**(2005) 07 NCDRC CK 0065**

**In the National Consumer Disputes Redressal Commission**

P. KALLIANIKUTTY AMMA — APPELLANT

Vs

UNITY HEALTH SERVICES (P) LTD. — RESPONDENT

**Date of Decision :** 14-07-2005

**Acts Referred:**

**Citation :** 2005 2 CPC 599 : 2005 2 CPR 139 : 2005 4 CPJ 84

**Hon'ble Judges :** K.S.Gupta , Rajyalakshmi Rao J.

**Advocate :** P.Chandrasekhar , Vibhu Bhakra , V.U.Eradi , Jos Chiramel

**Final Decision :** Dismissed

## Judgement

1. THIS complaint dated 10.8.1996 is filed, for negligence in rendering medical services to the deceased Smt. Ratnam Nair, by her mother complainant No. 1, P. Kallianikutty Amma; complainant No. 2 Shri K. Govindankutty Nair, her husband; complainant Nos. 3, 4 and 5 their children, against respondent No. 1, Unity Health Services (P) Ltd.; respondent No. 2 Dr. Kamala Unni, Gynaecologist and respondent No. 4 is New India Assurance Co. Ltd.; respondent No. 3 Dr. Jyothi has been dropped during the proceedings.

2. SMT. Ratnam Nair, aged 47 years having three grown up children was admitted on 27.4.1995 at about 10.00 a.m. in Unity Hospital, Trichur with a complaint of bleeding and abdominal pain arising after menses. She was examined by Dr. Kamala Unni, Gynaecologist and after the checkup, she was referred to be admitted in the hospital on the same day. It is the case of the complainant that the nurse came at 5.30 p.m. and started giving blood transfusion to SMT. Ratnam Nair after taking blood bags from the fridge which were kept in the ward. It is alleged that blood transfusion was started without taking the consent of the patient or her mother who was present at the relevant time. Within minutes of receiving blood, the patient started having reaction with chills and rigor along with breathing difficulty. It was peak summer as it was in the month of April and yet Mrs. Nair felt chilly after blood transfusion. Immediately after seeing the adverse reaction and difficulty felt by the patient, her mother, Mrs. Kallianikutty Amma, the complainant No. 1 called the nursing

 

assistant and brought this to her notice. The nurse had told her that O.P. No. 2 Dr. Kamla Unni had gone to her residence and that her junior, O.P. No. 4, Dr. Jyothi was also not available. Thus, no doctor being available in the ward, the nursing assistant had stopped the blood transfusion waiting for further instructions from the Doctors. It is further alleged that O.P. No. 2 came in at about 7 p.m. for evening rounds and although the complainant''s son explained about the adverse reaction to blood transfusion, yet she did not take it seriously and did not care to examine the patient.

It is also alleged that the patient did not have fever at the time of admission but soon after receiving blood transfusion in the evening she had fever of 103 Degree F. After stopping the blood transfusion in the evening on 27.4.1995, the Nurse kept the opened, partly used blood bag hanging carelessly over the cot. It is alleged that there were flies around the blood bag and the complainant had to give a towel which was placed too, cover the blood bag. The Nurse restarted the blood transfusion with the same blood bag used earlier at about 1.30 a.m. next morning on 28.4.1995. It is contended that there is a possibility of the blood being contaminated at that stage. The patient''s condition was not good on 28.4.1995 and O.P. No. 2 merely told them that it was due to the medicines that were given to her.

3. SMT. Ratnam Nair''s condition became serious on 29.4.1995 as she had breathing difficulty and also suffered pain all over the body. On inquiry it was told to the mother that O.P. No. 2 was away in a Conference to Calicut and her junior Dr. Jyothi is also not available in the hospital at that time. When complainant insisted that a competent doctor see her daughter and for that she had taken a fresh O.P.D. card on payment of Rs. 50/- so that Dr. R.M. Varma Surgeon could examine the patient. Dr. R.M. Varma told that the condition of the patient was serious on account of blood poisoning i.e. Septicaemia and therefore, he advised to take the patient to Medical College Hospital, Trichur in an ambulance. He further told the relatives of the patient to arrange for ambulance on their own since no ambulance was available in the hospital. Therefore, the relatives had to arrange an ambulance from a distant place after making great efforts considering the critical condition of the patient. Although the patient was taken to Trichur Medical College Hospital which is a new medical college, the dialysis facility was not available there. The doctors in Trichur Medical College Hospital advised to take her to Calicut Medical College. The patient was then taken to Calicut Medical College and reached there by late night of 29.4.1995 and she was admitted. Her condition became critical due to septicaemia and she died in the Calicut Medical College Hospital next day on 30.4.1995 at 12.30 p.m. Following issues have been raised regarding alleged medical negligence: (i) Blood transfusion to the deceased without obtaining consent either from the patient or from the relative. The consent form attached in the medical record is blank which itself is evidence. Further Dr. Unni, O.P. No. 2 in a cross-examination also admitted that there was no written consent.

 

(ii) O.P. No. 2 was not present when the blood transfusion started and as per the cross-matching report it is seen that blood given to the deceased on 27.4.1995 was issued by Royal Blood Bank, Kunnamkulam for another patient, namely, Smt. Nafeesa, at Unity Hospital on 19.4.1995. This clearly shows that the said blood was used after 16 days. It is also contended that blood once issued from the blood bank should be used within 24 hours and beyond 24 hours blood bank does not take any responsibility. It is also alleged that when a reaction of "chill/ rigor/fever" is noticed after blood transfusion, the Doctors have to fill up a reaction card and send for blood testing as instructed by the blood bank. This instruction has not been followed. Thus, the patient was given contaminated blood which led to Septicaemia.

(iii) Cross-matching test was done only from the sample bag attached to the blood bag and not from the main blood bag. Even after the adverse reaction to the patient after giving the blood, O.P. did not bother to send the blood for testing to the blood bank.

(iv) Ultrasound scanning of pelvic region was done at O.P. No. 1''s Hospital on 27.4.1995. There was no pelvic infection whereas the hospital took a stand that Dr. R.M. Varma examined the patient on 29.4.1995. Patient was having pelvic infection going for Septicaemia. This is an afterthought by the hospital to cover up the negligence or giving contaminated blood transfusion to the deceased.

(v) Lastly, O.P. No. 2, Dr. Unni examined the patient on 28.4.1995 at about 7.30 p.m. and left for Calicut. Her statement that she had instructed the patient to be taken to Dr. R.M. Varma on 29.4.1995 cannot be relied upon and that it is a blatant lie.

4. THE complainants also relied on the expert opinion of Dr. Sudhanshu Mishra who in his opinion dated 24.1.2002, given on the basis of medical records made available to him stated that the TLC report dated 29.4.1995 was 20,000 and platelet count 80,000 which is one of the known consequences of contaminated blood transfusion. Complainants claimed on account of loss, physical and mental agony caused to them and they are liable to be compensated by giving Rs. 25 lakhs as compensation from the O.P. jointly and severally. Complainant No. 1 is about 72 years old who is the mother of the deceased and deceased was the only person to look after her. Complainant No. 2, husband of the deceased who is 60 years old who denied of companionship of his wife; complainant Nos. 3 and 4 who are in Dubai were also affected in their jobs and lastly complainant No. 5 unmarried at the relevant time and she was appearing for M.A. Final exams and had to forego studies on account of death of her mother. The O.P. denied all the allegations of complainant and contended that Mr. P. Chandrasekharan who is an applicant residing in Delhi reached Kerala only on 1.5.1995 before his sister passed away at about 12.30 p.m. He filed his affidavit which included Dr. Sudhanshu Mishra''s opinion. The patient actually had a dysfunctional uterine bleeding since December, 1993. As her haemoglobin count was dangerously low at 6.5 mg % as against normal range of 13.5 to 14.5 mg % O.P. No. 2 advised

 

blood transfusion and advised the patient''s relatives to arrange for the supply of blood. This has been confirmed by the oral testimony of complainant No. 1 and the statement of Mr. P. Radhakrishnan another brother of the deceased, recorded by the Circle Inspector of Police in connection with the criminal complaint filed by the patient''s husband before the Judicial First Class Magistrate, Kunnankulam. It is due to inordinate delay by the relatives of the patient in procuring blood that O.P. No. 2 decided to use blood of the same group which had been obtained for administering to another patient which had been properly stored in O.P. 1''s hospital. The blood chosen for transfusion was well within the period of expiry. The Drug Controller also conducted an inquiry and verified this fact. O.Ps. also stated that transfusion started after due cross-matching with the patient''s blood. The transfusion started at about 6.30 p.m. as directed by the treating doctor and in the presence of the duty doctor. When the duty nurse noticed rigor and shivering in the patient shortly after the transfusion started, it was stopped by her after obtaining directions in this regard from O.P. No. 2. It is also clarified that as soon as the transfusion was stopped, the blood was taken back to the temperature controlled cold storage. O.P. No. 2 saw the patient at 8.00 p.m. and patient mentioned that she was feeling better and after the temperature came down blood transfusion was resumed. Subsequent blood test revealed that as a result of blood transfusion haemoglobin content had gone up from 6.5 mg % to 7.5 mg %.

5. O.P. No. 2 examined the patient on 28.4.1995 and had to leave for a Medical Conference at Calicut on 29.4.1995. But before she left she saw the patient and patient complained of difficulty in breathing and abdominal pain, some loose motion and tenderness in abdomen. O.P. No. 2 asked Dr. Jyothi who was her Assistant to refer the patient to the Physician as well as to the Surgeon regarding further complications apart from gynaecological problems. She had made arrangements for Dr . Padmasini who is a Gynaecologist to attend to patient.

6. THE patient was examined by a Physician Dr. Joshua, M.D. M.R.C.P., as well as by a Surgeon, Dr. R.M. Verma. Dr. Verma saw the patient on 29.4.1995 and he came to the tentative diagnosis that the patient was having pelvic infection going in for septicaemia and advised blood test for haemoglobin, TC, MDC ESR; blood urea, serum creatine estimation, serum bilirubin, etc. THE investigation report was available at 2.00 p.m. which revealed high blood urea (109 mg %), Serum creatine, (4.2 mg %), serum bilirubin (8 mg % direct and 12.2 mg % total). Opposite parties argued that the haemoglobin content had gone up to 7.5 mg % as against 6.5 mg % at the time of admission which clearly shows that the blood transfusion had clearly been resultant in the rise of haemoglobin content. It is further argued that the serum bilirubin done on 29.4.1995 shows direct bilirubin 8 mg % in the total 12.2 mg % whereas in a case of mismatch transfusion or transfusion of contaminated blood, the indirect bilirubin would have been higher. The patient was advised to be taken to Medical College, Trichur and then to Calicut. O.Ps. relied on the reports and statements of Dr. K.P. Ramamurthy, M.D., Associate Professor (Medicine) (P. 63, Vol. V) and Dr. V.P. Sasidharan, Assistant

 

Professor and Blood Bank Officer, Medical College (P. 46 and P. 47-48, Vol. V) that the patient was seriously ill and that the clinical symptoms commonly seen in leptospyrosis. Dr. V.P. Sasidharan an expert in haematology has expressed the view in P. 46 and P. 47 Vol. V that "but it is too early to have such a serious state of septic shock following the blood transfusion. It is unlikely that there was any serious complication related to blood transfusion. The primary disease itself is responsible for fatal outcome."

The O.P. argued that Mr. Chandrasekaran (the Delhi based brother of the deceased) lodged complaints to several authorities such as Govt. of Kerala through the Drugs Controller, Medical Council of India, and criminal complaint in Kunnamkulam Police Station under Section 304(A) of the Indian Penal Code. After examining all the reports and records all of them have opined that the allegation levelled in the petition was not substantiated in the criminal complaint. The investigation report after examining the three concerned hospitals, recording the statements of the concerned doctors came to the conclusion that cause of death is leptospyrosis and acute renal failure. It was also pointed out that the dead body was cremated without conducting post-mortem and Mr. P. Chandrsekaran also admitted that he did not request for a post-mortem. Hon''ble High Court of Kerala quashed the prosecution proceedings against O.P. No. 2 and came to conclusion that evidence on record "practically ruled out transfusion of blood as a cause of death".

7. AFTER giving serious consideration to the arguments of both the parties and after careful perusal of the record, we are of the opinion that the case of medical negligence has not been established against the opposite parties for the following reasons: The complaint is not that the blood obtained from the blood bank was not cross-matched with the patient''s blood. The complaint essentially is that the blood obtained from the blood bank got contaminated at the Unity Hospital and that the contaminated blood was administered to the patient causing adverse reaction which ultimately led to death. The crux of the argument of the opposite parties is that there was no contamination in the blood and that though there was a mild adverse reaction to the blood transfusion, it was properly attended to in time and that the rest of the blood transfusion took place in an uneventful manner. Their case is that the patient was suffering from -dysfunctional uterine bleeding for at least 14 months before she came to the Unity Hospital and that Septicaemia took place because of the progression of the disease leading to her death and that there was no negligence. Evidence on record shows that the patient was suffering from dysfunctional uterine bleeding for a few years. A D & C was done on 14.2.1994 at some other hospital but did not relieve the problem. The patient was seen by another doctor on 13.4.1995; 19.4.1995 and 25.4.1995 before she came to the Unity Hospital. She came to Unity Hospital only on 27.4.1995 with a complaint of heavy bleeding and passing of blood clots and with anaemia since 6.4.1995. Evidence has also come on record to show that there was no vacancy of bed in the Gynae ward, she was admitted as an emergency case in the surgical ward as the situation was causing anxiety.

 

8. WE also found that there is no substance in the argument of the complainant that they had not given consent for blood transfusion. It has come on record that the husband of the deceased enquired about the availability of blood from the Royal Hospital from where it was subsequently obtained. If there was no implied consent, he would not have gone around making inquiries about the availability of blood for transfusion. It is true that the blood bank has advised that in case there is adverse reaction during blood transfusion, the matter should be reported to them within 24 hours, otherwise the blood bank cannot be held responsible. This does not mean that blood transfusion has to take place within 24 hours after obtaining the blood from the blood bank, provided it is stored properly. This instruction obviously is by way of caution where severe reaction to blood transfusion takes place indicating some serious deficiency like non-matching of blood, etc. In this case though there was adverse reaction in the Unity Hospital the adverse reaction was well managed and normal parameters were restored within a short while. In any case, the expiry date for the blood was 9.5.1995 and the blood transfusion took place much before the expiry date. In addition to all these, as mentioned above, after the death of the patient, the Delhi based brother of the deceased, Shri P. Chandrashekharan filed a number of complaints before various authorities alleging negligence and mala fides against the opposite parties. Firstly, on 23.5.1995 he filed a Criminal Complaint No. 246/1995 under Section 304-A of the IPC. This complaint was investigated by the police and recorded by judicial order (filed as closed) as investigation showed that there was no negligence and that the patient died because of septicemia. Thereafter the Drug Controller, Govt. of Kerala, Thiruvananthapuram was approached on 11.8.1995 alleging that the blood obtained from the Royal Hospital was improperly stored and hence got contaminated. The report of the Drug Controller dated 27.9.1995 clearly held that no evidence has been produced to show that the blood was improperly stored from the time of procurement till the time of administration. Shri Chandrashekharan filed a complaint before the Medical Council of India on 16.6.1995, which directed T.C. Medical Council to appoint the Commission of Inquiry. The Commission of Inquiry of Medical Experts appointed by T. C. Medical Council vide its report dated 20.11.1995 exonerated the opposite party holding that there was no negligence. There was also the report of the Blood Bank Officer, Medical College Hospital, Calicut to the Principal, Calicut Medical College dated 23.11.1995 that the blood transfusion is not the cause of death. As this report clinches the matter, we quote from the report: "There is a history of blood transfusion but it is too early to have such a serious state of septic shock following blood transfusion. It is unlikely that there was any serious complication related to blood transfusion. The primary disease itself is responsible for the fatal outcome." (Ex. No. R-1 Page 46 Vol. IV.)

9. NOT satisfied with all these, Shri chandrashekharan filed a private criminal complaint No. 239/1998 under Section 304-A once again before the Judicial Magistrate, First Class, Kunnamkulam. On appeal to the High Court by opposite party No. 2, Dr. Kamala Unni, the High Court vide its order dated 4.4.2000

 

quashed this complaint against O.P. No. 2.

10. THE only expert evidence produced by the complainant is an opinion dated 24.1.2002 given by one Dr. Sudhanshu Mishra, a Delhi-based doctor, on the basis of medical record made available to him. In his opinion he states, "According to the record one unit of whole blood transfusion was started followed by the patient developing symptoms of chills and rigors with pyrexia (fever). As per the medical records (Doctor''s orders) the transfusion was stopped after 5 minutes. THE patient had 1030F. temperature. Blood transfusion as per record re-started after 3 hours. However, there is nothing on medical record regarding recross-matching and mode of storage of that particular unit of blood during that 3-hour period. "Subsequent TLC report dated 29.4.1995 was 20,000 and platelet count 80,000 which shows severe Septicaemia which is one of the known consequences of contaminated blood transfusion". This report does not indicate that there is any evidence of contamination of blood. Dr. Mishra has only stated that there is nothing on record to show how the blood was stored during that three hours period. In our judgment, this opinion of absence of record does not show that blood was wrongly stored or that there was contamination. As regards low platelet count, Dr. Mishra himself states that it is one of the known consequences of contaminated blood transfusion. This again is only one of the many possibilities and since it has not been established that contaminated blood was given in transfusion one cannot conclude that Septicaemia was due to transfusion of contaminated blood. Dr. Mishra''s opinion therefore is of no consequence. As a result, the case of negligence against the opposite parties has not been proved. The complaint stands dismissed. Complaint dismissed.

 