

(2005) 10 NCDRC CK 0046

In the National Consumer Disputes Redressal Commission

SUPRIYA GUPTA

APPELLANT

Vs

TRUSTEES OF BREACH CANDY HOSPITAL AND RESEARCH
CENTRE

RESPONDENT

Date of Decision : 27-10-2005

Acts Referred:

Citation : 2005 0 NCDRC 53 : 2005 4 CPJ 261

Hon'ble Judges : M.B.SHAH , RAJYALAKSHMI RAO J.

Advocate : DHARMESH SHRIVASTAVA , A.RATHORE , ASHISH DHOLAKIA , RAJIV SHAKDHAR , ARVIND KUMAR , U.A.RANA

Judgement

1. THIS complaint is filed by Shri Supriya Gupta against the trustees of Breach Candy Hospital (the opposite party) for the deficiency and negligence in service by the opposite party and their staff. Facts of the case are: The Complainant, Supriya Gupta is a professional banker and was holding the post of Chairman of UTI Bank, an undertaking of the Govt. of India at the relevant time of the complaint. He was 60 years old in July 1995. The Complainant was suffering from coronary artery disease. On the basis of medical advice given by Dr. Sushil C. Munshi, Consultant Cardiologist and Dr. Sudhanshu Bhattacharyya, Consultant Cardiovascular and Thoracic Surgeon he got himself admitted in Breach Candy Hospital on 21st August, 1995. After examination, the above doctors confirmed the previous diagnosis and advised the Complainant to undergo coronary artery bypass surgery. Various blood tests including test for Hepatitis were conducted. Dr. Bhattacharya who was attached with the Hospital, performed coronary bypass surgery on 23.8.1995 and calcified aortic valve was replaced. Cardiac pacemaker was implanted in his heart on 9.9.1995 in order to improve the functioning of his heart. It is stated by the Complainant that both before and after the surgery and also during the post operative treatment at the hospital the Complainant was subjected to many pathological tests and blood was extracted for conducting the same. Intravenous drips and blood transfusion was also given to him in the post operative period. The Complainant paid an amount of Rs.8,00,930/- which included an amount of Rs.4,26,000/- as the attending doctors' fee. He was

discharged on 16.9.1995 but was bed ridden for four months after the operation. He was feeling unwell and got himself checked by Dr. Sharad C. Shah, Consultant Gastroenterologist on 16.2.1996. Dr. Shah advised him to get his blood test done again where it revealed that he had contracted Hepatitis infection and that the level of infection was already very high. It was found that he had an attack of serum Hepatitis "B" virus on further examination by the same doctor.

2. LEGAL notice was sent to opposite party vide letter dated 26.11.1996 and thereafter present complaint has been filed. It is stated that this infection has seriously affected not only his professional career but has also caused acute mental strain and anxiety to him and his family. Learned Counsel for the Complainant argued that he had no past history of Hepatitis infection and that prior to the coronary bypass surgery it was found negative. It is alleged that he got affected by this disease in February 1996 which can be attributed to the negligence of the opposite party. It is also argued that during the intervening period between September 1995 and February 1996 he was never admitted to any hospital or nursing home and no treatment was given to him for any other illness. It is stated that he went during this period for periodical examination by the cardiologist and for some pathological examination from time to time. It is further contended that during such pathological examination the contracted infection is ruled out because only disposal syringes were used.

3. IT is further submitted that the Complainant did not have any injury or wound nor did he take any dental treatment during this period except a partial denture for which a mould was taken by dentist in November 1995. The said procedure did not involve any anesthetization or injection. It is alleged by the Complainant that during operation, he was given blood transfusion out of the blood supplied by the opposite party's blood bank known as Breach Candy Blood Bank. As and when any blood transfusion is required for any patient, the hospital's blood bank releases required units of blood and patients are required to replace the blood issued by the hospital. Before accepting the blood from the donors the laboratory checks the blood, interalia for any possible infection and platelet counts and blood is accepted only from the donors whose blood is clear. He submitted that 20 donors turned up to donate blood on 21.8.1995 and out of the said 20 donors ten were short listed and out of the said ten, eight donors were selected and their blood was also selected by hospital blood bank/Pathology Department. The virus serum Hepatitis is extremely dangerous and is capable of inflicting lasting and debilitating damage on the patient which could even turn fatal. Alleging negligence and deficiency in service by the hospital and that this infection which takes 5-6 months for incubation and it has developed and surfaced in February 1996 it could only be due to infected medical/surgical instruments or transfusion of the infected blood given in the Breach Candy Hospital. It is stated that the total cost incurred by him upto the date of filing the complaint was Rs.40,000/- and since he is entitled to the cost of the prolonged treatment at his residence, the same should be awarded along with Rs.25 lakhs as compensation for the mental strain, agony and anxiety.

4. SUBMISSION by Opp. Party: Medical Director of opposite party Dr. V.P. De Sa in his affidavit of evidence stated that history of the patient for admission along with the medical notes of attending nurses and angiography procedure in the hospital elaborately gone into and there is nothing to show or prove that said infection was caused in Breach Candy Hospital. He further alleged that Complainant had undergone tooth extraction during this period; and the reports of blood tests prior to the admission to the Breach Candy Hospital and after the release from the hospital, had not been brought on record. He had taken Angiography in Jaslok Hospital and said record has also not been brought on record. He further alleged that medical/surgical supplies which are used in the Hospital are sealed and packed and sterilized by gamma irradiation prior to utilization. We produce hereunder the relevant extracts from the affidavit of Dr.V.P. De Sa, Medical Director: "The instruments used for surgery are sterilized by ethylene oxide sterilization which is the most advanced and sophisticated form of sterilization, commonly practiced all over the world. The sterilization process is monitored by using a colour coded marker which affixed on the instrument pack which changes colour following complete sterilization thus indicating 100% sterility after the procedure is completed. Under these circumstances, there is no possibility of any instrument being infected or contaminated. There is no case of serum hepatitis reported by any patient during the entire period from 1995 and thereafter" The blood bags which were supplied to the patient during the surgery were checked at the opposite party's laboratory and nothing were contaminated. The blood was checked by Elisa method which is a standard test for detection of Hbs Ag (Hepatitis "B" infection or Australian Antigen)".

He further submitted that Operation Theatre Linens in the Hospital are washed by a fully automatic laundry and thereafter sterilized by auto claving which is the accepted method for sterilization of the OT linen and therefore there could not be any possibility of OT linen being contaminated. This OT linen is packed, sealed and sterilized within the operation theatre complex itself. It is argued that serum hepatitis B could be contracted by of the following methods: a) By use of infected needles whilst administering injection; b) Blood transfusion-exposure to infected blood products; c) By sexual intercourse; d) By undergoing a surgical procedure or operation; and e) By dental extraction. In absence of a thorough medical history and both pre-operative and post operative investigations and treatments it is impossible to come to any reasonable or probable conclusion why and how the Complainant has contracted Serum Hepatitis B. Unless the actual source of infection can be located and identified, it is impossible for any expert to identify the source of infection by Hepatitis B Virus and the opposite party's hospital cannot be blamed by theories based on probabilities.

5. WE have carefully gone through the records and heard the arguments of both the parties. In our opinion the complaint of medical negligence is merely based on surmises and there is no prima facie evidence to establish any case of negligence on the part of the opposite party. While the Complainant unfortunately got the infection of Hepatitis "B", there is no evidence to link this

infection as arising from any act of negligence at the opposite party's hospital. The Complainant's hypothesis is that the infection might have come during the blood transfusion at the Breach Candy Hospital or because of use of improperly sterilized medical equipment or linen.

6. ON the first point, the opposite party has categorically stated that almost all the blood required for transfusion was fresh blood taken from the relatives and friends of the Complainant who were brought by him to the hospital for donating the blood, and that all necessary tests for detecting Hepatitis "B" virus were properly carried out. Only one unit/bottle of blood from the hospital blood bank was given on 25.8.1995 to the Complainant. The opposite party has clearly stated that this unit of blood was taken from one Pramod Alve a few days ago for another patient and as it was not used on that occasion, it was given to the Complainant. They have categorically stated and produced the record of the blood taken from the said Alve to show that it did not have any Hepatitis "B" infection. 7. As regards the use of sterilized equipment, the hospital authorities have categorically stated that fresh and disposable cardiac catheters were used on the Complainant. They have in clear terms described the procedure which they follow for sterilizing all the equipments and the hospital linen to show that they were properly sterilized. On the other hand, the opposite party correctly stated that the patient had undergone Angiography at Jaslok Hospital before being admitted in the opposite party's hospital. He had undergone a tooth extraction sometime in November, 1995 somewhere else. In addition to these known facts, the Complainant might have gone to certain other hospitals prior to the heart operation and also after discharge from the opposite party's hospital.

7. THE opposite party has right from the beginning been asking the Complainant to give proper details of treatment, injections, blood transfusions, operations and other procedures at any other hospital whereby an infection could have been contracted prior to being admitted to in the opposite party's hospital and after discharge from the hospital. In spite of these requests, the Complainant has not provided any details whatsoever of the treatment undergone by him elsewhere.

11. THEREfore, in the absence of any evidence it would not be possible to hold that the said infection has arisen from the opposite party's hospital. THE opposite party has correctly stated that Hepatitis "B" infection reveals itself upto 100 days after infection and that in the case of the Complainant, the infection revealed itself after five months and there are various other possibilities from where the infection would have come. THE opposite party has also correctly stated that during the period of infection in question, i.e. in 1995 and thereafter, no other cases of Hepatitis "B" infection from the hospital have been reported by any other patient. 12. Initially the Complainant argued that the Hepatitis "B" infection reveals itself 5 to 6 months after infection and since it was detected after 5 months he argued that it could have come from the opposite party's hospital. In subsequent statements he reduced this period of infection to 3-4 months. In order to show that the opposite party's hospital has not conducted its affairs properly to avoid infections, the Complainant produced an anonymous

letter from the Breach Candy Hospital staff union stating that the hospital was regularly reusing disposable equipment and catheters till April 1996 when a circular for stopping the same was issued by the Hospital authorities. 13. Learned Counsel for opposite party has categorically stated that while there was a practice earlier in some Government hospitals for reusing cardiac catheters 3 to 4 times after properly sterilizing them, in case of poor patients who could not afford the high costs involved for fresh catheters, no such practice was followed in Breach Candy Hospital.

8. THEY clearly denied that any circular allegedly stopping the using of cardiac catheters was issued in April, 1996. THEY have categorically stated that in the case of the Complainant who is from affluent section of the society, fresh cardiac catheters and equipment were used. In any case, no weightage can be given to an anonymous letter. 14. Similarly, the affidavit of one Dr. S.D. Chhabria filed on behalf of the Complainant that he was operated in Breach Candy Hospital in March, 1992 and in April/May, 1992, he was detected to have contracted Hepatitis "B" also does not help the Complainant. The period relevant to the case under consideration is the year 1995 and hence a matter relating to 1992 is of no relevance. Similarly, the newspaper reports of 16th and 18th September, 1996 filed by the Complainant which alleges that the hospital laundry was closed for some time and some of the children in the hospital developed conjunctivitis also are not material to the matter under consideration in this case. The Complainant has failed to show any prima facie evidence to indicate that the said infection has arisen from the opposite party's Hospital due to any negligent procedure. As stated above, admittedly Hepatitis B could only be contracted by a) use of infected needles whilst administering injection; b) blood transfusion-exposure to infected blood products; c) sexual intercourse; d) undergoing a surgical procedure or operation and e) by dental extraction. The Complainant has not produced on record any evidence to rule out the possibility of contracting Hepatitis B except while undergoing procedure or operation. The complaint, therefore, fails and is dismissed. There shall be no order as to costs.