l) The pattern of the billing and their arrangement thereof is due to the technological challenges faced by the RTIICS in its billing procedure. However, it is submitted that such technological challenges are trivial and that it any manner is not detrimental to the interest of person to whom treatment is being rendered.

m) The most drugs or medical devices or medical equipments or other such ancillary items are ordered prior to its use and that the night shift nursing staff takes on the responsibility to

indent for planned medications and consumables for use during the following day. In the impugned case of an earlier admission, the night shift nurse had ordered for 8 strips on April 2, 2017 at around 1 am, for use on the same day itself i.e. April 2, 2017. However, the following night shift nurse ordered for 8 strips at around 11.40pm on April 2, 2017, for use on April 3, 2017. It is therefore submitted that since both the requests for 'Blood Glucose Strips' were made on the same calendar date, it is reflected as a separate line items on the same date in the final bill.

n) We find the aforesaid affidavit on behalf of RTIICS was affirmed on 30th January, 2018.

3. Subsequently, another affidavit was filed on behalf of the complainant. In the said affidavit, the complainant made further allegations and same is summarized below,

a) In all previous hearing, it was claimed by RTIICS that Dr. Pratik Das had personally visited the patient at 8.20pm on 18.8.2017 at the time of admission but at the time of hearing, on 18.9.2018, they claimed that the patient was seen by Dr. Manoj and he consulted Dr. Pratik Das over phone. Thus the examination of the patient by Dr. Pratik Das personally was changed to telephonic conversation.

b) Dr. Manoj and Dr. Pramod may be good, energetic and young doctors but their experience, is no comparison with highly experienced doctor, Dr. Pratik Das.

c) Dr. Pratik Das personally examined the patient at around 12am on 19.8.2017 after complainant's wife suffered cardiac arrest.

d) No document was filed to show that on 18.8.2017 between 10.30pm -11pm, the patient was under necessary observation.

e) Suddenly, sisters hourly monitoring chart was produced on 18.9.2018

f) The first cardiologist, who visited the patient, was Dr. Kuntal Bhattacharya at 8.15pm on 20.8.2017 nearly 44 hours after cardiac arrest of the patient.

g) The claim of RTIICS, that Dr. Pratik Das visited the patient regularly. It is a lie and not proven by the records.

h) The investigation for blood for culture and sensitivity was done and reported only once but the complainant has been charged twice.

i) After cardiac arrest, a Neurologist, Dr. Haseeb Hassan was consulted. He in term referred the case to on Ophthalmologist Dr. Sudipto Gupta. The said Ophthalmologist advised for USG of both eyes even knowing she was blind for 2 years. USG was done 48 hours after advice. Dr. Pratik Das stated that there was no need to pursue the matter any further.

j) The allegation of medical negligence was categorically made even on the very first day.

4. The RTIICS also used a further reply in the form of affidavit and in the said affidavit they came out with the following explanations,

a) On account of consultation by Dr. Pratik Das, on 27.8.2017, the patient party was never charged twice. Dr Pratik visited the patient at least once every single day during the stay of the patient at the Hospital. The patient was billed for Dr Pratik Das's consultation for 9 times from 19.8.2017 to 27.8.2017, i.e during the phase of admission and treatment at the hospital. Therefore, it may be concluded that for a visit for every day of the 9 (nine) days, the patient / complainant was billed justifiably.

b) The Glucose strip and Lancet are two separate surgical consumables and as such are charged separately.

c) The said patient, Sumana Maiti, was known to be blind and was accordingly evaluated by the neurologist for history of tongue bite and altered sensorium. The examination by the neurologist revealed 'right eye corneal opacity', with bilateral pupils dilated. To evaluate any ophthalmic etiology, a referral was given to the ophthalmologist. On examination by the ophthalmologist, the Learned Ophthalmologist was unable to evaluate the right eye fully due to the opacity and as such requested a USG of both eyes to rule out Endogenous Endophthalmitis as one of the differential diagnoses which would affect the body and other organs. Hence, the USG was felt necessary and accordingly was performed.

d) The bill was done twice for Culture and aerobic sensitivity test for blood because two simultaneous blood cultures for patients are being done as per medical standards, and hence the 2 investigation results are reported together.

e) The death summary is a hand-written report, and the 'an' is a typographical error in place of 'no'. That the fact that there was no obvious bleed in the CT-head or that CT head was essentially normal has been recorded multiple times in the doctor's progress note and the same is a matter of record. The typographical error had no bearing on the treatment of the patient.

f) It is stated that Causes of death are defined by WHO as "all those diseases, morbid conditions or injuries which either resulted in or contributed to death and the circumstances of the accident or violence which produced any such injuries".

g) Underlying cause of death is defined as "the disease or injury which initiated the train of morbid events leading directly to death, or the circumstances of the accident or violence which produced the fatal injury", in accordance with the rules of the International Classification of Diseases. In Smt Sumana Maiti's case, cause of death was 'septic shock in a case of chronic kidney disease stage 5 on maintenance hemodialysis.

5. It be noted on September 19, 2018, Dr. Pratik Das was examined on oath. In his such examination, he stated as follows,

On 18.8.2017, the patient Sumana Maiti, a known patient of end stage renal failure with diabetes and hypertension, regular patient of hemodialysis for more than three years presented to the emergency with shortness of breath. She was attended by emergency doctor, Dr. Rashed. After initial evaluation and primary management, he asked Dr. Manoj Gupta, the on call Nephrologist to see the patient. At around 8.20pm, Dr. Manoj Gupta saw the patient and provided management after consulting with him over telephone. Then he received a call from the emergency that the patient Sumana Maiti had a cardiac arrest and he immediately attended the patient, who was resuscitated and put on ventilator. It is true that in the bed head ticket there was no note by doctor from 8.20pm on 18.8.2017 to till 12.16am but the nursing chart exhibits that the patient was monitored hourly. As the patient had cardiac arrest

Neurologist consultation was sought for to exclude Hypoxic brain damage. On second visit by Neurologist on 22.08.17, he advised ophthalmologist referral. Ophthalmologist, Dr. Sudipta Ghosh examined the patient on 23.08.17 and advised for USG of both eyes. Ultra-sonography was done on 25.08.17 and report is noted in the bed head ticket. However, no further referral was sent to ophthalmologist, as after going through the report according to my judgment no further referral to the ophthalmologist was necessary. So I did not make any further referral. However, there is no note of mine in the bed head ticket. While advising blood culture this is not a routine practice to draw two blood culture at the same time from both hands but according to the international guideline it can be done. However, in the records there is only one blood culture report although hospital charged for both the report.

However, his cross-examination was declined.

6. The only other witness, who was examined before the Commission, was Dr. Joydeep Bhattacharya, Medical Superintendent of RTIICS. According to him, she was admitted on 18.8.2017 and expired on 27.8.2017. While she was in ITU, on medical advice, two blood samples were taken from her both hands and sent for culture. However, in the bed head ticket, there is only one report was attached not the other one. But they have charged for two reports.

7. Heard the parties at length. Their respective oral submissions and contentions made in the affidavits also considered very carefully. We have also perused the original medical records and the bills.

8. Before entering into the rival contention of the parties, it be noted that on the first day of hearing i.e. on 11.4.2018, the complainant, who appeared and argued the case in person, openly stated that he has no grievance against Dr. Pratik Das, the treating doctor and accordingly, the Commission observed that there is no need to proceed against Dr. Pratik Das except for reaching to a just decision in this case.

It be further noted, considering the nature of allegations as a matter of abundant caution, the Commission sent for the original medical files of the service recipient, Sumana Maiti, wife of the complainant and the progress notes, nursing charts, pathological reports and other relevant materials were duly perused and had taken into account.

9. This is a case, where the wife of the complainant, Sumana Maiti, aged about 47 years, suffering from Type II Diabetes Mellitus, Hypertension associated with Chronic Renal Failure Stage 5 and under hemodialysis for last 3 years on 18.8.2017 with history of 'shortness of breath', Altered Sensorium, History of Tongue Bite, Lower Limb Weakness and Restlessness was brought at RTIICS. According to the case of the complainant, they reached the hospital at around 6.30pm but the patient was left unattended and around 9.30pm, she was admitted after taking the history and her present complications by the emergency doctor. However, on perusal of the medical records, we find that she was first attended, at emergency, by Dr. Rashid at around 7.35pm and her medical condition was evaluated by him and advised for O_2 inhalation and Foley's catheterization SOS. He also advised PAN40 and injection Lasix Stat and referred the patient to Dr. Pramod (on call nephrologists). Thereafter, around 8.20 pm the patient was thoroughly examined by the on call nephrologists who assessed the parameters of the patient and gave additional advices as for example, Nebulization and other medicines. Subsequently, around 12.16 am on 09.08.2017 the patient had a cardiac arrest following chest pain, unresponsive and found to having suffered bradycardia, when the emergency doctor, Dr. Deep Chowdhury attended her at 12.16am and started CPR according to medical ACLS protocol and informed Dr. Pratik Das and referred the patient to Dr. H. Hasan. Dr. Pratik Das then attended her at around 12.20am at late night within a few minutes and examined the patient and advised accordingly. Therefore, we are unable to accept the claim of the complainant that the patient was not attended in time at the emergency and by the other doctors on the date of admission.

We further find after she suffered bradycardia, she was first attended by the Critical Care doctors, Inj. Atropine IV 1amp Stat, CPR started according to the ACLS protocol and within a few minutes, Dr. Pratik Das under whom she was admitted, on being informed, attended her and she was resuscitated. We further find during post cardiac arrest, the patient was put on ventilation and closely monitored, her vitals were noted and doctors from different fields as referred by her primary consultant Dr. Pratik Das, had examined her and given their valuable opinions and she was treated for her cardiac complications as per standard medical protocols. It is true that Dr. Kuntal Bhattacharya, Cardiologist attended the patient on 20.8.2017 at around

8.15pm nearly 44 hours after she suffered bradycardia but the fact remains that in between she was regularly attended by the doctors attached to the critical care unit and by the on call cardiologist, Dr. Pallav Kanti Bose. It be added that Dr. Kuntal Bhattacharjee, Cardiologists visited the patients, only when her primary consultant Dr. Pratik Das referred him and on the very first day of hearing, the complainant in no uncertain term submitted before the Commission that he has no grievance regarding the treatment of his wife by Dr. Das. It further be noted Dr. Kuntal Bhattacharya, on examination of the patient, did not advise any fresh medication implying that the earlier treatment was as per the standard protocol. Therefore, the issue raised, merits no consideration.

The next question raised that immediately after the patient was brought to the hospital and even after her admission for several hours, no bed was allotted and she was kept in a stretcher in emergency ward. In this regard, it be noted that every hospital has its own capacity and when the beds are not available, the hospital authority cannot be blamed for not allotting bed to any patient. In the case in hand, rather it was a good gesture on the part of the hospital authority instead of refusing admission of the patient, she was kept in a stretcher and put on supplemental oxygen therapy and nebulization to stabilize her condition and undertook further medical management. Then, she was thoroughly examined and all parameters were noted by senior resident nephrologists and was admitted. We further find when at the emergency, the patient suffered bradycardia that too at midnight around 12.15am within a few minutes Dr. Pratik Das attended her and all steps including CPR were started according ACLS Protocol and she was resuscitated. We therefore do not find any fault on the part of the Clinical Establishment as far as the treatment as per standard protocol is concerned.

So far as the question of examination of the patient by an Ophthalmologist even though the patient was blind for a year, we are satisfied with the explanation given by Dr. Pratik Das, her primary consultant, in his statement on oath made before the Commission and there is nothing wrong.

10. Now coming to the issue of overbilling, we find that it is not correct that Dr. Pratik Das, without visiting the patient, raised his bill for 27.08.2017. We have gone through the original medical papers and found that in the progress notes Dr. Das in his own handwriting noted

down his observations. It was then alleged, for a blood culture done on 20.08.2017 the complainant was charged twice and only one report was handed over to the patient party. However, on examination of the medical papers, we find that there are two reports for the said blood cultures. It was also alleged that without actually testing blood for sugar, the bills were raised and in the progress notes there was no reflection that those tests were actually done. Now, on examination of the original medical records from the nursing chart, we find that the allegations are not correct and on each occasion whenever the blood was tested for sugar the result was very much recorded in the nursing chart.

11. Having regards to above, we are of the opinion that the charge against the Clinical Establishment has not been established. The case accordingly fails 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.

Sd/-
Dr. Maitrayee Banerjee, Member.

Authenticated

ARSHAD HASAN WA
WBCS (Ex)
Secretary
W. B. C. E. R. C.