

(1999) 03 GUJ CK 0026

In the Gujarat High Court

Case No : Spl. Civil Application No. 1233 of 1999

Jan Sangharsh Manch

APPELLANT

Vs

State of Gujarat and Others

RESPONDENT

Date of Decision : 30-03-1999

Acts Referred:

Constitution of India, 1950 — Article 226

Citation : (2000) ACJ 1523 : AIR 1999 Guj 286

Hon'ble Judges : K.G. Balakrishnan, C.J;C.K.Thakker, J

Bench : Division Bench

Advocate : Mukul Sinha, for the Appellant; S.N. Shelat, A.A.G. and Harsha Devani, AGP, for the Respondent

Judgement

1. This special civil application is filed by a public spirited citizen alleging that there was negligence on the part of the Civil Hospital, Ahmcdabad i n trcati ng patient by name Ushaben.

2. Smt. Ushaben was the wife of Anokhelal Umrao Rajput who was formerly working in a Mill which has now been closed down. Ushaben was admitted to the Civil Hospital, Ahmedabad on 25-1-1999 as she had some gynaecological illness. According to the petitioner, she was advised to undergo an operation. The operation was conducted on 3-2-1999. During the course of operation, blood transfusion had to be done. After the operation of the patient, the condition of the patient deteriorated and she died on 4-2-1999. According to the petitioner, there was negligence by the doctors and para medical staff and on account of supply of wrong sample of blood, the patient died. The petitioner has also alleged that the patient was not given proper care and attention by the members of the hospital staff. It is alleged that there is inadequacy of staff in the hospital and one nurse was attending 58 patients who were undergoing treatment in that ward. The petitioner has prayed that adequate compensation should be paid to the legal heirs of deceased Ushaben and that there should be further directions to the respondents to appoint adequate staff in the hospital and negligence of

this nature should not take place hereafter.

3. An affidavit in reply has been filed by the Superintendent of the Civil Hospital wherein it is stated that Ushaben was admitted on 25-1-1999 in Ward B-3 and at the time of admission, she was suffering from bleeding and the patient had also the history of right pleural effusion and she had taken treatment for Tuberculosis for one and half years. The patient was admitted with a provisional diagnosis of anterior wall of fibroid of uterus. The patient was severely anaemic at the time of admission and blood transfusion was given on 25-1-1999 at about 6 p.m. The second blood transfusion was given on the next day and on that day, operative procedure was carried out without any complication and on the third day, again blood transfusion was done and it is further revealed that she had a severe heart complication in the nature of mitral valve prolapse and the patient was taken for further surgery and operation for removal of uterus was done on 4-2-1999. The patient developed further complications and as there was symptom of haematuria for which she was advised transfer to the Institution of Kidney and the patient expired on 4-2-1999. It is further stated that initially, the first three units of blood given by way of transfusion between 25th and 28th January, 1999, were of O+ve blood group. However, at the time of giving fourth unit of blood on 3-2-1999, due to error in labelling at the site of collection of patient's blood sample, the patient was given blood of AB+ve blood group.

4. In the affidavit in reply, it is also stated that several steps were taken to see that such mishap do not occur hereafter. Disciplinary action has also been initiated against the members of the staff who were found negligent.

5. We heard the learned Counsel for the petitioner and the learned Additional Advocate General. Learned Counsel for the petitioner submitted that there was negligence on the part of members of the staff of the Civil Hospital, otherwise, person having O+ve blood group would not have been given AB+ve blood. It is also submitted that because of inadequate staff strength in the hospital, proper care and attention is not given to the patient. Several other irregularities were also pointed out in collecting blood samples and it is prayed that such negligence should not occur in a Government Hospital.

6. The learned Additional Advocate-General submitted that adequate steps have been taken and such steps which are taken have been mentioned in the affidavit and proper instructions have been given to the members of the staff. In para 4 of the affidavit, it is mentioned that there was an Inquiry Committee and most of the recommendations of the said Committee have been implemented and the rest are in the process of implementation and it is submitted that the following are the recommendations:

"(A) At the Ward/Operation Theatre level :

(1) The doctors should fill up the forms properly. They are responsible for taking blood samples for grouping and cross matching with due precautions. The patient's blood group should be boldly written on the front page of the case

sheet.

(2) Planned blood transfusion should be given in routine hours.

(3) Proper record of the transfusion should be maintained by the doctors.

(4) The doctor should remain present in the ward and assess the patient throughout the transfusion.

(5) The hospital is in the process of purchasing prelabelled PET collection tubes. This will reduce the chance of mismatch.

(B-3) Blood bank level :

(1) The sample should be received by a responsible qualified person. The receiver should sign the ward register.

(2) A duty list should be notified on the board and a register of this should be preserved for future reference if need arises.

(3) Incomplete forms should be rejected.

(4) The processed form should be sent to the ward on the same day before 5 p.m.

(5) Supplying of blood on the plain paper requisition slips should not be done.

(6) Separate register of the blood supplied in emergency should be maintained.

(7) The name and signature of the doctor performing the cross matching should be written on the respective forms.

(C) Anaesthetic level :

(1) Proper documents of the pre-operative assessment should be kept. All data including blood group should be noted.

(2) Intra operative proper data should be recorded in the university accepted format.

(3) The person who receives and checks the blood should transfuse it himself/herself after checking the relevant data from the case sheet and the blood bank form. Any discrepancy should deter transfusion till it is rectified.

7. It is also submitted that report has been forwarded to the higher authorities for further action in the matter.

8. We are satisfied that adequate steps are taken by the concerned authorities and we hope that the instructions as stated above will be followed by the hospital authorities.

9. This is a case where the patient was admitted for serious illness. According to the petitioner, there was negligence by the hospital authorities. The patient was having O+ve blood group and while giving further unit of blood, it is suspected

that there must have been some error and prima facie, it is proved that there was some negligence. This sort of negligence should not happen in a hospital. The patient, as stated above, was the wife of unemployed mill worker. The deceased and her husband were engaged in manufacture of Agarbatti and were earning their livelihood. The husband has lost the help and service of his wife. The State is bound to compensate the legal heirs of the deceased for the negligence done by the members of the hospital staff.

10. Having regard to the facts and circumstances of the case, we think that amount of Rs, 50,000/- (Rs. fifty thousand) shall be reasonable compensation. We, however, make it clear that this is without prejudice to civil claim, if any, made by the legal heirs of the deceased. If any such claim is pending, this amount shall be adjusted towards the amount if any fixed in any such proceedings.

11. The respondents are directed to deposit a sum of Rs. 50,000/- on or before 15th May, 1999, with the Registrar of this Court. Registrar shall pay the said amount to Anokhelal Umrao Rajput, husband of the deceased, on proper identification who will receive the amount for and on behalf of all the legal heirs of the deceased. We also make it clear that the instructions issued to the authorities shall be followed scrupulously.

12. Learned Counsel for the petitioner further submitted that adequate staff should be appointed, in the Civil Hospital. The respondents shall look into this matters and if there is any inadequacy of staff, such appointments shall be made and the functioning of the hospital shall be made more effective to meet needs of the people. Learned Counsel for the petitioner also submitted that there should be Grievance Cell so that public may register their grievances. It is for the Superintendent of the Civil Hospital to solve such problems.

Our observations regarding negligence of the hospital staff are made only for the limited purpose of disposal of this petition and they will not have any persuasive effect in determination of any such similar question that may arise in civil proceedings under the same cause of action.

13. With the above observations, the petition is disposed of.