



IMA HQs. Standing Committee For Medicolegal Cell

MEDICO LEGAL TIP No.- 3 Continue II



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As the judgments have lots of fact this Medico Legal tip will be sent as three issues.

CONSUMER CASE NO. 874 OF 2015

1. RANJIT SARKAR

9B, NORTHERN AVENUE

KOLKATA-700037

.....Complainant(s)

Versus

1. ILS HOSPITALS & 6 ORS.

1, KHUDIRAM BOSE SARANI, BESIDE NAGERBAZAR

FLYOVER, KAZIPARA, DUM DUM,

KOLKATA-700080

BEFORE:

HON'BLE MR. JUSTICE R.K. AGRAWAL, PRESIDENT

For the Complainant :

Mr. Rabin Majumder, Advocate

Ms. Akanksha Srivastava, Advocate

with Complainant in person

For the Opp.Party :

Mr. Partha Sil, Advocate

Mr. Tavish B. Prasad, Advocate

Ms. Binota Roy, Advocate

Dated : 09 Mar 2021

ORDER

R.K. AGRAWAL, J., PRESIDENT

The complainant had approached the West Bengal Medical council, who conducted enquired the involved individuals and gave the following conclusion. Extracts from the Judgment is as follows

THE ENQUIRY TEAM OPINED THAT:

1. The Medical Management and Medical Investigation Team Concerned with the treatment of Late Indrajit Sarkar failed to diagnose the cause of abdominal pain in the time in spite of the clinical findings of the Surgeon on 11.07.2014 morning and all the investigation facilities in the institute to diagnose such cause. The said teams' more aggressive efforts with a higher degree of suspicion to locate the cause of this abdominal pain could have diagnosed the cause (Adrenal injury and hemorrhage) at a stage when the patient was relatively stable and thus could have given some opportunity to the patient to be treated in accordance with the diagnosis.

2. The casual attitude on the part of the concerned doctors and the ILS Hospital-Dumdum authorities in not informing the Police initially for an accidental case and not sending the body for an autopsy later is Medico legally an act of negligence.

84. The PE-8 Committee of WBMC issued a report on File No. 74-C/2-14. The committee examined all the doctors namely.... The WBMC after completion of deposition of above doctors sent a file to three experts for opinion namely Prof. (Dr.) Anandakishore Pal, HOD, Deptt. Of Orthopaedic IPGME&R, Prof. (Dr.) Makhanalal Saha, Deptt. Of Surgery, IPGME&R and Dr. Sugata Dasgupta, Associate Professor of Critical Care Specialist, RG Kar Medical College & Hospital, Kolkata, We note WBMC also sought an expert opinion from Dr. Sushil Ranian Ghosal, Professor & HOD, Deptt. Of Surgery, NRSMC&H.

After going through the relevant documents lying with the file along with the deposition of complainant, accused doctors and expert opinion in various fields the PE Committee has come to the following opinion:

1. As it was not a natural disease process, on admission a Police Case should have been registered.
2. Patient should have been admitted / assessed by a General Surgeon first.
3. In a patient with multiple trauma injury/poly-trauma USG examination immediately on arrival / admission in an international norm, which was not followed here.
4. CT scan of abdomen & thorax was also delayed by more than 24 hours (in a setting where USG is inconclusive).
5. The copy of the report as received from the concerned hospital regarding D-Dimer assay appears fraudulent (date of report & stay of patient not matching Page-329).

6. As CT abdomen pointed multiple pathologies (related to injury as in the case), not advising a medical autopsy/PM Examination after death was highly unethical.

85. The Complainant preferred an appeal (No. MCI-211 (2) 90 (Appeal)/2014 before the Medical Council of India. It was held as below:

The above matter was considered by the Ethics Committee at its meeting held in 27th & 28th February, 2017. The operative part of proceedings of the said meeting is reproduced as under:

1. Individually and collectively all the doctors failed to properly assess the condition of the patient.
2. They failed to have the required level of clinical suspicion about the condition of the patient and totally missed the significance of abdominal pain. Investigation findings of CT, MRI etc. and also failed to diagnose adrenal hemorrhage the delay in investigation points to deficiency in services.
3. There was significant delay in doing various investigations and initiating necessary treatment after tests.

The Ethics Committee further observed that all the facts mentioned above appear that the hospital and doctors have not continuously monitored the welfare of the patient. They only managed the crises as and when they appeared. The absence of team work and improper care led to the unwanted demise of patient.

All the above points clearly indicate the medical negligence in the management of the patient on the part of above treating doctors.

In view of above, the Ethics Committee unanimously recommended to remove the name of all the above doctors for a period of ONE YEAR.

We have done our best to edit the 32 page judgment and present with an iota of expectation in three issues. The next issue will be an interesting presentation and also a lesson for our thoughts to.....