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: KOL/2018/000413/422.

Mr. Abhijit Saha.....Complainant.

-versus-

Columbia Asia Hospital.....Respondents.

Date of judgment: 18th December, 2018.

J U D G M E N T.

The case of the complainant is that his wife Baisakhi Saha, aged about 31 years, had been to Columbia Asia Hospital, Salt Lake being accompanied by him with abdominal pain. At the said hospital, his wife was attended at Outdoor Patient Department by Dr. Sujoy Maitra, Gastroenterologist. The Gastroenterologist then referred the case to Dr. Joyeeta Roy Mitra, a Gyneacologist attached to the said hospital. Dr. Joyeeta Roy Mitra prescribed other blood tests to be done immediately. According to the advice of Dr. Roy Mitra, those tests were done at the said hospital. The investigation revealed that she was suffering from an ectopic pregnancy and Dr. Joyeeta Roy Mitra suggested for an immediate operation on that night itself. Dr. Roy Mitra also informed them the operation was not at all serious and the patient would have to stay in the hospital 1/2days. Immediately, the wife of the complainant took admission in the said hospital and was allotted Bed No.504.

On that day, i.e. on 05.06.2018 at around 9.30p.m, his wife underwent surgery and thereafter around 11.30p.m, the complainant was informed that she was out of danger and the patient was shifted to general bed. He was further informed that from the next day, she will be able to walk and on the day after, she will be discharged. He was further told that during operation, there was loss of blood and transfusion of 2 units of blood was needed and the blood would be supplied by the hospital.

Around 1a.m midnight, one on duty ward sister was found preparing for blood transfusion. At that time, the complainant asked her the blood group which is going to be transfused and was told that was AB+, immediately, the complainant pointed out to the said sister that her blood group was A+. However, the said ward sister without giving any importance to his words told that what she is doing that as per Serology Report and she will not go by what the complainant was saying.

Within a few hours of transfusion of blood, side effect and reaction started. At around 5a.m, in the morning, the complainant found that the Catheter tube and urine bag was full of dark blood. The blood was coming out with urine and hematuria started. He immediately asked the ward sister to send for REGISTRAR Dr. Priyanka and Dr. Joyeeta. But nobody attended her call. Even the nurses on duty did not show any interest. Finally, REGISTRAR Dr.Priyanka came at around 7.15a.m and then at around 8a.m Dr. Joyeeta Roy Mitra came. Both of them had not taken the matter seriously and told him that everything was fine. In the midst, Dr. Joyeeta Roy Mitra told him that she was going on leave and left the patient. The patient started vomiting but nobody was there to support her. In next 2 to 3 hours, his wife started turns yellow. In spite of his vigorous search, no doctor was available. Around 11.30a.m, doctor came and she was sent to ICU. At that time, ICU Doctor told him that due to transfusion of wrong blood, she became very serious and her lungs are badly affected. She was put on BiPAP and on the next day i.e. on 07.06.18, she went on ventilation. Simultaneously, the kidney functions were also damaged and dialysis started thrice in a day.

At the ICU, the doctor and support staffs started trying their level best to save her life. But enough damage has been caused to his wife due to the negligence of Dr. Joyeeta Roy Mitra, Dr. Priyanka and nurses on duty between 5.6.2018 till 6.6.2018 morning at Bed No.504.

Though on 13.6.2018 from afternoon, the ventilation support was weaned of still his wife was kept in ICU with high oxygen support, her hemoglobin level came down alarming range 6.6, creatinine level vey high 6.6 but the hospital authority arranged for no Senior Nephrologists to see and examine her. In the meanwhile, his wife started running fever.

Most shockingly, Dr. Joyeeta Roy Mitra, Dr. Priyanka all gone on a leave immediately after incident. Mr. Arindam Banerjee gone for a vacation when his wife battling in ventilation. Till date, neither Mr. Arindam Banerjee nor Dr. Joyeeta Roy Mitra has not called him once to ask about his wife.

The hospital administration in spite of the fact that his wife became seriously ill due to their fault and has shifted to ICU, still pressurizing him for making payment and told him that his bill has crossed 7lakh but due to no fault of him. In spite of the fact that his wife suffered permanent damage, due to the fault of the hospital, the hospital authority overlooking the same, insisted for payment.

Action Taken by the Commission on receipt of the complaint.

Immediately upon receipt of the complaint, the Commission issued notice against the Columbia Asia Hospital and sough for their explanation against the allegations made.

The reply of the Clinical Establishment, Columbia Asia Hospital.

The patient, Baisakhi Saha, aged 31 years came to hospital on 5th June, 2018 afternoon, with lower abdominal pain for over 2 weeks, started vomiting on 23rd May 2018, with urine pregnancy test positive. To rule out an ectopic pregnancy, an ultrasound abdomen and pelvis was done and it showed a right tubal ectopic pregnancy with hematoma. She had bled profusely into the abdominal cavity as a consequence of her tubal pregnancy which required urgent surgery.

After surgery she was given PRBC transfusion to which she reacted it was identified that this was due to a mismatched transfusion.

Urgent and immediate action was instituted and opinion of various consultants like intensivists, pulmonologist, and others were taken. Aggressive treatment was commenced and patient was treated as per protocols.

As patient developed symptoms of acute respiratory distress syndrome, she was immediately placed on ventilator support and monitored round the clock by the team of specialists.

She was weaned off ventilator and with ongoing treatment and monitoring she showed gradual improvement and all her vital parameters were stable.

She was discharged on 22nd June, 2018 as she had completely stabilized and was eating and mobilizing normally. She was advised to return for follow up after 3 days.

The patient returned on 24th June, 2018 with macular rashes over the limbs and body. She has been admitted and investigated completely by performing blood and radiology tests. Although her liver function tests were deranged initially, the values have returned to near normal. She is now on the road to recovery and rashes have come down and she is stable She will be discharged when she completely stable. The hospital commits to continuing aggressive care and continuous monitoring to ensure complete recovery of the patient until discharge and thereafter without any monetary demands for bill payments.

Conclusion.

Going through the medical records and considering the respective submissions of the parties, we find Baisakhi Saha, firstly visited OPD of Columbia Asia Hospital with acute abdominal pain. Subsequently, she was attended by a Gynecologist Dr. Joyeeta Roy Mitra and considering the investigating reports, it was diagnosed she was having ectopic pregnancy. In the same evening, she was operated upon and the operation was uneventful. Since she suffered blood loss during operation her attending doctor, Dr. Joyeeta Roy Mitra advised for transfusion of 2 units of blood. Accordingly, blood was started at around 12 midnight by the ward sister Arjun Khan who is registered Odisha Nurses & Midwives Council, bearing Registration No.19273 of 5.12.2016. (A Xerox copy of the EPIC Card of the said ward Sister, duly verified by the Clinical Establishment, was filed on their behalf before the Commission at the time of hearing and it appears that in the said EPIC Card she was described as Arju Khan.) The blood group which was transfused on her by the said ward sister was AB+ although the blood group of the patient was A+. It is claimed by the complainant all through the night and at the time of transfusion of blood, he was very much present at the bed side of his wife and having noticed such mistake, he and his wife also pointed out the same and told the ward sister that she was having A+. But the ward sister refused to pay any heed to such words of the complainant and his wife. Consequently, due to the transfusion of wrong blood, the patient developed severe transfusion reaction, namely, hematuria, acute renal failure, ARDS and other complications. Since her condition was quite serious, she was shifted to ICU, where she underwent treatment in first phase from 6.6.2018 till 18.6.2018 and finally discharged from the hospital on 22.6.2018. She again readmitted on 24.6.2018 for further treatment and discharged on July 7, 2018.

The Clinical Establishment, either in their written reply or during hearing, has not disputed the facts that wrong blood was transfused to the patient, i.e. instead of Group A+ which was the real

blood group of the patient, the blood transfused was AB+. It is also not disputed that due to such wrong blood transfusion, the patient developed severe transfusion reaction, hematuria, acute renal failure and other complications and had to undergo treatment at the hospital initially for more than 2 weeks and then for another 2 weeks. Although the disease with which she was admitted only required her retention in the hospital for 2 to 3 days. The fact that at the time of transfusion of blood, the ward sister was pointed out about her mistake by the complainant and his wife was in full sense still the ward sister turned a deaf ears to their words. The above fact was stated by the complainant and his wife before the Commission and in presence of the representative of the Clinical Establishment and their Counsel but such fact was not disputed. We have no reason to disbelieve such statement of the complainant when no fact is forthcoming to doubt the same.

We further find, after the operation the on duty REGISTRAR Dr. Priyanka Shiv Kumar Mandve attended the patient, only once and thereafter on the next day around 6.41 am, after 7 hours of transfusion of the wrong blood and noted in the progress note 'patient conscious, oriented, comfortable, no complaints, afebril'. The complainant categorically claimed at the time of hearing in presence of Dr. Priyanka Shiv Kumar Mandve, finding the medical condition of her wife deteriorating grossly and the content of urine in the catheter and urine bag was containing blood and she was turning yellowish, the complainant not only urged the ward sisters to attend her but he also rushed to the rest room of the REGISTRAR where Dr. Priyanka Shiv Kumar Mandve was found sleeping and Dr. Mandve declined to see the patient then and there and finally attended around 6.41 am. As already noted, the complainant made such allegations in presence of Dr. Priyanka Shiv Kumar Mandve but she never challenged nor disputed the claim of the complainant. Therefore we have no reason to disbelieve the complainant. Thereafter, Dr. Joyeeta Roy Mitra, under whom the patient was admitted visited her at around 8.44a.m. Now from the progress note, we do not find in such a serious situation where due to transfusion of wrong blood the condition of the patient was grossly deteriorating even her life was at stake, both the doctors took a very casual approach and nowhere advised how to confront with such a situation to save the life of the patient. Instead, in the progress note Dr. Mandve noted that "patient conscious, oriented, comfortable and no complaints, P/V bleeding within normal limits, urine haematuria". At 8.44 am when Dr. Joyeeta Roy Mitra attended the patient, she noted haematuria post blood transfusion, vital stable—omit blood transfusion and start IV fluids and referred to Dr. Dibakar Ghosh and then she transfer the patient to Dr. Jyita Chakraborty, another gynecologist. The approach of both the doctors towards a patient, in a case where wrong blood group was transfused on her and due to that her medical condition worsened, as is manifests from their observations and advices noted in the progress note, undoubtedly is quite casual and not befitting with the approach of a doctor in such a serious situation. This is highly

deplorable act on the part of a doctor. The doctor under whom the patient was admitted after attending her transferred the charge of the patient to another gynecologist, Dr. Jayita Chakraborty. In response to our query as to why she transferred the charge of the patient to another doctor, it was told by Dr. Joyeeta Roy Mitra that on that day i.e. on 06.06.2018 she was supposed to undergo a surgical operation which was scheduled to be held at 12 noon. In our opinion, a doctor might have personal reasons and more so, for his/her medical condition can take leave from treating a patient but when such treatment, as the case in hand, a surgical operation is already scheduled, it is the duty of the doctor to intimate the same to the patient party beforehand and taking the treatment of the patient, otherwise such perfunctory action of a doctor is not at all acceptable. It is true that the concerned sister, who transfused the wrong blood was actually responsible in deficiency in patient care service but at the same time, the two doctors, more particularly the on duty REGISTRAR and Dr. Joyeeta Roy Mitra have not also shown their real concern towards such a serious patient, who became so serious due to the fault of their paramedical staffs. How far those two doctors are negligent in patient care service in such a life threatening situation is required to be gone into by the State Medical Council and we restrain ourselves to enter into such arena on the face of the prohibition contained in Second Proviso to Sub-section (iii) of Section 38 of the West Bengal Clinical Establishment (Registration, Regulation and Transparency) Act, 2017. We keep it open for the complainant to approach the concerned State Medical Council for taking appropriate steps against the above two doctors in accordance with law, if so advised. So far as the ward sister is concerned, we have been informed by the Clinical Establishment that the concerned ward sister has left her job and from her registration certificate, produced before the Commission by the Clinical Establishment, we find that she was registered with Odisha Nurses & Midwives Council bearing Registration No.19273 dated 5.12.2016. It will also be opened to the complainant to approach the concerned State Medical Council against the erring ward sister for appropriate legal action, if so advised.

So far as the Clinical Establishment, Columbia Asia is concerned, they have admitted the fault of the ward sister in transfusing wrong blood (instead of Group A+, blood transfused AB+). The said ward sister was under their employment. Therefore, the Clinical Establishment cannot absolve of its deficiency in patient care service. We further find, in spite of the fact that there was manifestation of reaction of wrong blood transfusion, no doctor including the Registrar on duty, Dr. Priyanka Shiv Kumar Mandve has not attended the patient until 7.41 am and nearly 7½ hours after the blood transfusion, when she examined the patient her attitude was not proper and was callous. She never advised for urgent medical action. In a case of this nature, it was the duty of the on duty REGISTRAR to attend the patient at once, because due to such lapse a life threatening situation may arise. Both the ward sisters and the Registrar are under the employment of the Clinical

Establishment, through whom the Clinical Establishment was providing patient care service. Therefore, the hospital authority cannot absolve of its responsibility for the wrong committed by them.

It goes without saying, due to the above reasons, the wife of the complainant had to suffer extreme physical pain, sufferings and trauma and was confined in bed for a total period of 4 weeks and during that period her only daughter aged about 9 years remained unattended and was deprived of motherly care. We conclude the Clinical Establishment is guilty of deficiency in patient care service and such deficiency has posed a threat to the life of the patient and this is a fit case for awarding compensation.

Quantum of compensation

A total bill for Rs.10,36,008/- has been raised and out of that, an amount of Rs.90000/- has been admittedly realized by the Clinical Establishment from mediclaim against the package of Rs.110000/- for the treatment of Ectopic Pregnancy. The clinical establishment in their written reply has stated that the patient was discharged without any monetary demands for her treatment during two phases. It also be noted a sum of Rs.97000/-was taken from the complainant by the Clinical Establishment but the said amount has admittedly been refunded. In the second occasion a bill for Rs.311707/- was raised but without realizing the same the patient was discharged. Such claim has not disputed by the complainant. The lawyer of the Clinical Establishment, Jyoti Chowdhury in presence of Mr. Arindam Banerjee, Senior General Manager of Columbia Asia Salt Lake, intimated the Commission that they are ready to waive the entire outstanding amount of Rs.1257715/-.

In any event, by waiving off the bill amounts, which accrued due to a serious lapse on the part of the clinical establishment, it cannot be said either a mercy was shown to the patient or that was an act of charity.

Considering the fact for the treatment of the patient due to the wrong transfusion of blood nothing was charged from the patient party and out of the package amount of Rs.110000/- an amount of Rs.90000/- was realized out of medicalim and considering the nature of deficiency caused in patient care service we are of the opinion that awarding a sum of Rs.100000/- as compensation would be enough for doing the real and substantial justice. Such amount of compensation shall be paid to the complainant by the Clinical Establishment by and a/c payee banker's cheque within 15 days from this date. In addition to above, we direct in future, if the wife of the complainant suffers

from any medical complications due to the reason of wrong blood transfusion and for that she is required to be treated at OPD or in indoor, her entire treatment to be done free of cost. In case of her treating as indoor patient, she should be treated in a superior single room.

Henceforth, due precaution should be taken while any blood transfusion is required starting from sample collection to blood bank processing and just before transfusion, it should be certified by the on duty doctor.

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 WARSI
WBCS (Ex)
Secretary
W. B. C. E. R. C.