Office of the West Bengal Clinical Establishment Regulatory Commission
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Case Reference: NPG/2018/000439

Present: Justice Ashim Kumar Banerjee (Retired), Chairman
Dr. Sukumar Mukherjee,
Dr. Makhan Lal Saha
Dr. Madhusudan Banerjee,
Dr. Maitreyee Banerjee.

Mira Banerjee.....Complainant
- Versus-
ILS Hospital, Dum Dum .....Respondent

Heard on: February 14, May 16 and June 11, 2019.

Judgment on: September 11 , 2019

Sri Rabindranath Banerjee was aged about 84 years. He had been suffering from critical kidney ailment with progressive renal failure. He had urinary infection, enlarged prostate, decompensated diastolic heart failure, hypertension and anemia. He had a fall outside ILS Hospital, Dum Dum and sustained musculoskeletal injury around left hip. However, treating doctor did not find any fracture. He had series of complications while he was admitted in the clinical establishment on two successive occasions, i.e., on February 16, 2018 to February 25, 2018 and March 28, 2018 to April 23, 2018.

The patient ultimately died on April 24, 2018 one day after his discharge from the second hospital admission. The complainant, the widow of the deceased, approached us on May 27, 2018 alleging medical negligence as well as deficiency in service. The detailed complaint would appear from a letter dated July 24, 2018 that the commission received from the complainant duly signed by her and her two sons, namely, Sandip Banerjee and Joydeep Banerjee.

If we summarise the complaint, we would find, the patient condition became serious mainly due to kidney ailment. He was not properly advised by the dietitian about the food that would be apt for him. He was treated in a private establishment in December, 2017. The present complaint would relate to two successive hospitalization at the clinical establishment in February, 2018 and March, 2018. According to her, at the time of discharge from the first hospitalization, the patient was not fully cured as his sodium level was touching below the normal range, his electrolyte balance was not properly managed. No specific way to enhance the sodium level was suggested. There had been post-discharge complications elaborated in her complaint. In the case of readmission in March, 2018, the patient had blood vomiting and respiratory issues, oxygen desaturation and cardiac failure. The doctors put him on ventilation and constant supervision. Ultimately, the treating doctors advised shifting of the patient to higher set up. The higher set up clinical

establishment asked for proper diagnostic report that the clinical establishment failed to supply. They rather started aggressive treatment. They discharged the patient on April 23, 2018 and on the very next day, he passed away. The discharge summary also did not mention, medicine doze/timings, when the patient party insisted the nursing staff unwillingly wrote it down.

The complainant raised the following issues that are quoted below:-

> *1. Why dialysis had not been performed during early stage of treatment? It could have been performed on*
> *an emergency basis when the patient was hospitalized first time.*
> *2. Electrolyte imbalance was not managed with care w.e.f. Dec, 2017 consultation. Why?*
> *3. How an aggressive diuretic treatment was applied w.e.f. last week of Dec, 2017 even when he is showing symptoms of low sodium?*
> *4. Why all cultures came negative even when it is clear that he had some kind of infection? How was it concluded that he had been suffering from UTI and nothing else?*
> *5. Why his pleural effusion had not been taken seriously during first hospitalization? No HRCT was done. No pleural fluid sample was taken.*
> *6. Decompensated heart failure detected during 19 hospitalization was completely ignored. Did the hospital doctors conclude it solely based on ECG report? Why ECHO has not been done? No medication were applied. No follow up procedure or clinical correlation done. No cardiologist was appointed and no medical board was formed to supervise the treatment of the patient considering the fact that the patient*

had so many co-morbidities. Why?

7. Chest X-ray report was not taken seriously. No follow up or clinical correlation was done. Why?

8. During patient's discharge after 1st hospitalization his low sodium level was not taken seriously. Why?

9. How was patient treated with Faropenem which is a debatable drug with contraindications, side effects and drug interactions not good for renal patients?

10. During 2nd hospital stay, why it took almost a month to perform ECHO? Why no cardiologist had ever been consulted? Same question during his 1st stay. During 2nd hospital stay, the patient had repeated cardiac arrests yet no cardiologist was called. Why?

11. How can CRP/procalcitronin markers jump sharply during ICU stay? Both were normal on the date of admission.

12. How did the patient develop so many heart complications during second hospital stay? With this condition how was the doctor even planning to perform permanent catheter OT procedure?

13. With such unfavorable ECHO report just before the discharge, how can the doctor discharge the patient as "Stable"?

14. Why no standard advisories have been issued to patient family members regarding impending heart failure on the date of discharge?

The matter appeared before the commission on February 14, 2019 when direction for filing affidavits were given.

The complainant filed a supplementary affidavit dated February 26, 2019 that would however, not reveal any further issue. By the said affidavit, they produced the final bill and the discharge summary wherein, we would find, the timings of the medicines were written in hand by someone.

The clinical establishment filed a counter affidavit dated June 10, 2019. They gave a detailed summary of the treatment that the patient had at the clinical establishment. Paragraph 2(a) to 2(o) being pertinent herein are quoted below:-

> *a) Mr. Rabindranath Banerjee (hereinafter referred to as the patient), since deceased, an 84 year-old male, first attended Dr. Pratim Sengupta, Consultant Nephrologist, at our Hospital on16/11/2017. However, the patient was earlier treated by Prof. (Dr.) Abhijit Tarafder at Apollo Hospital and had come to Dr. Pratim Sengupta to seek a second opinion and on his own volition and ever since then it transpired that he was under the care and treatment of said Dr. P. Sengupta.*
>
> *b) However, on 16/02/2018 at around 11:45 pm for the first time the patient was brought to the Emergency Department of our Hospital with a history of fall on road while walking on the same day in the evening. From the record it transpires that immediately after fall/accident the patient was taken to AMRI Hospitals, Salt lake wherein X-Ray of pelvis and hand were done and the patient had come to our hospital with the X-Ray films. From the said X-Ray films together with clinical examination it transpired that this patient had come with Trauma to hip and swelling of left hand with difficulty to lift lower limb.*

c) After clinical examination by the on duty Emergency Medical Officer, the patient was provisionally diagnosed with (?)query Fracture Acetabulum left side and was managed accordingly with oral Paracetamol for pain and referred to Orthopaedic Surgeon.

Chief Operating Officer, ILS Hospitals, Dum Dum

d) However be it noted, since the patient was already undergoing treatment under Dr.Pratim Sengupta, Consultant Nephrologist, the patient as well as his relatives wanted to admit him specifically under said Dr. Pratim Sengupta.

e) Accordingly as per their wish, the patient was duly admitted to the

Nephro ward of our hospital. After admission in Nephro ward the patient was advised to do the following investigations. Blood for - calcium, vitamin D3, phosphate, uric acid, RFT (urea, creatinine, sodium, potassium). p-time, INR, APTT, Complete Blood count, Chest X-Ray, PA view, X-Ray pelvis after bowel preparation, ECG, Urine RE&CS. Kindly note that since the patient already had come with X-Ray of hand, our Medical Officers did not think it proper to repeat the same. Besides, for orthopaedic consultation patient was referred to Dr. Suresh Kejriwal (consultant Orthopaedic surgeon).

f) Dr Suresh Kejriwal, Consultant Orthopaedic Surgeon, examined the patient on 17/02/2018.Upon clinical examination and after perusal of the CT Scan Pelvis report, it transpired that the patient did not have any bony fracture. Accordingly, no active orthopaedic intervention was needed. The doctor had advised rest and ice compression only.

g) After admission, the patient was seen by Dr. Pratim Sengupta, the aforementioned Consultant Nephrologist. Dr. Sengupta repeatedly counselled the patient, since deceased,

and his family members to have dialysis performed on the patient but neither the patient nor his family members gave their consent to such dialysis. As a result, in the absence of such consent, dialysis could not be performed on the patient and he was discharged on 25/02/2018 with advice of fistula creation,

h) Thereafter, post discharge on 25/02/2018 in a haemodynamically stable condition, the patient never came for follow up as was advised on discharge. However, after about a month later, on 28/03/2018, he was brought to the Emergency Department of our Hospital with shortness of breath, homeoptysis and desaturation.

The patient was suffering from severe respiratory distress and as a result, he was ventilated.

i) That after admission the patient's creatinine was 12.7 Urea was230. ABG was done which showed severe metabolic acidosis. So we had to stabilize the patient with urgent haemodialysis with blood product transfusion (5 unit PRBC & 4 unit FFP) on 28/03/2018 and 29/03/2018. After stabilising the patient HRCT chest was done on 30/03/2018 and we referred Pulmonologist Dr. Saibal Ghosh on the same day.

j) That Dr. S. Ghosh after clinically examining the patient had advised to continue conservative treatment and if Haemoptysis recurred he opted for 3 modalities of treatment. 1) If Controlled-- Continue same treatment. 2) Mild-Fibre Optic bronchoscopy may be an option. 3) Moderate to Severe– BAE (Bronchial Artery Embolization may be considered, which was not available in our Hospital.

k) That be it noted that the patient was categorically advised to be shifted to advanced pulmonary unit which had facilities for

conducting such treatment as advised by the Pulmonologist. Kindly note that such advice was clearly communicated to the patient and his family members. Neither the patient nor his family members gave consent to shift the patient to such advanced <pulmonary unit to perform treatment advised by the Pulmonologist

L)That on 31/03/2018 patient again had massive haemoptysis with desaturation and was put on mechanical ventilation. After that patient relatives were again counselled to take patient to a higher centre where BAE can be done but they again refused to take and preferred to keep their patient in our Hospital.

m) That on 22/04/2018 again patient became hypoxic and on clinical examination there was increased basal crepitation in both the lung field so echocardiography was advised to look for any possible vegetation and to plan future dialysis UF rate, tolerance calculations, clearance understanding and volume related adjustment issues because he was ventilated multiple times during hospital stay mainly due to pulmonary and renal issues and multiple co morbidities.

n) That thereafter on 23/04/2018, the patient was discharged from our Hospital on request of the family members of the patient. Kindly appreciate that the patient was not discharged on our own accord and hence, we could not generate official discharge certificate.

o) That kindly appreciate that till the time the patient was under our care and treatment, he was rendered medical treatment absolutely as per accepted standard medical protocol with no reason to think otherwise. Every death, undoubtedly, is unfortunate that but that does not render a

clinical establishment and its doctors negligent for such death at all times.

The clinical establishment also produced medical records containing 380 pages.

We heard the matter on the abovementioned dates. The medical experts present in the panel duly examined the medical records produced by the clinical establishment.

At the hearing held on June 11, 2019 we heard the parties at length. We also gave opportunity to the complainant to file rejoinder, if any, and observed if we find any scope for further hearing after examining the rejoinder we would place it again in the list otherwise, the hearing was concluded and judgment was kept reserved. The complainant did not file any rejoinder.

Dr. Sukumar Mukherjee, one of our esteemed Members, gave his opinion that is set out hereunder: -

Sri Rabindra Nath Banerjee (84 years) since deceased husband of Mira Banerjee had been suffering from Chronic Kidney disease with progressive- renal failure and urinary infection, enlarged prostate, decompensated diastole heart failure, hypertension and anemia .His right kidney was visualised but left kidney was not visible (appears to have single kidney). He had a fall outside ILS Hospital and sustained musculoskeletal injury around left hip but there was no fracture. He had series

of complications in two hospitalisation at ILS Dum Dum and he was sick time to time with major complications,

The main complaint is against Dr. Pratim Sengupta, MD, ON Nephrologist during two hospitalisations in 2018 which need to be looked into by West Bengal Medical Council and not by us as per direction. -

Complaint against Clinical Establishment.

1. Communication and counselling have been done time to time about the seriousness of the disease process.

2. Early dialysis was suggested but relatives did not accept.

3. Bronchoscopy was available in ICU but bronchial arterial embolization (advanced procedure) was not available. For this the patient was referred to higher centre which was negated by the party.

4. Hospital acquired infection is well known and cannot be eradicated totally, specially in high risk patient.

5. Reviewing the voluminous bed head ticket and documents we are unable to blame CE for their appropriate support care during the course of hospital stay of very sick patient.

6. No complaint about billing received.

I have considered the pleadings and the opinion of Dr. Mukherjee. As observed hereinbefore, Dr. Mukherjee already considered voluminous medical records before giving his opinion. The patient had multiple ailments resulting in serious complication to him. The complaint would mainly relate to medical negligence that would be outside the scope of our adjudication. The Medical

Council is the appropriate forum for the same. We are not sure whether the patient party already approached the Medical Council. They would be free to approach the Medical Council if they have not done so earlier.

Our job is to examine as to the deficiency of the clinical establishment. The patient was under the treatment of Dr. Pratim Sengupta, nephrologist for a consideration time. It appears from the medical records, the treating doctor advised dialysis that the relatives did not accept. Doctor also advised advanced procedure of bronchoscopy for which the patient was referred to higher centre that was negated by the patient party. The complainant did not raise any specific issue on billing. They also did not raise any specific issue on hospital deficiency save and except the medical negligence for which they would also blame the clinical establishment along with the treating doctors.

The commission by its Memo dated February 4, 2019 requested the Director, Medical Education to form an expert committee for an independent opinion. Accordingly, the Medical Board was set up having the following Members: -

1. Prof (Dr.) Debabrata Sen Professor, Department of Nephrology IP GME & R. ...Chairman.
2.Prof. Dr. Nandini Chatterjee Professor General Medicine IP GME & R
3. Dr. Saroj Mondal Associate professor, Cardiology IPG ME & R.
4.Dr. Ranjit Kumar Halder, Assistant professor, Chest Medicine, IPG ME & R

The expert committee considered the nature of treatment and gave their report.

The relevant extract is quoted below:

Documents reveal that:

Mr. Rabindranath Banerjee, 83 yrs old gentleman, was admitted in ILS hospital, Dum Dum, on two occasions from 17/02/2018 to 25/02/2018 and from 28/03/2018 to 23/04/2018 under treatment of Dr. Pratim Sengupta,

On the first admission (on 17/02/18) he presented with H/O trauma around his left hip joint due to fall on the road. However, X-ray of his hip joint did not show any bone fracture. Patient, Rabindranath Banerjee, was a known case of chronic kidney disease (CKD), dyslipidemia, hypothyroidism, hyperuricemia with past H/O Left nephrectomy (aetiology not mentioned), incisional hernia repair, left inguinal hernioplasty and cholecystectomy.

After admission, investigations revealed advanced kidney disease (CKD stage 5). pyelonephritis to right kidney and severe iron deficiency anaemia, hypovitaminosis-D. Bi-fascicular heart block and fluid overloaded state,

As he had advanced azotemia(S.Urea 209mg/dl and serum creatinine 9.9mg/dl),he was counseled for long term renal replacement therapy (RRT) and advice for A-V fistula creation for maintenance heamodialyis (MHD).But patient refused to undergo haemodialysis therapy and A-V fistula creation surgery ,citing some family problems as the reason .He received conservative medical treatment .He was discharged in a stable state with medical advice on 25/02/2018 .

During second admission an 28/03/2018 M. Rabindranath Banerjee, presented with decompensated heart failure (ADHF) with severe respiratory distress and repeated episodes of massive haemoptysis He was admitted in ITU. Investigations showed that

patient was having brochiectasis, sepsis and B/L pleural effusion with hyporaemia, He was unable to sustain adequate oxygen saturation of blood under such condition, and patient was intubated and put on mechanical ventilation. Blood tests reports revealed that he had advanced azotemia (Very high serum urea and creatinine levels) and severe anaemia. Short daily haemodialysis (SDHD) was initiated with Fresh frozen plasma (FFP) and packed Blood (PRBC) transfusions through right sided double lumen internal jugular venous catheter

On the same day (28/03/2018) patient suddenly developed Cardiac arrest while on Ventilator support Cardio pulmonary resuscitation (CPR) was done following ACLS protocol and ventilatory support was continued Patient's condition was stabilized. On the following days. four (4) units FFP and two (2) units PRBC transfusions were given during haemodialysis for hemoptysis and anaemia. He had been on MHD Subsequently; patient underwent further blood tests, echocardiography and HRCT of thorax. His serum Procalcitonin levels was found. to be high suggesting severe sepsis. Echocardiography revealed concentric LVH. Garde-2 left ventricular diastolic dysfunction (LVDD) and severe pulmonary arterial hypertension (PAH) HRCT of thorax on 31/03/18 showed B/L pleural effusion, atheromatous calcification in aortic arch, atheromatous calcification was seen in coronary arteries and prominent left atrium & ventricle

Chest physician Dr. Saibal Ghosh was consulted for further management of pulmonary ailments. Patient was treated with antibacterial and antifungal drugs for chest infection and sepsis following standard treatment protocol. At the same time patient party was informed about the grave condition of the patient, and about lack of advanced pulmonary care set up in ILS Hospital. During his hospital stay patient required intubation on four occasions for ventilatory support. Ultimately he was extubated on

03/04/18 and put on BiPAP support for the remaining days of hospital admission. His ill health and multiple episodes of intubation and ventilation and infections were related to his advanced age, frail health condition and multiple pre-existing co. morbid and immune- compromised condition.

On 23/04/2018 patient was discharged on risk bond (DORB) from ILS -hospital. Patient expired on 24/04/2018, on the next day of discharge from hospital.

This elderly gentleman (83 yrs old) with CKD stage 5, Sepsis; Chest infection, heart failure and hemoptysis had several co-morbiditles. He was regularly attended by treating physicians and underwent all necessary investigations. His condition necessitated use of maintenance haemodialysis and mechanical ventilation (respiratory support). His grave prognosis was explained to his relatives. On his 1'" admission despite being counselled for haemodialysis and AV fistula creation for long term MHD, patient refused to take such life saving treatment procedures, citing family problems as the reason, Ultimately, he was discharged on request by DORB) on examination of all documents and considering all clinical facts NO MEDICAL NEGLIGENCE could be ascertained on the Part of doctors of ILS Hospital.

In my view, the hospital authority did their best as they could do. The infirmities, if any, as alleged by the complainant, would be within the domain of Medical Council, as observed above. If ultimately Medical Council is approached and a decision is arrived at holding the treating doctors guilty of negligence, the complainant would be free to approach us again for appropriate compensation as the clinical establishment would then be responsible such

negligence and an appropriate compensation would automatically be a consequential relief to the complainant. The complaint is disposed of accordingly.

Sd/-

ASHIM KUMAR BANERJEE

We agree,

Sd/-
Dr. Sukumar Mukherjee,

Sd/-
Dr. Makhan Lal Saha

Sd/-
Dr. Madhusudan Banerjee,

Sd/-
Dr. Maitreyee Banerjee.

Authenticated