STATE CONSUMER DISPUTES REDRESSAL COMMISSION,
MAHARASHTRA, MUMBAI

**Consumer Complaint No.CC/12/112**

Mr.Harindra U.Singh
R/o.41, Jagat Enclave Building
Panchpakhadi, Lokmanyanagar
Thane (West) .....Complainant

**Versus**

1. Dr.K.S.Sethna
Lokmanya Tilak Municipal Medical
College and General Hospital
Sion, Mumbai

2. The Dean
Lokmanya Tilak Municipal Medical
College and General Hospital .....Opponents
Sion, Mumbai

BEFORE: P.B.Joshi, Presiding Judicial Member
Dr.S.K.Kakade, Member

PRESENT: Advocate Mr.A.V.Patwardhan for complainant
Advocate Mr.G.N.Shenoy for opponents

ORDER

Per Hon'ble Dr.S.K.Kakade, Member

1. The complainant's wife was diagnosed as cancer of the gallbladder and was being treated at the opponent no. 2 hospital in the year 2010-11. She was admitted in the hospital for blood transfusion on 8 October 2011. She received two units of A positive blood instead of B positive, which was her blood group. She died on 10th October 2011. Alleging the medical negligence and deficiency in service due to wrong group blood transfusion, the complainant approached this Commission and filed this complaint under section 17 of the Consumer Protection Act 1986.

2. The brief facts of the complainant's case are as follows :-

Complainant's wife deceased Mrs.Asha, assistant teacher in one of

the schools, was diagnosed with a cancerous lump in her gallbladder in the year 2010. She was therefore taking treatment for the same with the opposite Party no. 2 hospital under the supervision of the opposite party no. 1. She received chemotherapy treatment and was responding well as per the complainant. On 27$^{th}$September 2011 during routine examination of blood, it was revealed that her haemoglobin dropped to 6.3 gm% for which as per the advice of the opposite party no. 1, she got admitted to the opposite party number 2 hospital on 8 October 2011 at 7:30 pm.

3. On duty house officer in opposite party no.1- Dr.Sethna's unit, Dr.Bhushan Vispute arranged for blood transfusion by sending the patient's blood sample to the blood bank for grouping and cross matching. On duty technician in the blood bank Smt.Jaya Anand Wakode received the blood sample, conducted grouping and cross matching tests on the blood sample. She found the blood group to be "A positive" and so issued two units of “A positive” blood for transfusion. In the ward, the same two units were transfused overnight to the patient. Though the complainant raised concern over non acceptance of the blood by his wife, the assistant doctor and the nurse on duty dismissed his concern. The condition of complainant's wife deteriorated on 9th of October 2011 and she died in the early hours of 10th October 2011. As per the complainant, his wife blood group was "B positive" and previously she had received the blood of same group without any complication. Alleging the wrong blood transfusion responsible for the death of his wife, the complainant approached this Commission for claiming relief under Section 17 of the Consumer Protection Act 1986.

4. The OP no. 1, Dr K.S.Sethna and OP no. 2, Dean, LokmanyaTilak Municipal Medical College and General Hospital, Sion, Mumbai in their written statements raised few preliminary objections, gave

information about the medical facilities available at the hospital and the information about the impressive curriculum vitae of OP no.1. Also gave the treatment details of Mrs.Asha who suffered from cancer of gallbladder. On the day of 8th October 2011, late in the evening, deceased was admitted with severe anaemia for blood transfusion. That day being Saturday, indoor case records were not available and hence the blood group of the patient was not known, so "A positive" blood was accepted and transfused to the deceased by the on duty hospital staff. The reaction to the wrong blood transfusion was not observed and the patient was passing clear urine which was indicative of no transfusion reaction. The opposite parties explained this on the basis of the change of blood group due to the suppression of immunity in the terminal cancer patient. The complainant's wife died due to the terminal cancer and not due to the wrong blood transfusion. Hence the opposite parties denied the allegations of medical negligence and deficiency in service. Also the opposite parties mentioned that the complainant is not consumer as no consideration was paid by the complainant, hence the case should be dismissed.

5. Considering the submissions made before us, considering record and scope of the complaint, following points arise for our determination and our findings thereon are noted against them for the reasons given below:

| Sr.No. | Points | Findings |
|---|---|---|
| 1. | Whether the complainant establishes that he is "Consumer" as per the definition in Consumer Protection Act 1986? | Yes |
| 2. | Whether the complainant proves that there was "deficiency in service" on the part of opposite parties and there was "medical negligence"? | Yes |
| 3. | Whether the complainant is entitled for | Yes- As per |

| | | |
|---|---|---|
| | compensation as claimed? | order |
| 4. | What Order? | Complaint is partly allowed. |

**REASONS**

6. **As to the Point No.1-Whether the patient is "Consumer"?**

The opposite parties raised preliminary objection no. 2 in the written version that since no consideration was paid the complainant was not consumer. OP no. 1 stated that he has given his services "gratis" and he has not collected any consideration either from the complainant or from the deceased. Hence under the situation as no consideration is paid, promised or partly paid or partly promised the complainant can never be a consumer and therefore the State Consumer Disputes Redressal Commission has no jurisdiction.

7. In written arguments opposite parties referred and relied upon **Indian Medical Association - appellant versus VP Shantha and others - respondents 1986- 1996 consumer 1569 (NS).**

" 44. The other part of exclusionary Clause relates to services rendered "free of charge ". The medical practitioners, hospitals/ nursing Home and private hospitals / nursing Homes (hereinafter called " doctors and hospitals") broadly fall in three categories-

i) where services are rendered free of charge 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 person who cannot afford to pay are rendered service free of charges.

There is no difficulty in respect of first two categories. Doctors and hospitals to render service without any charge whatsoever to every person availing the service would not fall within the

Ambit of "Service" under section 2(1)(o) of the act.

**8.** The learned advocate for complainant submitted that the consideration was paid to buy fresh frozen plasma two units, during the treatment of the deceased after the wrong blood transfusion. And hence the complainant becomes consumer. The learned advocate for the opposite parties during the arguments on 25th June 2018 submitted that the complainant had paid the bed charges and the charges for investigations (reference page 161 of the compilation). Hence he admitted that the patient is consumer as per the definition in the consumer protection act 1986. With the available documents on record and the advocate for opposite parties admitted, the patient is consumer hence the answer to the point number 1 is **affirmative.**

**9.** **<u>As to the Point No.2 Whether there is "deficiency in service and medical negligence"?</u>**

In the complaint, the complainant alleges that his deceased wife Mrs Asha, who was suffering from cancerous lump in the gallbladder and was under treatment with chemotherapy and PTBD (Percutaneous Trans hepatic Biliary Drainage) in the year 2010. She was apparently improving with this treatment, during routine blood investigations she was found to be anaemic (Hb 6.3 gm%) on 27 September 2011. She was admitted for blood transfusions on 8 of October 2011, when she received two units of "A- positive" blood instead "B-positive" which was her blood group. She died on 10$^{th}$ of October 2011.

10. The complainant further states that, his wife died due to negligence of opposite party no. 1 who is employed at opposite Party no. 2. He also stated that failure to take reasonable medical care has caused the loss of life of his wife. He alleged that despite the knowledge of medical history of deceased, the opposite parties and their staffs have

transfused wrong blood to her that is a positive which caused her death on 10th of October 2011 at 00.45 a.m.

11. In the written statement, the OP no. 1 and 2, denied all the allegations and claims made in the complaint and stated that the services rendered by OP no. 1 was neither deficient nor sub-standard and always did whatever was in the best interest of the patient. They also stated that the OP no.1 has very much impressive career graph and he is senior Oncosurgeon at LTMG Hospital, Sion Mumbai. The opposite Party no. 2 is renowned tertiary cancer care hospital with all available facilities of treatment.

12. The learned advocate for the complainant submitted that, as per the reports available under Right to Information act 2005, there was deficiency in collecting blood sample, labelling the blood sample correctly and transporting the same to the blood bank for grouping and cross matching.

13. The Part A of the report from the Food and Drug Administration in relation with suspension of the blood bank during 11.05.2012 to 17.05.2012 ( pages 82, 83 of compilation) reads as under,

"1. The blood bank has not ensured appropriate labelling at the time of blood sample receipt and entertained the changes made by resident doctor instead of adhering to the requirement of fresh sample (in case of discrepancy) as requirement of DGHS Manual and as per schedule F of Drugs and Cosmetics act 1940.

2. The approved BTO has left the blood bank premises on dated 8th October 2011 at 1.00pm and Blood Grouping, Cross matching and

issue of whole blood unit had happened in their absence.

3. Blood bank had not adhered to the requisition demand of PRC (Packed Red Cells) for the transfusion of the subject patient Mrs.Asha Singh who was suffering from cancer and was issued whole human blood units.

4. Blood bank has not maintained the records for un- identified blood group requisition samples from the various words for the blood transfusion.

5. The master record does not specify the patient's/ recipient's name and type of blood donation. (Whether voluntary or replacement).

In view of the above observations in conclusion, Part A (Sr.No.1 to 5) the investigation team is of the opinion that deemed fit action may be taken against the Blood Bank as per the provision of the Drugs and Cosmetics Act 1940."

14. In the same report part B reads that

"1. The hospital administration has put undue pressure on blood bank for issue of blood unit by falsifying the fact about emergency / OT as mentioned in request form for Blood Use.

2. The subject patient had been admitted and transfused thrice prior to this blood transfusion and death incident, but the hospital has not maintained records pertaining to the correct blood group (medical history) of the patient.

3. The patient had been transfused with incompatible blood group unit however it seems to be manipulated data is recorded in clinical notes because patient is having B positive blood group and had been transfused with A positive blood unit".

The report also mentions that," the medical certification of cause of

death is mentioned as Disseminated Intravascular Coagulation (DIC) which is relevant to wrongly transfused blood unit and no primary investigation has been carried out by hospital administration to reveal the facts."

15. As per the report submitted by the learned advocate for the complainant that was available through RTI from LokmanyaTilak Municipal General Hospital, Sion dated 7th of December 2011 the departmental inquiry was conducted and the Professor and Head of Surgery from Department of Surgery reported that as per the records deceased Mrs.Asha received two units of A positive blood on 8 October 2011, who on previous occasion; on 23rd of February 2011 received B positive blood unit.

16. In the RTI reply given by Lokmanya Tilak Municipal General Hospital on 18th February 2013, full-fledged departmental enquiry reports of the blood bank technician Smt. Jaya Anand wakode and the house officer Dr. BhushanVispute, the report reads as "Smt. Wakode allowed the house officer change the registration number on the blood sample label and processed the same blood sample instead of firmly requesting a fresh sample with proper labelling. The house officer had collected the blood of deceased Mrs Asha for Grouping and Cross matching on 8$^{th}$October 2011 and sent the blood sample to the blood bank without proper labelling. He also wrongly informed the technician that the 'patient is on operating table' which was not true." The report on the Lab. Technician reads that "while working as a lab technician of blood bank in LTMG hospital she did not adhere strictly to the standard operating procedure of blood bank" and regarding the house officer the report mentions "while working in LTMG hospital as a house officer in doctor Sethana's unit, he did not adhere strictly to Standard Operating Procedure as norms of filling form, collecting blood sample for grouping and cross matching for

blood transfusion". After the Departmental enquiry of the lab technician, she was given punishment by stopping the next increment and warning was given to the house officer Dr. Bhushan Vispute.

17. The learned advocate for the opponent submitted that deceased Mrs Asha was advanced case of cancer of the gallbladder. The report of the enquiry conducted by Sir JJ Hospital Blood Bank, Byculla, Mumbai was submitted on 27th of June 2012 on the request of the senior police inspector of Sion police station. The Enquiry Expert Committee included Dr. D.N. Lanjewar, Professor of Pathology and in charge of the blood bank, Professor and head of surgery department and Resident Medical officer of Sir JJ Hospital.(pages 434 to 439 of compilation).

18. The report mentions after the brief clinical summary that described the clinical condition of the patient deceased and investigations as well as the treatment undergone by the patient including two units of A positive blood transfusion for anaemia. The learned advocate for the opponents invited our attention to the following observation of the committee. "Clinically no adverse reaction such as fever with chills, haematuria and anuria, tachycardia and breathlessness was noted. The urine output calculated by intake output chart and findings recorded by on duty sister in charge shows that her urine output of October 8 2011 was 500 ml and on October 9 2011 was 600 ml." Further in the part of observation by the committee the report reads as follows "However the findings on case paper suggest that manifestations of mismatched blood transfusion reaction such as fever, chills, haematuria, anuria, tachycardia and breathlessness were not noted in this patient. Similarly her urine output on October 8, 2011 was 500 ml and on October 9, 2011 was 600 ml which suggests that her kidney function was within normal limits."

19. Part C of Observations in the report (page 438) reads as under,

"Patient expired on October 10, 2011 at 1.00 am. The cause of death certified: Immediate cause of death Disseminated Intravascular Coagulation and antecedent cause as advanced Cholangiocarcinoma."

20. As per the opinion of this expert committee," in the present case even though mismatch blood transfusion was given to Mrs Asha Harindra Singh, it cannot be concluded that her death was resulted from mismatched Blood transfusion as Mrs. Asha Singh was also suffering from advanced carcinoma of gallbladder and she was treated with chemotherapy. Post mortem examination of Mrs.Asha Singh would have helped to establish exact cause of death." And the post-mortem examination was not carried out on this patient to know exact cause of death.

21. The National AIDS Control Organization (NACO) under Ministry of Health and Family Welfare under Government of India have issued Guidelines for "Standards for Blood Banks and Blood Transfusion Services (in 2007)", directing all the blood Banks and Blood Transfusion services to follow. We endorse the relevant part of these standards **Issues of Blood for Transfusion, Transfusion of Blood and components and Transfusion Complications**; as applicable in the instant case. These standards must be followed by all blood banks and blood transfusion services,

"**Issue of Blood for Transfusion**

K-1.0 Blood should be issued from the blood bank along with the blood cross matching report form. A portion of the integral tube with at least one numbered segment should remain attached with the blood bag being issued.

K-1.1 The cross matching report form should have patient's first name with surname, age, sex, identification number, ward, bed number, ABO and Rh (D) type.

K-1.2 The form should have donor unit identification number, segment number, ABO and Rh(D) type and expiry date of the blood.

K-1.3 Interpretation of cross matching report and the name of the person performing the test and issuing the blood should be recorded.

K-2.0 A label or a tag with patient's name, hospital, identification number, blood unit number assigned by the collecting/intermediary facility, interpretation of the cross matching test, should also be attached to the blood bag container before it is released from the blood bank.

K-3.0 Each unit of blood should be visually inspected before issue. It should not be issued if there is any evidence of leakage, haemolysis or suspicion of microbial contamination such as unusual turbidity, or change of colour.

K-4.0 REISSUE OF BLOOD

K-4.1 It is recommended that blood once issued should not be taken back by the Blood Bank, especially if the cold chain is broken.

K-5.0 URGENT REQUIREMENT OF BLOOD

K-5.1 Blood or blood components should be issued before completion of routine cross matching tests in cases where delay in providing blood may jeopardize the patient's life, on receipt of a signed written request of the treating physician stating that the clinical condition of the patient requires urgent release of blood before completing ABO and Rh(D) tests and compatibility testing. Records of such requests should be retained for 5 years as per the relevant standards.

K-5.2 Under such circumstances, recipients whose ABO and Rh(D) type is not known should receive red cells of group O Rh(D) negative if available, otherwise O Rh(D) positive blood should be used.

K-5.3 Recipient whose ABO, Rh(D) type has been determined should receive ABO and Rh(D) specific blood group whole blood or red cells before the tests for compatibility have been completed.

K-5.4 The donor tag or label on the blood container and the cross match report form should indicate that compatibility testing has not been completed at the time of issue.

K-5.5 However, standard compatibility test should be completed promptly. If discrepancy in the result is noted, the concerned clinician should be informed immediately to discontinue the transfusion.

N.B.

It is the responsibility of the blood bank to train the clinical staff and provide necessary forms to be used.

**Transfusion of Blood and components**

INFORMED CONSENT

The patient should be informed about his/her need for blood, alternatives available, as well as risks involved in transfusion and non-transfusion. His / her written consent should be taken in the language he / she understands best only after providing information. For minors and unconscious patients the next of kin should sign the informed consent.

L-2.0 IDENTIFICATION OF RECIPIENT AND DONOR UNIT

L-2.1 Immediately before transfusion, the doctor / transfusionist should verify the identification of the patient, the blood unit, blood group and cross matching report and associated records.

L-2.2 All identifications attached to the container should remain attached at least until the transfusion is over.

L-2.3 The blood compatibility report should be attached in the patient's file.

L-3.0 SUPERVISION

Transfusion should be prescribed and administered under medical direction. The doctor / transfusionist should observe the patient for an appropriate time at the initial stage and during the transfusion to observe any evidence of untoward reaction and to regulate the speed of transfusion.

L-3.1 To ensure good clinical practice (GCP) the user hospital should formulate a hospital transfusion committee.

L-4.0 ADMINISTRATION OF BOOD & BLOOD COMPONENS

L-4.1 Blood and blood components should be maintained at the optimum temperature before transfusion.

**Transfusion Complications**

M-1.0 ERROR PREVENTION As the most common cause of haemolytic transfusion reaction is a clerical error, a system of preventing such errors should be in place.

M-1.1 The request form and the sample label should have the phlebotomist's name and initials.

M-1.2 The blood group of the bag being issued should be re-confirmed by testing the sample from the donor tubing attached to the bag.

M-1.3 Instructions should be given to transfusionist to check the identity of patient and ensure correctness of unit number on the bag as well as segment and the cross match report.

M-1.4 Barcoding should be introduced and used whenever feasible.

M-2.0 DETECTION, REPORTING & EVALUATION

M-2.1 Each blood bank should have a system for detection, reporting and evaluation of suspected adverse reaction to transfusion (Hemovigilance). In the event of suspected transfusion reaction, the personnel attending the patient should notify immediately the responsible physician and transfusion service with necessary documentation and appropriate samples.

M-2.2 All suspected transfusion reactions should be evaluated promptly. The evaluation should not delay proper clinical management of the patient.

M-2.3 The details of all cases along with the interpretation of evaluation should be recorded and reported to the transfusion committee.

M-2.4 There should be a written protocol for the investigations of transfusion reactions.

M-2.5 Reported cases of serious reactions should be evaluated.

M-3.0 IMMEDIATE COMPLICATION

M-3.1 If there are symptoms or findings suggestive of a haemolytic transfusion reaction, transfusion should be discontinued and the following must be done immediately and records maintained.

M-3.1.1 The label on the blood container and all other records should be checked to detect if there has been an error in identifying the patient or the blood unit.

A post transfusion properly labelled blood sample, (avoiding haemolysis) should be obtained from the patient and sent to transfusion service along with blood container and attached transfusion set.

M-3.1.3 The patient's post-reaction serum or plasma should be inspected for evidence of haemolysis, comparing with pre-transfusion sample.

M-3.1.4 A direct antiglobulin test should be done on the post transfusion specimen and on pre reaction sample for comparison.

M-3.2 Based on evaluation of clinical findings, review of accuracy of records and results of laboratory tests, additional tests should be done such as:

M-.3.2.1 Determination of ABO and Rh(D) types on pre and post reaction blood sample from the patient and from the blood bag.

M-3.2.2 Repeat tests for unexpected antibodies in donor and recipients' blood and repeat cross-match using pre and post reaction blood samples of the patient and donor blood from the bag.

M-3.2.3 Examination of post transfusion urine should be carried out for haemoglobin and its metabolites.

M-3.2.4 Determination of bilirubin concentration in serum should be obtained preferably 5 to 7 hours after the transfusion.

M-3.2.5M-3.2.6 Supernatant plasma and remaining blood in the blood container as well as the post-reaction sample of the patient should be tested for smear and culture. Expiry dated blood units should be tested periodically for bacteriological smear and culture.

M-3.3 If investigations are suggestive of a haemolytic reaction or bacterial contamination; patient's physician should be informed immediately.

M-4.0 DELAYED COMPLICATIONS

M-4.1 Weak antibodies in recipient's serum directed against antigen on the donors red blood cells undetectable at the time of pre

transfusion tests, may appear after a week and result in delayed haemolysis or unexplained fall in haemoglobin. Appropriate tests should be done to detect the cause of reaction. A record should be maintained in patient's medical file.

M-4.2 Reported cases of suspected transfusion transmitted disease should be evaluated. If confirmed, the involved blood unit must be identified in the report. Attempt should be made to recall the donor for retesting and counselling. Other recipients who received components from the suspected blood unit should also be investigated.

M-4.3 All reported cases of unexplained acute liver dysfunction occurring between two weeks to 6 months after the transfusion of blood or components should be investigated as possible post transfusion hepatitis. The donor of the implicated unit should be informed, counselled and permanently deferred."

We do not find that the standards and guidelines have not been followed in the instant case.

22. The learned advocate for the opponents, who himself is qualified doctor and specialist in Obstetrics and Gynaecology, submitted that this is one of the rare most cases in which the blood group has changed from B positive to A positive, due to immunosuppressive stage of the cancer. He further submitted that this case being of advanced gallbladder malignancy, that received chemotherapy, the immunity of the patient was reduced. He explained with the help of diagrams how blood groups are determined. On the surface of red blood cells, the antigens are present that determine the blood groups. The antigenicity of these antigens is altered due to immunosuppressant stage of cancer. So A, B and H antigens are lost in this stage resulting into erroneous expression of another blood

group. He submitted that it is due to this erroneous expression deceased Mrs.Asha's blood group must have been expressed as A positive instead of B positive. He referred and invited our attention to various articles from Medical literature.

23. The learned advocate for the opponents, referred number of medical articles from various medical text books and journals, in support of his contention that the antigenicity and accordingly blood group changes due to immunosuppressive nature of the cancer itself; the comprehensive list of which is as follows-

**Medical literature**

1. Tumors of the gallbladder : DL Bartlett, Y.Fong

2. Gallbladder cancer : Stavros Gourgiotis, Hemant M Kochar and others ; The American journal of surgery(2008) 196, 252- 264

3. Tumors- chapter 44, Clinical Gastroenterology- 4th edition, by Howard M Spiro

4. Cancer associated alterations of Blood group Antigen expression in human colorectal polyps, by Steven H. Itzkowitz&others.CANCER RESEARCH 46,5976- 5984, November 1986

5. The role of blood group antigens in malignant progression apoptosis resistance and metastatic behaviour by Gennadi V. Glinsky and others, transfusion medicine reviews, wall 14, No 4 (October), 2000: PP 326 - 350

6. Tumors of the Bile ducts, Gallbladder and Ampulla- by Boris Blechacz and Gregory J Gores,

7. Red blood cell Antigen changes in malignancy: Case report and review by JL Winter and DS Howard

8. T-Category reflects the histopathologic characteristics of gallbladder cancer by SY Cho and others: Sci Verse Science Direct: EJSO: the journal of Cancer Surgery, EJSO 38 (2012) 537-542

9. Transfusion medicine: Technical Manual by Directorate General of Health Services, Ministry of Health and Family Welfare Government of India

10. ABH Blood Group Isoantigen expression in Breast carcinomas- and Immunohistochemical evaluation using monoclonal antibodies, by Arthur k.Lee and others, A.J.C.P. Vol. 83, No.3 March 1985, pp 308-319

11. Alterations of Membrane Glycopeptides in Human Colonic Adenocarcinoma by Young S.Kim and others: Proc.Nat.Acad.Sci.USA, Vol.71, No.12, pp 4869-4873, December 1974

12. Enzyme activity in Invasive Tumors of human breast and Colon: by H.Bruce Bosmann and Thomas C.Hall, Proc.Nat.Acad.Sci.USA, Vol.71, No.5, pp 1833-1837, May 1974

13. Blood Group Antigenicity of Purified Human Intestinal Disaccharidases by John H Kelly and David H Alpers, the journal of biological chemistry volume 248 number 23 issue of December 10, 8216- 8221, 1973

14. Blood Group Isoantigens in leukemic cells: reversibility of Isoantigenic changes by Neuraminidase by J.T. Kassulke and others: Journal of National Cancer Institute volume 46, number 6 June 1971 PP 1201-1208

15. Tumor-Associated Glycolipid Antigens and Modified Blood Group Antigens by S Hakomori and WW young JR:

Scand.J.Immunol.,Vol 7, Suppl.6, 1976 pp 97-117

24. The learned advocate for the opponents submitted that the literature mentions that the mean survival of such Gall Bladder Cancer is between 7.2 months and 1 year and there are 5 % chances of one year survival, in the instant case the symptom free survival was more than 11 months. So finally death of the patient occurred due to the advanced disease rather than mismatched blood transfusion.

25. We have carefully gone through the medical literature submitted by the learned advocate of the opponent, careful analysis of the medical literature and articles submitted can be summarised as per the summary of one of the articles ( Red Blood cell Antigen changes in Malignancy by J.L. Winters and D.S. Howard) as follows

26. "In the case of solid tumours such as Pancreatic, Gastric, Colonic, Ovarian and Biliary carcinoma an apparent loss of A, B and O antigen also can be seen. The term Apparent is used because unlike in haemopoietic malignancies the number of A, B and H antigens on the bases is not altered. Instead tumours secrete large amounts of soluble and A and B substance. The soluble blood group substance that neutralizes the typing reagents resulting in the loss of A and B antigen.

27. "Changes in RBC antigen phenotype rarely occur. They are most frequently seen in association with dermatologic malignancies, but can be seen in association with solid tumours as well. The identification of these changes represents more than just an academic exercise. Changes have been identified prior to the diagnosis of the responsible underlying malignancy and have heralded relapse of the malignancy. For this reason, it is important for blood bank

professionals to be aware of existence of this phenomenon."

28. We do not accept the contention of the learned advocate for the opponents that the blood group changes from B to A as the medical literature does not support this contention and only says that due to the change in the antigenicity of surface antigens, they are neutralized and as per the literature no blood group should surface as altered one. Also the patient was suffering from cancer for about one year, why the change in the antigenicity and blood group did not express previously and also why only one Blood group expressed, when immunosuppression of all Blood Group Antigens takes place; are the questions unanswered. This is pure academic discussion and after thought after the mismatched blood transfusion was given to the deceased.

29. The learned advocate for the opponents argued on the point of law by submitting and discussing on the ratios of various decided cases, the list of which is as follows-

1. Jacob Mathew petitioner v state of Punjab and ANR. Respondent 2005 (3) CPR 70(SC)

2. Martin F. d'Souza appellant v Mohammed Ishfaq respondent, Civil Appeal no. 3541 of 2002

3. Surendra Kumar Kumawat and another Complainants v Dr. Smt. Sunil Jain and ORS. Obp.Parties. Rajasthan State Consumer Disputes Redressal Commission, Jaipur ; CC no. 53 of 1991. Decided on 19.8.1993

4. Ramji Lal appellant V Mrs Sarvodaya Medical Respondent 2542 Consumer 1986- 1996.First appeal number photo of 1993. Did on 17th February 1995

5. Dilip Narayan Bhelande Complainant .Dr.Prakash N. Pant And ORS. Opposite parties. Complaint case number 13 of 1990.Decided on 5.9.1990

6. DCM Data Products, appellant v Hanuman Prasad Poddar Cancer Hospital, Gorakhpur respondent 1986 1995 consumer 290 NC first appeal number 220 of 1993 decided on 9th February 1994

7. Kusum Sharma and others appellants versus Batra Hospital and Medical Research Centre and others respondents civil appellate jurisdiction Civil Appeal number 1385 of 2000

8. IMA v. VP Shantha Supreme Court

9. Mrs Shazia Syed Naveed and another v. The Commissioner of Greater Mumbai municipal corporation

10. Mrs. Sushma Surendra v The Commissioner Brihan Mumbai Mahanagar Palika

30. The learned advocate for the opponents submitted that from the list of various decided cases cited above, while holding medical professional one should be careful and should be based on the principles and guidelines given by Hon'ble Supreme Court.

31. In "Kusum Sharma & Ors vs. Batra Hospital and Medical Research Centre and Ors" the Supreme Court has provided principles ( paras 50,51 and 52) must be kept in view as mentioned in following paras.

32. "50. Medical science has conferred great benefits on mankind, but these benefits are attended by considerable risks. Every surgical operation is attended by risks. We cannot take the benefits without taking risks. Every advancement in technique is also attended by risks."

33. "51. In Roe and Woolley v. Minister of Health (1954) 2 QB 66, Lord Justice Denning said : `It is so easy to be wise after the event and to condemn as negligence that which was only a misadventure. We ought to be on our guard against it, especially in cases against hospitals and doctors. Medical science has conferred great benefits on mankind but these benefits are attended by unavoidable risks. Every

surgical operation is attended by risks. We cannot take the benefits without taking the risks. Every advance in technique is also attended by risks. Doctors, like the rest of us, have to learn by experience; and experience often teaches in a hard way."

34. “52. It was also observed in the same case that "We must not look at the 1947 accident with 1954 spectacles:". "But we should be doing a disservice to the community at large if we were to impose liability on hospitals and doctors for everything that happens to go wrong. Doctors would be led to think more of their own safety than of the good of their patients. Initiative would be stifled and confidence shaken. A proper sense of proportion requires us to have regard to the conditions in which hospitals and doctors have to work. We must insist on due care for the patient at every point, but we must not condemn as negligence that which is only a misadventure.”

35. “94. On scrutiny of the leading cases of medical negligence both in our country and other countries especially United Kingdom, some basic principles emerge in dealing with the cases of medical negligence. While deciding whether the medical professional is guilty of medical negligence following well known principles must be kept in view:

I. Negligence is the breach of a duty exercised by omission to do something which a reasonable man, guided by those considerations which ordinarily regulate the conduct of human affairs, would do, or doing something which a prudent and reasonable man would not do.

II. Negligence is an essential ingredient of the offence. The negligence to be established by the prosecution must be culpable or gross and not the negligence merely based upon an error of judgment.

III. The medical professional is expected to bring a reasonable degree of skill and knowledge and must exercise a reasonable degree

of care. Neither the very highest nor a very low degree of care and competence judged in the light of the particular circumstances of each case is what the law requires.

IV. A medical practitioner would be liable only where his conduct fell below that of the standards of a reasonably competent practitioner in his field.

V. In the realm of diagnosis and treatment there is scope for genuine difference of opinion and one professional doctor is clearly not negligent merely because his conclusion differs from that of other professional doctor.

VI. The medical professional is often called upon to adopt a procedure which involves higher element of risk, but which he honestly believes as providing greater chances of success for the patient rather than a procedure involving lesser risk but higher chances of failure. Just because a professional looking to the gravity of illness has taken higher element of risk to redeem the patient out of his/her suffering which did not yield the desired result may not amount to negligence.

VII. Negligence cannot be attributed to a doctor so long as he performs his duties with reasonable skill and competence. Merely because the doctor chooses one course of action in preference to the other one available, he would not be liable if the course of action chosen by him was acceptable to the medical profession. VIII. It would not be conducive to the efficiency of the medical profession if no Doctor could administer medicine without a halter round his neck.

IX. It is our bounden duty and obligation of the civil society to ensure that the medical professionals are not unnecessary harassed or humiliated so that they can perform their professional duties without fear and apprehension.

X. The medical practitioners at times also have to be saved from such a class of complainants who use criminal process as a tool for pressurizing the medical professionals/hospitals particularly private hospitals or clinics for extracting uncalled for compensation. Such malicious proceedings deserve to be discarded against the medical practitioners.

XI. The medical professionals are entitled to get protection so long as they perform their duties with reasonable skill and competence and in the interest of the patients. The interest and welfare of the patients have to be paramount for the medical professionals."

36. We are of the considered view on the submissions of the learned advocate for opponents that from above paras 28 to 32, the medical professionals should use ordinary skill in reasonable manner so that there is no damage to the patient. All the above cited principles can be applied when reasonable care in given by ordinary skills of the doctor and the professional team working under him. In the instant case, it is observed that the ordinary care was not extended to the patient by the professional team under the leadership of opponent no.1.

37. After considering the submissions made before us, documents submitted and evidence affidavits; we are of the opinion that there was deficiency in service while treating deceased Mrs Asha. The reports of enquiry of the on duty doctor and the blood bank technician, clearly established that there was rashness and negligence in the way the blood sample was sent to the blood bank and the Grouping and Cross matching that was done, or unlabelled or wrongly labelled that sample resulting into a wrong blood group A instead of B Blood Group and hence the blood bags with wrong blood group were issued and transfused by the staff in the ward. Non availability of previous medical record on Saturday evening is also

negligence on the part of hospital system.

38. Though learned advocate for opponents vehemently stated with the help of Dr. Lanjewar report that there was no blood transfusion reaction due to mismatched blood transfusion, DIC (Disseminated Intravascular Coagulation) after the blood transfusion was the admitted fact and confirmed by the same report. This itself is one of the manifestation of mismatched blood transfusion reaction. And hence we are of the opinion that due to the reduction of immunity, the blood transfusion reaction was not severe and disseminated intravascular coagulation itself confirms that there was mismatched blood transfusion. Hence, this Commission holds the opponents responsible for the wrong group blood transfusion and declares that there was deficiency in service and medical negligence by opponent no. 1 and 2 and answers the Point no.2 as **Affirmative**.

39. **As to the Point No.3 Entitlement for compensation**

The complainants have prayed for the total compensation of Rs. 49, 06,900/- under various headings. The details of which are as follows-

1. Salary from November 2011 to 2021 to the tune of Rs. 30, 36,9 00 /-,
2. Pension for 5 years Rs. 12,00,000 /-,
3. Medical expenses Rs. 1,50,000 /-,
4. Amount towards mental agony and loss Rs.5,00,000 /- ,
5. Cost of litigation Rs. 20,000/-.

We are of the pinion that deceased suffered from very high grade cancer of gallbladder, the prognosis of which even after best treatment was guarded and the life expectancy was very low which is 7.2 months to one year. The claim appears to be exaggerated, so we

are of the opinion that based on the receipts submitted by the complainants, the medical expenses to the tune of Rs. 10,000/ - and the compensation towards mental agony and loss Rs. 6,00,000/- is just and proper and hence we order the total compensation accordingly. The answer to the point number 3 is **Affirmative.**

40. **As to the Point No.4**

As per final order.

**ORDER**

1. Consumer Complaint is partly allowed with costs of Rs.25, 000 /- (Rupees Twenty Five Thousand only) to be paid by the opposite parties jointly and severally to the complainant.

2. It is hereby declared that, the opposite parties have indulged in deficiency of service while giving blood transfusion to the patient.

3. The opposite parties are directed to pay Rs.10, 000/- (Rupees Ten thousand only) jointly and severally towards the medical expenses incurred by the complainant on the last admission to the hospital , with rate of interest @ 9 % from 8th October, 2011 within 3 months failing which the amount shall carry interest @ 12 % p.a. from the date of this order till realization.

4. The opposite party No.1 and 2 are also directed to pay jointly and severally to the complainant, Rs.6 Lakh only towards compensation for loss of income, pain, suffering and mental agony within 3 months from the date of this order. In case of default, the amount will carry interest at the rate of 12% per annum from the date of order till realization.

5. Certified copies of this order be furnished to the parties free of cost.

Pronounced on 24th October, 2018.

[P.B.Joshi]
Presiding Judicial Member

[Dr.S.K.Kakade]
Member