ASANSOL CIRCUIT BENCH
of
WEST BENGAL STATE CONSUMER DISPUTES REDRESSAL COMMISSION
KSTP COMMUNITY HALL , DAKSHIN DHADKA
ASANSOL, PASCHIM BURDWAN - 713302

Complaint Case No. RBR/CC/10/2018
(Date of Filing : 31 Oct 2017)

1. Smt. Nilima Haldar

W/o Lt. Dhiraj Kr. Halder & sons of Dhritiman Haldar, Dhritiraj Haldar, 32/7, Secondary Road, A-Zone, P.O. Durgapur-4, P.S. Durgapur, Dist. Burdwan West, Pin -713 204.

.....Complainant(s)

Versus

1. The Mission Hospital

Durgapur 219(P) Immon Kalyan Sarani, Sector-2C, Bidhan Nagar, Drugapur -713 212, P.S. - New Township, Dist. Burwan West.

2. Dr. Manas Kr. Banerjee, M.B.B.S, FICM, Jr. Consultant, Critical Care(SICU), Regd. no. 62510(WBMC)

Attached with The Mission Hospital Durgapur, Durgapur 219(P) Immon Kalyan Sarani, Sector-2C, Bidhan Nagar, Drugapur -713 212, P.S. - New Township, Dist. Burwan West.

3. Dr. Dipankar Sen, Ms.(Ortho) FRCS, M.Ch(Ortho), Liver Pool FRCS(Trauma & Ortho) Consultant(Ortho Paedics), Reg. no.50082(WBMC)

Attached with The Mission Hospital Durgapur, Durgapur 219(P) Immon Kalyan Sarani, Sector-2C, Bidhan Nagar, Drugapur -713 212, P.S. - New Township, Dist. Burwan West.

.....Opp.Party(s)

BEFORE:

HON'BLE MR. KAMAL DE PRESIDING MEMBER
HON'BLE MR. ASHIS KUMAR BASU MEMBER

PRESENT: **In-person/, Advocate for the Complainant 1**
Mr. Subrata Ghosh., Advocate for the Opp. Party 1
Mr. Subrata Ghosh., Advocate for the Opp. Party 1
Rudrajit Saha., Advocate for the Opp. Party 1

Dated : 20 Jan 2021

Final Order / Judgement

HON'BLE MR. KAMAL DE, PRESIDING MEMBER

Final Order / Judgement

HON'BLE MR. KAMAL DE, PRESIDING MEMBER

Order No. : 25

Date : 20.01.2021

The case of the complainant in short is that complainant is helpless victim of medical negligence who had to witness negligent act, dereliction of duty and deficient medical service of the opposite parties resulting in death of her beloved husband, the sole earning member of the family.

That complainant comes up with a case that her husband Dhiraj Kumar Halder, aged 55 years collides with a Tanker at around 3.00 p.m. on 24.11.2016 while driving his own car. He was admitted to the Mission Hospital, Durgapur (OP No. 1) on the date itself.

During the course of treatment of complainant's husband C.T. Scan of whole abdomen was done on 28.11.2016 revealing all the organs of the abdomen normal and again on 16.12.2016 C.T. Scan was done for whole abdomen revealing all the organs of the abdomen normal but on 06.12.2016 treating doctor Dr. Manas Kumar Banerjee noted in the B.H.T. that patient was suffering from acute pancreatitis, which is contradictory to the C.T. Scan report. A physician should neither exaggerate nor minimize the condition of a patient as per MCI Rules. In the instant case Dr. Banerjee palpably exaggerated the patient's condition as he noted pancreatitis in the B.H.T.

That on 02.12.2016 Dr. Manas Kumar Banerjee noted that patient's lung condition was poor, but no pulmonologist consulted to clinically examine the lung.

It is alleged that as per B.H.T. till 17.12.2016 no kidney abnormality was noted. The patient was sent for dialysis on 18.12.2016 without taking any informed consent from the complainant.

Before operation Dr. Dipankar Sen did not inform the patient party about the alternative treatment other than orthopaedic operation and its effect and post effect of the operation. Patient party was not informed of deteriorating condition of the patient and instructed accordingly which is serious lack of vicarious responsibility of the hospital.

It appears from the bill that 32 unites of Meroza/Inj. Meronem was given with respective changes of Rs. 99,059.20 but the B.H.T. shows that only 3 unites of Meroza/Inj. Meronem. 06.12.2016 – Inj. Meronem (1gm) lamp 1v T.D.S. – 3 units which deficiently attract unfair trade practice warranting penal action.

It appears that ANAESTHETIST consultation was done at the rate of Rs. 300/- on 25.11.2016, 26.11.2016, 27.11.2016, 28.11.2016, 29.11.2016, 01.12.2016, 05.12.2016, 08.12.2016, 09.12.2016, 12.12.2016, 13.12.2016, 14.12.2016, 15.12.2016 and 16.12.2016 but there is no

reflection in B.H.T. and no signature of Anaesthetist despite signature of Dr. Manas Kumar Banerjee whish also differs in different sheets, which goes to attract the provision of unfair trade practice.

It is alleged that the complainant was supplied with the reports and bills only but on being asked through petition under section 1.3.2 of MCI Rules, the opposite parties supplied the B.H.T. and other clinical reports but the same also inadequate misleading and palpable suppression of records. There is no blood test report of 06.12.2016, 07.12.2016, 08.12.2016, 18.12.2016 but the bill reflects no blood test was held serial no. of the bill – 102, 103, 104, 105, 107, 109, 110, 113, 114, 115, 116, 117, 119, 189, 190, 191, 192, 193, 194 with respective charges for the same.

The report Cards, Bills and clinical report are attached where with this complaint which are combined annexed A to C.

The complaint put her grievance before the West Bengal Medical Council against the OP No. 2 and 3 dated 28.07.2017 and waiting for their decision.

Doctors should keep that the patient party's relatives informed with knowledge of the condition as will serve the interest of the family and patient.

Doctors should not neglect the patient nor mislead the patient party inasmuch as the patient died in the process of dialysis but there is no noting in the programme report as to failure of kidney, nor it is reflected in the Death Certificate of the patient.

It is stated that the complainant is consumer in terms of section 2(1) (9) of the Consumer Protection Act, 1986 as OPs rendered service against consideration in terms of section 2(1) (0) of the said Act.

The cause of action has been continuing since 18.12.2016 (the date of death) and, thereafter, on each day till the filing of this complaint which is within the jurisdiction of this Hon'ble Commission.

It is also stated in he petition of complaint that hat the complainant's husband was an employee of E.C.L. at Sonepur Bazari Project being MAN No. 691016 having a monthly salary of Rs. 85,813.12 and the sole earning member of the family so in consideration of kind of damage suffered by the complainant and her two sons and mother-in-law expenditure incurred in treatment, the prayer for compensation on the following counts as stated in the prayer of the complaint petition may kindly be judged in its correct perspective together with the penalty for unfair trade practice and granted by the Hon'ble Commission as it may deem fit and proper.

OPs 1 and 2 have contested the case in filing written version contending inter-alia, that the complainant herein having filed the case on diverse frivolous and motivated grounds. OPs 1 and 2 i.e. the Mission Hospital and Dr. Manas Kumar Banerjee have denied and controverted the same in the manner following.

It is alleged that the complaint is not maintaibale and liable to be dismissed in limini, inter-alia, on the following grounds.

a. The instant complaint is bad for non-joinder of parties and as such is liable to be dismissed.

b. Though the complainant purported to disclose the medical treatment records and other paper for the treatment of her husband, the patient herein, now deceased, but the same has not been disclosed in full and some part has been concealed with malafide intention.
c. The proceeding before this Hon'ble Commission being summary in nature and the issues involved in this case being complicated particularly when the allegations involved are of medical negligence of very highly technical nature, this Hon'ble Commission would be pleased not to exercise jurisdiction in the matter and direct the complainant to approach civil Court of the appropriate Forum for the appropriate reliefs.
d. From the allegations made in the complaint it would be clear that the same would involve not only complicated question of facts of high technical nature at the same time to adjudicate the dispute the evidence of experts would be required. The evidence to be extended by the parties in support of the respective contentions would involve elaborate oral evidence and adducing of voluminous documentary evidence and detailed scrutiny and assessment of such evidence by the Hon'ble Commission.

It is stated that Dhiraj Kumar Halder (hereinafter referred as the patient) since deceased, husband of the complainant herein aged about 55 years old had presented to the Department of Emergency in the Mission Hospital, Durgapur, the OP 1 herein with history of Road/Traffic accident at around 5:45 p.m. on 24.11.2016 while driving his own car.

It is also stated that in the said Emergency Department of the OP 1 Hospital the concerned Emergency Medical Officer (E.M.O.) had clinically examined the patient and upon such clinical examination the patient had temperature 98.4 degree F, BP – 120/90 mm of Hg, Pulse – 130/min, Respiratory Rate – 33, Spo $_2$ – 100% with oxygen support, CNS - E $_4$ V $_5$ M $_{6,}$ CVS – S $_1$ S $_2$ audible. After the laboratory investigation it further revealed that right side of 2 nd to 10 th Rib there was Haemo pneumothorax with Right side surgical emphysema, left side of 3 rd to 5 th Rib with haemothorax, right acetabulam and left forearm comminute both bone. He was further diagnosed with bilateral lung contusion, mild liver laceration and ABG – Respiratory Acidosis.

In Emergency department that patient was urgently intubated and ventilated. For rib fracture CTVS opinion was sought . Bilateral inter – costal drainage was given . Due to Hypovolemic shock setting in volume resuscitation and blood product transfusion (2 units PRBC) was given . It is stated that despite the same, hypo-tension persisted. Inotropic support had been started. For the fracture both bone, left forearm POP slab was applied. The patient had been reviewed by orthopaedics. It is alleged that immediate intervention from orthopaedic side was not required and was intended to be provided the patient would become clinically and haemodynamically stable.

Thereafter, the patient was shifted to the Intensive Care Unit (SICU) with working diagnosis of RTA with Polytrauma . He was treated with multidisciplinary approach involving Department of Orthopaedics, Cardio Thoracic Vascular Surgeon, Gastroenterologist and Critical Care Team.

Thereafter, following resuscitation at ER Dept. the patient, since deceased, was shifted to intensive Care Unit (I.C.U.) wherein he was under the care and treatment of Dr. Manas Kumar Banerjee, the Consultant I.C.U. in-charge, the OP 2 herein and I.V. antibiotics, Analgesics, Antacid, Mechanical Ventilation, Inotropic Support and other supportive care was started as per patient's need. As on due course the patient gradually became clinically more stable Inotropic support tapered off. In view of critical illness (RTA with Poly trauma with multiple injuries leading to high catabolic phase) and lack of gut motility, total parental nutrition and human albumin was started along with other supportive care (keeping in mind the energy requirement –

25-30 Kcal/Kg/Day and target Plasma albumin level > 30 gm/L, to decrease gut oedema inflammatory process).

It is also stated that on due course the next few days thee was air leak through Rt. ICD, Sluggish IPS and President ICD (no haemorrahagic) collection remained with supportive care. Be it noted that initial laboratory investigation showed increase in TLC count with increase in procalcitonin value.

On 30.11.2016, ORIF (Open Reduction Internal Fixation) of comminuted both bone of left forearm was done after detailed discussion with patient relative/parties. However, despite an imporved chest X-ray report, due to the fracture of multiple ribs bilateral, lung complication remained compromised and weaning from ventilator failed.

On 02.12.2016 Tracheostomy was done on ground of persisting poor lung compliance and there was need for prolonged ventilation. During this course of treatment RT feeding trail had been given but the same had failed. However, after the Blood investigation as per the advice of Dr. Manas Banerjee, the OP 2 herein 06.12.2016, it transpired that there was increase in Lipase/Amylase along with persisting pain in abdomen, which was suggestive of acute pancreatitis. In view of pancreatitis, sepsis, collapse consolidation of lung, broad spectrum antibiotics was initiated along with such other supportive care.

Thereafter, the ORIF of right acetabulum was done on 07.12.2016. During this whole phase weaning trail continued. In due course patient weaned and was put on T-piece. It is imperative to note that intensive physiotherapy and out-of-bed mobilization was carried out (one of major reason behind acetabular fixation).

It is further stated that irrespective of broad spectrum of antibiotics, anti-fungal and other supportive, sepsis persisted. Blood culture and urine cultures had showed growth of candida spices. Sensitive anti-fungal had started as per sensitivity report. Irrespective of everything, the patient had gone into intractable hypotension and on 18.12.2015 at around 02:10 p.m. the patient had sudden cardio arrest. Active resuscitation was done as per ACLS Protocol but he could not be revived and was finally declared clinically dead on the said date i.e. on 18.12.2015 at around 2:45 p.m.

It is stated that the cause of death was primarily due to septic shock, acute pancreatitis in a case of RTA with Polytrauma. It is no doubt unfortunate that despite every sincere effort on the part of treating doctor and such other staffs of the OP hospital, the life of the patient, since deceased, could not be saved.

It is contended that the OP Hospital had done several investigations which included IV Fluids, Invasive Ventilation, IV Antibiotics, Nebulisation, ECG/Echocardiography, ABG Analysis, USG of whole abdomen, Blood Component transfusion, RT Feeds, Parental Nutrition, Physiotherapy any other modalities, CT scan of whole abdomen, Tracheostomy and CT Thorax. Despite every sincere effort, the patient could not survive, though the patient was treated at the said OP hospital sincerely and he was rendered medical service absolutely as per accepted medical protocol and the treating doctors there had done exactly that which any reasonable prudent medical person in his place would have done and there cannot exist any reason to think otherwise. These OPs have prayed for dismissal of the case.

It is alleged that nowhere in the for corners of the complaint petition, the complainant could establish that what was done would not have been done and what was not done should have been done as per accepted medical practice and the same be supported by expert evidence or available medical literature.

It is important to note that in the instant case there was no breach of duty towards the patient, and there was no failure on the part of the OPs abovenamed to attend the standard of care, and the damage incurred was not connected. Standard responsible medical care had been provided by the hospital and doctors involved have conformed to the standard of medical care and there cannot exist any reason to think otherwise. OPs 1 and 2 have prayed for dismissal of this case.

OP 3 has also contested the case and filed written version contending, inter-alia, that the present complaint is wholly misconceived, groundless, frivolous, vexatious and scurrilous which is unsustainable in the eyes of lay and has been filed without any justified reason/cause against the OP 3 just to harass, defame and extort illegal sum of money from the OP 3 hence the complaint is liable to be dismissed.

It is contended that the complainant has filed this complaint with false allegations of negligence to the Hon'ble Forum by claiming exorbitant amounts without any basis, just to waste the valuable time, harass and defame the OP 3. Although it is a fact that the OP 3 has not committed any negligence in this case, while providing the said treatment, hence complaint is liable to be dismissed.

It is stated that the OP 3 is a well-qualified and a reputed doctor, with substantial good will and experience of long standing successful medical practice since 18 years and the instant complaint is full of concocted facts, defamatory language, derogatory words.

Patient and the relatives of Mr. Dhiraj Kumar Halder, aged 55 years was presented to the Department of Emergency. This shows the patient was suffering from life threatening, serious severe injuries. In such a bad condition the patient was admitted to the Mission Hospital, Durgapur with a history of serious Road Traffic Accident caused by own negligence of the patient on 24.11.2016 at 5.45 p.m. In the life threatening, emergency, the clinical condition showed Temperature was 98.4F, BP was 120/90 mm of Hg, Pulse was 130/min, Respiratory Rate was 33, SPO2 was 100% with oxygen support, CNS was E4V5M6 and CVS was S1S2 audible. Investigations revealed (a) right side 2 nd to 10 th Rib fracture, with Right side life threatening haemothorax (c) extremely bad and severe Right Acetabular fracture (d) extremely bad and severe Left forearm comminuted Both Bone fracture (e) Bilateral life threatening lung contusion (f) Mild liver laceration which was also serious (g) ABG – Respiratory Acidosis which is also serious. In Emergency department the patient urgent life saving intubation was done and put on ventilation. For life threatening rib fracture CTVS opinion was sought. Life saving bilateral intercostal drainage was given. Due to serious, severe, life threatening hypovolemic shock "setting", lifesaving volume resuscitation, with blood products and other transfusions (2 unit PRBC) were undertaken to save the life of the patient. In spite of all resuscitative efforts because of the life threatening disorder which the patient suffered due to the high impact trauma, then also Hypo-tension persisted to threaten the life of the patient for which inotropic support had been started as a last ditch effort to preserve the life in a dying-dying, dead patient. For fracture serious severe both bones left forearm POP slab could only be applied looking into the life-threatening condition of the patient. The patient has been continuously monitored by the orthopedician. Immediate intervention from the orthopaedic side not required in the presence of the

life-threatening general condition of the patient since the patient was hemodynamically unstable for which the patient was shifted to the Intensive Care (SICU) with a working diagnosis of RTA with Polytrauma and life-threatening resistance circulatory shock.

On 30.11.2016 ORIF of comminuted fracture both bones Left forearm was done after detailed discussion with the patient's relative, looking into the critical condition of the patient. X-Ray chest though improved, but due to the life-threatening fracture of multiple ribs bilateral, Lung compliance remained compromised and weaning from ventilator failed which shows the patient was critical at all the times and hence on 02.12.2016 lifesaving tracheostomy was done for persisting poor lung compliance and need for prolong ventilation to continue to keep the patient alive.

Another hard luck for the patient showed illnesses connected with Blood investigation showing an increase in Lipase/Amylase along with severe persisting pain abdomen which was clinically confirmative of acute pancreatitis. In view of adding on one more illness like pancreatitis added to already existing sepsis, collapse consolidation of the lung. All this was kept in check with broad spectrum antibiotics, which had been started as a life saving measure with other lifesaving supportive care continuing to make patient live. But even fracture needed to be fixed and since the patient was though little stable, but just fit for fixing the facture so on 07.12.2016 ORIF for fracture right acetabular was done. In due course the patient weaned and put on T-piece with intensive chest physiotherapy and out of bed mobilization carried out (one of the major reason behind acetabular fixation) since mobilization helps the patient. Irrespective of broad spectrum of antibiotics, anti-fungal and other supportive care sepsis persisted to threaten the life of the patient. Blood cultures and urine cultures showed growth of Candida species, hence lifesaving sensitive antifungals started as per sensitivity report. The critical condition of the patient was waxing and weaning even though the patient was given all the required treatment as per his condition which treaded the path of various complications created by original injury which were being taken care of in a multidisciplinary approach to keep the patient alive but finally the patient went into intractable hypotension and expired on 18.12.2016. On 18.12.2016 at 02:10p.m. patient had sudden cardiac arrest; active resuscitation was don as per ACLS protocol but could not be revived. The patient was declared clinically dead on 18.12.2016 at 02:45 pm. Cause of death was Septic Shock, Acute Pancreatitis with in a case of RTA with Polytrauma. Modality of treatment includes lifesaving IV fluids, lifesaving Invasive Ventilation, lifesaving IV Antibiotics, lifesaving Nebulisation, lifesaving ECG/Echocardiography and treatment lifesaving ABG analysis and treatment, lifesaving USG whole abdomen and treatment, lifesaving Blood Component transfusion, life saving RT feeds, lifesaving Parenteral Nutrition, lifesaving Physiotherapy. Other lifesaving modalities like CT Scan whole abdomen and treatment, lifesaving tracheostomy, lifesaving CT of Thorax and treatment. It is contended that OP3 treated the patient diligently, prudently, with utmost due care and caution. OP 3 contends that there was no negligence at least from his side, and other OPs. This OP has also prayed for dismissal of the case.

Points for decision

1. Is the case maintainable in its present form?
2. Whether the OPs are deficient in rendering proper medical services to the complainant?
3. Whether the OPs are guilty of medical negligence?
4. Whether the complainant is entitled to get the relief as prayed for?

Decision with reasons

Issue No. 1.

The medical practitioners, Govt. Hospitals/Nursing Homes and Private Hospitals/Nursing Homes ("doctors" and "hospitals") broadly fall in three categories –

i. Where services are rendered free of charges to everybody availing the said services.
ii. Where charges are required to be paid by everybody availing the services, and
iii. Where charges are required to be paid by persons availing services but certain categories of persons who cannot afford to pay are rendered service free of charge.

Doctors and hospitals who render service without any charge whatsoever, to every person availing the service would not fall within the ambit of 'service' u/s. 2 (1) (0) of C.P. Act. The payment of a token amount for registration purposes only would not alter the position in respect of such doctors and hospitals. So far, as the second categories are concerned, since the service is rendered on payment basis to all the persons they would clearly fall within the ambit of Section 2(1) (0) of the Act. The third categories of doctor or hospitals do provide free service to some of the patients belonging to the poor class, but the service for some patients is rendered on payment basis. The expenses incurred for providing free service are made out of the income from the service rendered to the paying patients. The service rendered by such doctors and hospitals to paying undoubtedly fall within the ambit of Section 2(1) (0) of the Act [The Indian Medical Association VS. V.P. Santha, AIR 1996 SC 550 (Medical Negligence) referred to].

We are given to understand by the Ld. Lawyers of both the sides that treatment is done by the OP 1 - Hospital through its doctors on payment basis for all patients. It is given to understand to us by the Ld. Lawyers of both the sides that the cost of treatment for all the patients is taken from the patient party or the relative of the patient by the hospital itself and the treatment is not completely free of cost for all the patients and there is paying bed also. So, we think that the service of the OP Hospital falls within the ambit of Section 2 (1) (0) of the Act.

We find that OP 1 hospital renders treatment on payment basis to all the persons and it is purely a Pvt. Nursing Home rendering medical treatment to all the persons against payment basis and as such, OP 1 would clearly fall within the ambit of Section 2(1) (0) of C.P. Act. May be decacased was covered under ECL Heath Scheme where he was employed and the payment, as such, was made or reimbursed by the ECL and the deceased is the beneficiary accordingly and, as such the case is maintainable against the OPs. It is also given to understand that OP 1 received payment from the deceased for the treatment. So, the case is very well maintainable in its present form.

Moreover, it is pertinent to mention that the cause of action has fallen within the jurisdiction of this Commission and this Commission has ample jurisdiction both pecuniary and territorial to try the instant case. Moreover, in medical negligence the rule of continuing cause of action and rule of discovery is applicable. We think that the cause of action is a continuing one and accordingly the case is not barred by limitation.

It is argued by the Ld. Lawyer for OPs that the complaint is bad for non-assignment and mis-assignment of parties. It is stated that OP 3 is insured with the Oriental Insurance Pvt. Ltd. through its professional Indemnity – Doctors policy No. 272200/48/2017/1707 effecting from 26.04.2016 – 25.04.2017 and the said insurance company is a necessary party and the case is bad for non-joinder of the said Insurance Company.

We cannot be consensus of opinion with such argument. It is a matter in between the concerned doctor and the insurance company. Patient party is not supposed to know about the insurance coverage of the doctor, if any, So, the case cannot be said bad in law for non-joinder of insurance company as a party. It is not necessary that the case should be heard/tried in presence of insurance company, specially the case relates to alleged medical negligence against the OPs. Moreover, the complainant does not have any claim against the insurance company.

Medical negligence is defined as lack of reasonable care and skill or wilful negligence on the part of a doctor in respect to acceptance of a patient, history taking, examination, diagnosis, investigation, treatment – medical or surgical etc. resulting any injury or damage to the patient.

The terms 'damage' means physical, mental or financial injuries to the patient. The law requires that the practitioner must bring to his task a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. The law does not except the very highest nor a very low degree of care and competence judged in the light of the particular circumstances of each case.

In general, a professional man owes to his client a duty in tort as well as in contract in advice or performing service.

Medical practitioners do not enjoy any immunity and they can be sued in contract or in tort on the ground that they have failed to exercise a reasonable skill and care of the patient.

The test as embodied in the Bolam's Case is the standard of ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill; it is well established law that it is sufficient if he exercises ordinary skill of an ordinary competent person exercising that particular skill.

It is also worthy to mention that at the very outset that there is no medical expert report in this case. In fact, neither of the parties have prayed for referring the matter to any medical expert or to any medical board to determine the medical negligence, if any, in this case.

We think that expert opinion is not necessary in all the cases. It is not also correct proposition of law that Consumer Fora has to refer the dispute of medical negligence to expert necessarily in all cases.

We are fortified by decision reported in Kishan Roa's Case in this regard. Hon'ble Apex Court in Kishan Roa's case has been pleased to hold that it is not necessary to obtain expert opinion in all cases.

The decision of Martin D'Souza Case is not consistent with the law laid down by the larger bench in Mathew.

The guidelines, as laid down in Martin D'Souza, regarding expert opinion before proceeding with any case do not hold good in Consumer Protection Cases. Both judges in Kishan Roa's Case held that observations of Martin D'Souza's case were per incuriam.

In the instant case, principle resipsa liquitor is applicable. The maxim applies in a case in which certain facts proved by the plaintiff, by itself, would call for an explanation from the defendant without having to allege and prove any specific act or omission of the defendant.

(Kuma Mahua Daripa V. Aniruddha Ghosai (Dr.) 2015 (3) CPJ 671 (NCDRC), Sunil V. Om Multi Specliality Hospita 2016 (2) CPJ 561 (NCDRC). …….

Issue Nos. 2 to 4 :

We take up all the issues altogether as the issues are inter linked and have close bearing up one another and also for the sake of brevity and convenience.

We have perused the documents on record i.e. Xerox copies of BHT, Xerox copy of treatment summary, discharge certificate, Xerox copy of death certificate, other documents on record, and evidences adduced from both sides.

The demise of the husband of the deceased has resulted in the present legal proceedings being initiated by the complainant on a belief that the cause of his death was medical negligence.

It appears that Dhiraj Kumar Halder, since deceased, husband of the complainant aged about 55 years old was admitted to the Department of Emergency in the Mission Hospital Durgapur with story of road traffic accident at 16.20 on 24.11.2016 while driving his own car.

At the said Emergency Department of the OP 1 Hospital the concerned Emergency Medical Officer (E.M.O.) had clinically examined the patient and upon such clinical examination the patient had temperature 98.4 degree F, BP – 120/90 mm of Hg, Pulse – 130/min, Respiratory Rate – 33, Spo_2 – 100% with oxygen support, CNS - $E_4 V_5 M_{6,}$ CVS – $S_1 S_2$ audible, as it appears from B.H.T. He was admitted under Dr. Dipankar Sen (Ortho) and Dr. Vikash Kumar Keshri (CTVS Surgeon).

In Emergency department that patient was urgently intubated and ventilated. For rib fracture CTVS opinion was sought. 2 units PRBC was given. Bilateral inter – costal drainage was given. Thereafter, the patient was shifted to the Intensive Care Unit (SICU) with working diagnosis of RTA with Polytrauma.

We find that the patient was shifted to intensive Care Unit (I.C.U.) in the care and treatment of Dr. Manas Kumar Banerjee, consultant ICU-in-charge, OP2.

We find that the patient was, mainly treated by OP 3 (Orthopaedic Surgeon). He was also treated by Dr. Ashis Banghbash Anaesthetist and Head of Critical Care Team and also by Dr. Manas Kumar Banerjee (OP2) who is a Jr. Consultant Critical Care Unit (SICU), as it appears from the Seal and Stamp of B.H.T.

Bed Head Ticket dated 25.11.2016 of the patient as noted by Dr. Sen reflects as follows :

“B/C Chest tube in Situ –

Urine flow – good

IV Spleen – Positive

Pulse 106/ BP 90/160

Air enters in chest : good

Abdomen : Soft

No abnormality detected

Pelvic compromise – Positive

Left PA – Splinted

Apparently no other external injury".

So, we find that vitals of the patients were more or less good. We find that Dr. Sen visited the patient day after day and he awaited for his first surgical operation till 30.11.2016 for the reason best known to him.

On 30.11.2016 ORIF (Open Reduction Internal Fixation) of comminuted fracture both bones Left forearm was done. It is not clear before us why Dr. Sen waited till 30.11.2016 for the first operation. Thereafter, ORIF of right acetabulum was done on 07.12.2016.

During the course of treatment of complainant's husband, C.T. Scan was done on 28.11.2016 and it revealed all the organs if the abdomen normal and again on 16.12.2016 C.T. Scan report for whole abdomen shows all the organ were normal. But surprisingly on 06.12.2016 treating doctor Dr. Manas Kumar Banerjee noted in the B.H.T. that patient was suffering from acute pancreatitis which is opposed to C.T. Scan Report. Be that as it may, it is also surprising that the patient was not referred to any physician or gastroenterologist for treating pancreatitis. Moreover, on 02.12.2016 and 06.12.2016 Dr. Manas Kumar Banerjee OP 2 and Dr. Dipankar Sen OP 4 in BHT noted that the patient's lung condition was poor but surprisingly no pulmonologist was called or referred for examination of the lung of the patient. Without clinical examination of lung by a pulmonologist Diagnosis was not possible. Some tests doctors may use – 1. Chest X-Ray, 2. Ultrasound, 3. C.T. Scan of Chest, 4. Tests for oxygen Tests.

It appears that the patient was examined by cardio thoracic vascular surgeon. But no pulmonologist was consulted, although OPs 2 and 3 have noted lung contusion in the BHT. A pulmonary contusion is lung contusion which is bruise of the lung caused by chest trauma. As a result of damage to capillaries, blood and other fluids accumulate in lung tissue. The excess fluid interferes with gas exchange, potentially leading to inadequate oxygen levels (hypoxia). Serious complications include respiratory infections, deep lung infections and acute respiratory distress syndrome (ARDS). These conditions are often accompanied by low oxygen levels as well. Chest injury, Respiratory acidosis is a condition that occurs when the lungs cannot remove all of the carbon dioxide the body produces. This causes body fluids, especially the blood to become too acidic. Arterial blood gas is ABG pulmonary disease.

Surgical intervention of the left hand of the patient was carried out twice on 30.11.2016 by Dr. Dipankar Sen, OP3. Dr. Sen conducted the operation of fixation on right acetabulum of the patient on 07.12.2016. Though BHT report of OPs 2 and 3 reveals that there is problem in the pancreatitis. But Dr. Sen took the path of operation. Poor condition of lung and pancreatitis of the patient as per BHT Report prepared by OPs 2 and 3 could not be considered unstable enough for operation. After operation on 07.12.2016, condition of the patient detoriated and during

07.12.2016to 17.12.2016 the patient was put in ICU, CT Scan Report on 16.12.2016 revealed that kidney was normal. But we find that the patient was planned for dialysis on 18.12.2016. Surprising enough the patient was not referred to any nephrologist for such plan. The Hospital Authority or OPs 2 and 3 did not think it is necessary to take the opinion of any nephrologist before plan for Dialysis. Post Mortem Report and Death Certificate reveals that the patient died due to septic shock on 18.12.2016 at 2.45 pm. It appears from BHT that tracheostomy was done on 02.12.2016 but surprisingly enough no ENT Specialist was consulted or called at the time of such tracheostomy.

It is also surprising that no medicine doctor or gastroentologist was consulted when the treating doctor suspected pancreatitis.

We also observed with anxiety that no nephrologist was called or consulted in acute kidney injury with Anuria as the treating doctor noted in the BHT that the patient is suffering from Acute Kidney Injury.

What is Septic Shock ?

A wide spread infection causing organ failure and dangerously low blood pressure. Septic Shock is a life-threatening condition caused by a severe localised or system-wide infection that requires immediate medical attention. Any type of bacteria can cause the infection. Fungi such as candida and viruses can also be a cause, although this is rare. At first the infection can lead to a reaction called sepsis. There are three stages of sepsis : sepsis, severe sepsis and septic shock.

We also find that there was high lipase, amylase was also high. It means that the patient had some disorder of pancreatitis or other medical conditions. High levels of amylase and lipase may induct acute pancreatitis, a sudden and severe incrementation of pancreatitis. But surprisingly enough no opinion of gastoentologist was obtained or the deceased was not referred to any medicine specialist or gastoentologist.

We find that OP2 is a Junior Consultant of Critical Care. OP 3 as an orthopaedic surgeon. He is not a doctor of Medicine. He did not refer the patient to any pulmonologist when the patient developed myocardial contusion. Moreover, no video recording of any operation was done by OP 3. The patient ultimately died of septic shock. OP 2 a Junior Consultant of Critical Care and OP 3 is an orthopaedic surgeon but they held the patient even when the condition of the patient became critical. No pulmonologist was consulted the patient was neither referred to any nephrologist even when he developed acute kidney injury. Tracheostomy was done in absence of ENT. No gastroenterologist was consulted when the patient developed pancreatitis. The patient ultimately developed infection and consequently septic shock.

Be that as it may, we find that infection spread into the body of the deceased and the condition of the patient detoriated and he succumbed to death on 17.12.2016. Hon’ble Supreme Court in a verdict reported in (2009) 9 SCC 221 held that Hospital would be held hospital responsible for nosocomal infection. Hospitals or Nursing Home where the patient is taken for proper treatment should not be a place for getting infection once. The patient is admitted in Hospital, it is the responsibility of the hospital to provide the service and to satisfy that all possible care was taken and no negligence was involved in attending the patient in the hospital/nursing home.

We think that there was negligence, latches or deficiency in the part of the OP 1. OP 1 failed to maintain hygiene sterility and immunity of environment to combat infection OP 1 did not also undertake any alternative management when the patient was not responding to medication suggestion by OPs 2 and 3. It is palpable that complainant's husband died due to no diagnosis or wrong diagnosis resulting into irrational therapy or procedure coupled with lack of caution and care constituting collective negligence of OPs 1,2 and 3 and all the OPs are jointly or several responsible, for the final catastrophe. The death certificate issued by Mission Hospital (OP1) discloses that cause of death was due to polytrauma, pancreatitis with septic shock but there is no whisper within the four corners in the medical report why the pancreatitis developed. OPs failed to explain satisfactorily in their written version as to how the consequences of the injury culminating into death of the patient.

OPs failed to exercise due care in treating the patient and there was breach of the duty and thus as a result, complainant lost her husband.

We find tha there was all along ben low albumin comparing to reference value. Even as we find, urea was higher than the reference value. Creatinine was also 1.3 mg/dl as is apparent from laboratory test report dated 24.11.2016. Hypo-tension also persisted even after blood product transfusion (2units of PRBC). But the patient was not referred to any nephrologist for the reason best known to the OPs. Patient was also suffering from acute severe Acidosis. The patient had low level of albumin also.

It appears that Dr. D. Sen is an orthopaedic surgeon. Surprisingly, he all along treated the patient along with Dr. Manas Kumar Banerjee who is a junior consultant Critical Care even when the deceased developed (SICU) multifarious complications in due course of his stay at the hospital like Acute Pancreatitis, lung contusion, low albumin, rise in urea and creatinine level severe Acidosis (Laboratory Test reports dated 24.11.2016 referred to). Separate consultation with Physician, Gastroenterologist, Nephrologist, ENT Specialist was required.

It is surprising why gastroenterologist was not consulted when Dr. Sen suspected pancreatitis?

He was not operated during his hospitalisation section from 24.11.2016 to 29.11.2016, when the vitals were more or less normal and it was unreasonable delay, immediate, intervention from the orthopaedic side was required.

There is a number of literature to suggest that bone fractures in polytrauma patient should be fixed as soon as the patient is okay to go to operation theatre. But surprisingly, the deceased was not oprated at the first opportunity possible. But he was operated on 30.11.2016 and thereafter, on 07.12.2016. On 30.11.2016 ORIF of comminuted facture of both bone Left Forearm was done. On 07.12.2016 ORIF for fracture of right actuabular was done even when the patient was not stable and his condition deteriorated. Meanwhile antifungul and sepsis developed and threatened the life of the patient. Blood cultures and urine cultures showed growth of candida species, as per sensibility report Cause of death was Septic Shock, Acute Pancreatitis with a cost of RTA within a case of polytrauma, as it appears from death certificate of the deceased. We find on 18.12.2016 at 1 pm, there was plan for dialysis but no nephrologist was consulted but on 18.12.2016 at 2.10 pm patient died of sudden cardiac arrest.

We also find that Traichostomy was done on 02.12.2016 but we are afraid no E.N.T. Specialist was consulted and in absence of any ENT Specialist. It is not also forthcoming which doctor performed the Trichotomy. We think consultation with ENT Specialist was required for such Trichotomy.

It is also alleged from the side of the complainant that "informed consent' was not also obtained from the complainant or from her family members. We find that there are two Xerox copies of consent form or record. We are afraid that the consent form as it appears does not bear any technical information. It appears to be a common formal consent form used for all purpose and it cannot be said that the valid consent was procured either from the patient or from any of her family member before surgery. We also find that the doctors have not communicated the gravity of situation to the patient party before operation. There is no detail of proposed surgery, independent medical opinion of the doctor before surgery, probable consequences of surgery, mode of surgery or anything details regarding mode and manner surgery appearing on such consent form. A doctor has to seek and secure the consent of the patient before commencing a treatment (the term treatment includes "surgery" also). The consent obtained should be real and valid which means consent should be voluntary and such consent should be on the basis of technical information concerning the nature of the treatment procedure so that patient/or patient party knows that he/she is consenting to. The consent should be a free consent as envisaged by Section 10 of the Indian Contract Act in the context of medical negligence "Informed consent" is full disclosure of information regarding the material risks, benefits of the proposed treatment, alternatives and consequences of no treatment so that the patient/patient party can make an intelligent or informed choice (Samira Kohli VS Prabha Machnanda 2008 (2) SCC 1 relied upon). There is no detail of the proposed surgery, independent medical opinion of the doctor before surgery, probable consequences of surgery appearing on the notes in the operation record and discharge summary. We think that no valid consent was procured either from the patient or patient party or from any of her family members before surgery.

No video recording of the progress of operation/surgery is also forthcoming before us to enable us to ascertain what exactly happened at O.T. on 30.11.2016, 02.11.2016 (trachostomy), 07.12.2016. It is the duty of the hospital authority to maintain and preserve record, videos of operation pertaining to treatment of a patient neatly and cleanly so that those can be supplied to the patient party or to the courts, when required or called for or to establish cleanliness and fairness of treatment.

Blood investigation showed increase in Lipase/Analyse along with severe persisting pain abdomen which was clinically perhaps confirmative of pancreatitis which itself is serious of life threatening. But no gastroenterologist was consulted.

We find that the patient caught the infection in OP 1 hospital. All the medical staff including the nursing staff and other staff are the employees of OP 1 and as such any negligence on their part can be treated as a negligence on the part of OP 1. It is the vicarious liability of the hospital and nursing staff and other medical staff because nursing staff and staff of the hospital are employed on the basis of "contract of service" i.e. as permanent staff. Hospitals or Nursing Home where the patient is taken for better treatment should not be a place for getting infection of sepsis. We think it was definitely a lapse or deficiency on the part of OP 1. OP 1 failed to maintain hygienic, sterility and immunity of environment to combat infections. OP 1 did not also undertake any alternative management when the patient was not respading to medication suggested by OP 1 and OP 3 and when the condition of the patient was detoriating day by day.

We find the element of breach of duty, negligence, absence of due care, wrong prognosis in the treatment of the deceased by the OPs. Accordingly, we come to hold that OPs are guilty of medical negligence.

It is a maxim of law that a medical practitioner would be liable only when his conduct falls below that of the standard of reasonable competent practitioner in his field.

OP 1 did not also undertake any alternative management when the patient was not responding to medication suggested by OP 3. OP 3 is an orthopaedic surgeon but he dared to undertake all out treatment of the patient, apart from CTVS and critical care team, specially when the deceased developed multifarious complications in due course of his stay in hospital. The conduct of OPs 2 and 3 has fallen much below that of a standard reasonable prudent, competent practitioner on the contrary they treated the patient erratically, prescribed medicines not relating to the realm of their specialization.

C.T. Scan report of whole abdomen dated 28.11.2016 reveals that liver, gall bladder, CBD, Pancreas, Spelan, Bowel as Meascutry. Retroperitoneum, adnemals, kidneys, ureers, krivary bladder, prostate etc. are normal. Liver laceration noted, AASI liver injury scale grade II.

CT Scan report of whole abdomen dated 16.12.2016 also reflects more or less the self same findings.

OP 1 is a supermultispeciality hospital.

We hold OP 1 for mismanagement regarding the treatment of the patient culminating into final catastrophe of the patient. The patient suffered from incurable infection and sepsis during his stay in the hospital. It has been argued from the side of the OPs that no expert medical opinion is forthcoming before this commission to come to any decision regarding medical negligence but we think it is not always necessary to obtain expert opinion. [Kisan Roa VS Nikhil Super Society Hospital (2010) 5 Supreme Court Cases 513 relied upon]. The maxim of res ipsa loquitar is applicable to medical negligence and in this case also. The maxim is applicable when the negligence is evident. It is a law of torts but it is practically a rule of evidence. Res ipsa loquitur (Latin for “the think speaks for itself”) is a doctrine that infers negligence from the very nature of an accident or injury in the absence of direct evidence or how any OP behaved. We find the element of breach of duty, negligence in the treatment of the deceased by the OPs. Accordingly, we come to hold that OPs are vicariously guilty of medical negligence. The expression res ipsa loquitor is not a doctrine but “a mode of inferential reasoning” and applies only to accidents of unknown cause. Negligence on the part of the OPs in the treatment of the deceased is palpable and established beyond all reasonable doubt.

Let us now pass to the question of compensation. It appears that the complainant has not stated in the petition of complaint about her expenses with regard to the stay of the deceased at the hospital and filed some bills of the hospital in a stay manner. Settlement of Final bill as we find amounts to Rs. 8,20,946/-.

It appears that the complainant’s husband was an employee of ECL at Sompure Bazari Project and was entitled to all medical costs of his treatment and his family. members. In fact, Mission Hospital forwarded the final bill to AMO Area Sonepur Bazari, Eastern Coalfields Ld. for

payment direct to Mission Hospital, complainant did not have to foot the bill of the hospital or the doctors.

It is stated by the complainant that her husband was 55 years old and was having monthly salary of Rs. 85,813.12/- and has prayed for compensation to the term of Rs. 99,39,946/- for loss of future income and also for distress, pain, suffering, agony etc. etc.

It appears that the complainant herself conducted the case in person and no legal professional was appointed by her in this case. So, the question of litigation cost does not arise apart from cost of typing, Xeroxing of documents etc. The complainant also did not have to foot expenditure incurred in treatment of her husband.

Complainant has also submitted during her argument before this Commission that she has filed claim case before Motor Accident Tribunal which is pending. Ld. Lawyers for the OPs have also drawn our attention to such claim case during their argument as well as in written version.

So, we are surprised why the complainant has claimed such massive or heavy amount when she has already moved before Motor Accident Claim Tribunal for future loss of the income of her deceased husband.

There is nothing on record regarding unfair trade practice against the OPs as alleged by the complainant. There is no tangible evidences regarding unfair trade practice established against the OPs.

It is true that the patient met with a serious accident and he was badly injured . It cannot be said also with certainty that the patient might have survived or his life would have been saved had he been referred t doctor of medicine, gastroenterologist, nephrologist or ENT Specialist. But the question remains what prevented the OPs to refer the patient to the said Super Specialist when situation demanded? OPs have failed in performing their duties on such account and this omission or commission constitutes negligence on their part, as we have discussed earlier. We also keep all such facts in our mind in awarding compensation.

We think that compensation must be just and proper and complainant needs to be compensated adequately.

Considering the facts and circumstances and considering the degree of negligence on the part of OPs, we quantify the compensation at an amount of Rs. 10,00,000/- (Rupees Ten Lakh only) in favour of the complainant.

(Perused these decisions – 2016 (4) CPR, P- 46/2016(4) CPJ – 667, 2018 (O) Supreme (SC) 963/2018 (4) CPJ – 738, 2019 (O) Supreme (SC) 209/2019 (2) CPJ – 99, as cited by the Ld. Lawyer for OPs 1 and 2).

These issues are thus answered in favour this complainant.

Consequently, the case merits success.

Hence,

ORDERED

That the instant case be and the same is allowed on contest against the OPs.

OPs are directed jointly and severally in equal proportion to pay an amount of Rs. 10,00,000/- (Rupees Ten Lakh only) to the complainant towards compensation apart from litigation cost of Rs. 25,000/- for medical negligence and deficiency in service within 60 days from the date of this judgements failing which the complainant will be at liberty to put the decree into execution U/S. 27 of the C.P. Act 1986.

[HON'BLE MR. KAMAL DE]
PRESIDING MEMBER

[HON'BLE MR. ASHIS KUMAR BASU]
MEMBER