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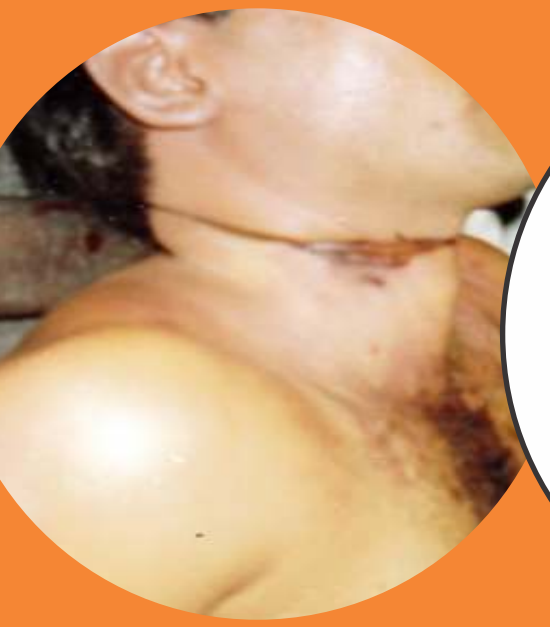

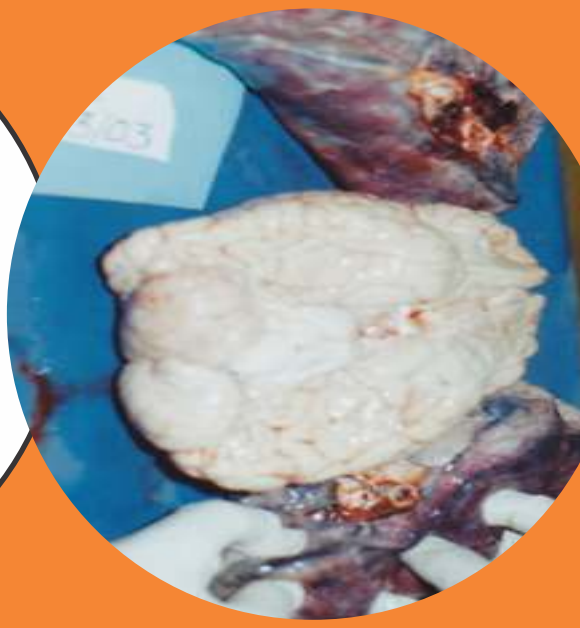

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Original Article

Failure in Duty to Keep Rare Blood/Blood Donors ready before LSCS: A Case of Medical Negligence: NCDRC

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ABSTRACT

NCDRC quoted in its judgment dated: 11.11.2021: "There is something about losing a mother that is permanent and inexpressible – a wound that will never quite heal." – Susan Wiggs. NCDRC further added that we understand how challenging and painful a Mother's Day without mom. The duties of the doctors to the patient are elaborated by the Hon'ble Supreme Court in the case of **Dr. Laxman Balkrishan Joshi Vs. Dr. Trimbak Bapu Godbole and Anr (AIR 1969 SC 128)[2]** observed that the practitioner must bring to his task 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. The above principle was again applied by Supreme Court in the case of **A.S. Mittal and Ors. vs. State of U.P. and Ors. (AIR 1989 SC 1570).[3]** It observed "A mistake by a medical practitioner which no reasonably competent and a careful practitioner would have committed is a negligent one." This Research Paper deals with reasons for holding doctor/hospital negligent in an alleged death after PPH, not able to transfuse blood timely and delay in referral as few of the reasons. NCDRC found deficiency in service /medical negligence on the part of Doctor/Hospital and enhanced in facts and circumstances of case.

Keywords: PPH, Cause of death, Referral, Expert opinion, Medical literature

INTRODUCTION

Case Laws on Standard of Care

Plethora of judgments have discussed about the Bolam's test with regard to the negligence of a doctor. It was held that a doctor is not guilty of negligence if he acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art.

The duties of the doctors to the patient are elaborated by the Hon'ble Supreme Court in the case of **Dr. Laxman Balkrishan Joshi Vs. Dr.TrimbakBapu Godbole and Anr (AIR 1969 SC 128)[2]** observed that the practitioner must bring to his task 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. The above principle was again applied by Supreme Court in the case of **A.S. Mittal and Ors. vs. State of U.P. and Ors. (AIR 1989 SC 1570).[3]** It observed "A mistake by a medical practitioner which no

reasonably competent and a careful practitioner would have committed is a negligent one."

In the opinion of **Lord Denning, as expressed in Hucks vs. Cole, 1968 118 New LJ 469,**[4] a medical practitioner was not to be held liable simply because things went wrong from mischance or misadventure or through an error of judgment in choosing one reasonable course of treatment in preference of another. A medical practitioner would be liable only where his conduct fell below that of the standards of a reasonably competent practitioner in his field. Thus, in cases where the doctors act carelessly and in a manner which is not expected of a medical practitioner, then in such a case an action in torts would be maintainable. [Para 24]

Background of the Case

The instant Appeal had been filed by Dr. Rajesh L. Tate (the 'Appellant/OPNo.2') and the Tate Hospital (the 'Hospital/ OP No. 1') against the Order dated 04.02.2015 passed by the Maharashtra State Consumer Disputes Redressal Commission (the 'State Commission'), wherein the Appellants were held liable for medical negligence. [Para 1]

Facts of the Case

Facts in brief are that Smt. Mayuri S. Brahmabhatt (the 'Patient') during her 2nd pregnancy was visiting the O.P. No. 1 Hospital for regular check-up. On 19.09.1995, Dr. Tate, the O.P. No. 2 examined her and informed the couple that the baby was full term, matured and the delivery could occur at any time. He further advised to bring the patient immediately on noticing pain, signs of bleeding or fluid. At home, on 20.09.1995 at about 5.30 am, the patient started bleeding and immediately she was admitted to the Tate Hospital at 6.30 am. At 6.45 am she was examined by Dr. Tate and decided to perform Lower segment Caesarean Section (LSCS). [Para 2]

The consent was obtained from her husband Mr. Sushrut Brahmabhatt (the 'Complainant No. 1'). The Anaesthetist Dr. (Mrs.) Kelkar (the 'Opposite Party No. 3') arrived at 8.00 am and the patient was taken to the operation theatre for LSCS under spinal Anaesthesia. It was alleged that at 8.45 am, the OP No. 2 asked the patient's husband to get a bottle of Haemaccel which was immediately purchased from local Pharmacist along with other medicines. At 9.30 am, the patient delivered a female baby.

Alleged Medical Negligence

It was alleged that the OP No. 2 told his assistant to call urgently another Gynaecologist and also told the relatives of patient to arrange 'A-Negative' blood. A note on a piece of paper was given for Amit Biological Blood Bank, Vasai for supply of blood. It was further alleged that the person who went to the Blood Bank returned because the blood samples were contaminated, therefore pure sample were redrawn and given with a proper requisition slip to the Blood Bank and thereafter at about 10.30 am, 4 bottles of blood were arranged.

In the meantime, due to anxiety, the co-brother of the Complainant, Dr. Ram Barot, contacted one Gynaecologist, Dr. Asha Sharik at Mallad, who performed 1st LSCS of the patient. She telephonically gave instructions to Dr. Tate to shift the patient to Bhagwati Hospital at Borivali where she could perform emergency hysterectomy to save the life of patient. The Complainant submitted that Dr. Ram Barot arranged 18 bottles of A Negative blood at Bhagwati Hospital and requested few doctors to remain present there.

Issue of Conduct /Referral

It was further alleged that the relatives requested the Dr. Tate to shift the patient to Bhagwati Hospital, however because of heated arguments between the Dr. Tate and the relatives, the request was refused. It was further alleged that at 3 pm, when the things were beyond control of the OP No. 2 and he realised the patient could not be saved, then decided to shift the patient to Bhagwati Hospital. While shifting the Opposite Parties Nos. 2 and 3 accompanied the patient in the ambulance which reached at Bhagwati Hospital at 4:30 pm, but the patient was declared dead before admission. The Post-Mortem (PM) was performed and the cause of death was stated as "haemorrhagic shock following surgery."

Being aggrieved by the alleged deficiency and negligence during the treatment (LSCS) causing death of the patient, the husband of the patient Sushrut Brahmabhatt filed a Consumer Complaint before the State Commission. [Para 2]

The OPs filed their reply and denied all the allegations of the negligence and deficiency during LSCS. The Dr. Tate admitted that it was 2nd LSCS and a female child delivered at 9.30am. He further submitted that because of patient previous delivery and her rare blood group (A negative); he specifically advised the couple to go for delivery, where Blood Bank facility is available; however, the couple expressed their inconvenience go to other place and decided for delivery at the O.P. No. 1 Hospital. [Para 3]

The patient's husband assured to arrange required blood but he failed to arrange blood in time, therefore, the OP No. 2 arranged the blood from the Amit Blood Bank. After LSCS, the patient suffered profuse bleeding; therefore another Gynaecologist was called for help and make every possible efforts to treat the complications. Lastly, the decision was taken to shift the patient to Bhagwati Hospital at Borivali(W). The OP No. 2 and 3 accompanied the patient in the ambulance, but unfortunately the patient died on reaching the Hospital. Therefore, there was neither negligence nor deficiency on the part of the OPs and the Complaint being frivolous, prayed for dismissal of the Complaint. [Para 3]

Compensation Awarded by SCDRC

Upon hearing the parties the State Commission partly allowed the Complaint and directed the Parties to pay Rs. 16 lakh as compensation and Rs. 15000/- towards the cost of the litigation to the Complainant. [Para 4]

Appeal before NCDRC

Being aggrieved, the OPs Nos. 1 and 2 have filed the instant Appeal before this Commission. [Para 5] After our thoughtful consideration; in the instant appeal two questions which arose for consideration are whether the OP No. 2 Dr. Tate failed in his duty of care and secondly whether it was reasonable care during treatment of the patient. [Para 8]

Issue of Expert Opinion

The Complainant in his support filed an opinion and affidavit of Dr. (Mrs.) Jennifer Sheth, a qualified Obstetrician and Gynaecologist, having 27 years of experience. The patient was "A Negative" and had 1st LSCS delivery; therefore for 2nd delivery there were chances of unexpected uncontrolled haemorrhage. The treating doctor should keep sufficient "A negative" blood ready or make necessary arrangement to handle such complication. She further opined that the **"emergency hysterectomy"** or **"vessel ligation"** was necessary. It is apparent from the record that the bleeding was not controlled for 1 ½ hour after the birth of the child.

Moreover, if we consider because of atonic uterus and adhesions caused primary haemorrhage which led to DIC; the patient could be saved if the blood and blood components were given in time and later on the patient to be shifted the higher centre.

Because cross-matched blood is not always available, maternity units should have immediate access (within 5 min) to O-negative blood. Consequently, in our view all maternity units should have their own reserve of blood products if there is no blood bank on-site. [Para 10]

In the instant case the witness Dr. Pawar on behalf of O.P. No. 2 stated that blood donors were available before surgery. We don't agree because, there is nothing on record to prove that the OP No. 2 took sufficient steps to keep A Negative blood ready. Beforehand the patient's blood was not sent to the blood bank for Grouping & Cross matching. [Para 11]

Failure to take immediate surgical intervention

It is pertinent to note that the OP No. 2 failed to control / arrest the bleeding till 12.30 PM. It is evident from the clinical notes that he failed to take immediate surgical intervention or failed to refer the patient to any higher centre. [Para 12]

The clinical notes are reproduced as below:

Table 1: Chronology of Events in OT

Time	Event
6.30 am	Mrs. Mayuri was admitted with a sign of Show on
8.00 am	Anaesthetist came to appellants' hospital
8.30 am	Mrs. Mayuri was given Spinal Anaesthesia
9.30 am	Baby delivered and the patient went in to atonic PPH
10.30 am	Mrs. Sujata went to the blood Bank to donate blood
11.30 am	Blood transfused
2.30 pm	Decision taken to transfer Mrs. Mayuri to Bhagwati Hospital
3.00 pm	Mrs. Mayuri was transferred to Bhagwati Hospital

Source: Para 12

Failure of timely referral/delay in referral

Thus the notes (supra) show, the patient developed Atonic PPH at 9.30 am, but crucial period of 5 to 5 ½ hours was lost before transferring the patient to Bhagwati Hospital. The opinion of Dr. Jennifer Sheth cann't be faulted. The treating doctor (O.P. No. 2) failed to exercise reasonable skill and care. In our considered view, the delay in referral was fatal; it was Negligence per se [Para 13]. In this commission considered view, the death was due to **Haemorrhagic Shock** and not due to Amniotic Fluid Embolism (AFE).

Observations of NCDRC

NCDRC did not agree the submission of OPs that the cause of death was AFE. Such defense was raised at the first time before this Commission. It is pertinent to note that, the Physician Dr. Deshpande was present at the relevant time who could have easily diagnosed AFE from the ECG monitor. NCDRC further noted that an affidavit of senior Gynecologist Dr. Prakash Pawar stated that patient suffered PPH, but he was silent on AFE. [Para 15]

Issue of Medical Literature

NCDRC took reference from few medical text books on Obstetrics & Gynecology viz Munro Kerr's Operative Obstetrics - 13th edition, Williams Obstetrics- 20th edition. Postpartum haemorrhage (PPH) is the leading cause of maternal death. In developing countries, approximately 8% of maternal death is caused by PPH [1-5]. The diagnosis of PPH begins with recognition of excessive bleeding and targeted examination to determine its cause. The causes of PPH can be simplified under the acronym "4T": tone (atony), trauma (trauma of the birth canal), tissue (retention of remains), and thrombin (clotting disorders). Regardless, of the cause of bleeding, physicians should immediately summon additional personnel and begin appropriate emergency hemorrhage protocols. Protocols should provide a standardized approach to evaluate and monitor the patients. The Uterine atony is the most common cause of postpartum hemorrhage. Brisk blood flow after delivery of the placenta unresponsive to trans-abdominal massage should prompt immediate action including bimanual compression of the uterus and use of uterotonic medications. [Para 17]

Lacerations and hematomas due to birth trauma can cause significant blood loss that can be lessened by hemostasis and timely repair. Patients with persistent signs of volume loss despite fluid replacement, as well as those with large (greater than 3 to 4 cm) or enlarging hematomas, require incision and evacuation of the clot. The involved area should be irrigated and hemostasis achieved by ligating bleeding vessels, placing figure-of-eight sutures, and creating a layered closure, or by using any of these methods alone. [Para 19]

Monitoring hemostasis is important during PPH. Routine coagulation tests are the most common methods for monitoring hemostasis during PPH, with the advantage of well-regulated quality control. [Para 20]

Issue of Surgical Interventions

The surgical interventions should be initiated sooner than later if the medical management fails to control hemorrhage, the most appropriate choice of treatment will depend, in part, on the team experience. [Para 21]

Duty to Keep Rare Blood/Blood Donors before LSCS

In the present case even if, it is assumed that the efforts were made by Dr. Tate to procure 'A Negative' blood, the fact still remains that but for he was knowing that it was rare blood group and chance of unexpected bleeding during 2nd LSCS, it was duty to keep standby blood bags and/or A or O Negative live blood donors before proceeding LSCS. It was lack of adequate care after the LSCS which led the patient into hemorrhagic shock. Under these circumstances, and in the absence of any valid explanation by the OPs which would satisfy NCDRC that there was no negligence on their part, we have no hesitation in holding that Mayuri died due to negligence of O.P. No 2. It was an act of Omission from the OP No. 2 wherein it fell below that of the standards of a reasonably competent practitioner in his field. [Para 25]

ENHANCEMENT OF COMPENSATION

The State Commission allowed the Complaint and vide Order dated 04.02.2015; awarded compensation of Rs. 1600000/- and Rs. 15000/- towards the cost of litigation. Now at this stage we cannot ignore that the incident occurred in the year 1995 and we are in 2021, (more than 2 ½ decades).

NCDRC concluded that in the interest of justice, we deem it appropriate to enhance the quantum of award to Rs. 2000000/- as a just and proper compensation. [Para 26]

NCDRC [We] directed the OPs Nos. 1 and 2 to pay compensation of Rs.2000000/- and Rs. 100000/- towards the cost of litigation to the Complainants. It is made clear that at present, if the Complainant No.1 got remarried, then the entire amount shall be paid in equal proportions to the both the daughters of deceased namely Ms. Krupali and Ms. Hetal. The OPs shall pay entire amount within six weeks from today, failing which the entire amount shall carry simple interest of 6% per annum till its realization. The First Appeal is dismissed. [Para 27]

REFERENCES

[1] Tate Hospital & Anr. vs. Sushrut Brahmabhatt & 2 Ors., F.A. No. 458 of 2015 (Against the Order dated 04/02/2015 in Complaint No. 155/1997 of the State Commission Maharashtra), Date of Judgment: 11.11.2021. NCDRC. URL: http://cms.nic.in/ncdrcusersWeb/GetJudgement.do?method=GetJudgement&caseidin=0%2F0%2FFA%2F458%2F2015&dtofhearing=2021-11-11

[2] Dr. Laxman Balkrishan Joshi vs. Dr. Trimbak Bapu Godbole and Anr (AIR 1969 SC 128).

[3] Lord Denning. Hucks vs. Cole, 1968 118 New LJ 469.

[4] A.S. Mittal and Ors. vs. State of U.P. and Ors. (AIR 1989 SC 1570).

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