How to Avoid Litigations in Medical Practice

Transmission of HIV

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Errors in laboratory tests, wrong blood group reporting and transfusion related complications are major areas of litigations in medical profession.

In this article I will focus mainly on Blood transfusion services.

Blood transfusion is one therapy which is used practically in all branches of medicine.

Over a period of years laboratory techniques have improved so much that any wrong blood group reporting or contamination of blood products are not taken as errors but as negligence and carelessness.

Following are some of example cases decided by various Councils, Courts and Forums in blood transfusion related complaints.

Issues related to wrong blood groups

A laboratory gave a blood group as A+ve, while other two Laboratories gave report of the same person as B+ve. Expert testified that on some occasions, fine clumping of RBCs may lead to error and gave reference of textbook by Gradwhol stating that blood group should be carried out in two Laboratories. It was held that a mistaken report in this respect is not necessarily a negligent report'

Normally one does not get blood group tested from two laboratories, but its recommended that a second technician should very the blood group.

In case of Bharat Pathology Laboratory vs Mangi Lal Vyas National CDRC. III(2003) CPJ:94; it was held that “Pathologist given wrong blood group report amounts to medical negligence, when contingency of transfusion of blood arises” and therefore court granted compensation to complainant

Mismatch Blood Transfusion

Positive Blood Group Patient Transfused Negative Blood

In a case, a patient having blood group B+ve was admitted in a critical condition. Blood grouping done thrice showed blood group of B-ve. Patient was given blood transfusion of B-ve. Court dismissed the complaint and held that "transfusion of B-ve blood to B+ve patient is a recognized treatment".

Wrong blood group transfused

In a case of mismatched blood transfusion, it was contended that cause of death of the patient was septicaemia. Court observed that patient's condition deteriorated after blood transfusion. Hence, the treating doctor was held liable.

Emergency Blood Transfusion with Different Blood Group

A six month old child was admitted to JIPMER with acute gastroenteritis and was again readmitted for reduced urine output at Child's Trust Hospital. Hemolytic uremic syndrome, septicemia, peritonitis and circulatory failure was diagnosed. Child's blood group was AB +ve and he was given B +ve blood after cross matching as an emergency procedure, since AB +ve blood was not available. Treatment was given for 13 days. Child did not improve. Father took discharge against Medical Advice (DAMA). Court held that,” All investigations and treatment given was as per the standard textbooks, expert witness opined that given such blood in emergency as correct. Therefore no negligence was held against the doctor

No harm no negligence

If treatment is not going to be based on the test done and test is found wrong, at the most, cost of test may be refunded. In case of Madhyamgram Consumers Welfare Society vs KK Chatterjee West Bengal SCDRC II(2002) CPJ, 381 wrong report was given by laboratory. No treatment was started on the basis of the wrong report. There was no loss or injury suffered by patient and therefore complainant not entitled to compensation. Court only ordered to refund blood examination charges and cost of litigation.

In similar case Blood group of complainant was tested by opponent and reported as AB +ve. Second report showed B +v. It was held that no blood transfusion was given and no suffering occurred to the patient. Hence, case was dismissed

Delay In Blood Transfusion

A child was admitted to the hospital with septicaemia, where patient party alleged wrong diagnosis as no investigations were done and there was delay in giving blood transfusion. The Forum held that the doctor guilty. Doctor appealed to state Commission saying that patient was referred to him in serious condition with septicaemia after two days and therefore, started antibiotics immediately; blood culture was not possible as it takes long time for results to come. Blood transfusion takes at least three hours after demand for requisition is put in, as blood bank has to carry out certain test as per government notification. Even civil surgeon also certified that treatment administered was proper, which was accepted by court and doctor was not held liable.

Transmission of Hepatitis

In one case, a patient underwent hysterectomy during which blood has to be transfused. Ten days after the operation patient took ill and her blood, tested positive for Hepatitis-B. It was alleged that this infection occurred as the blood was transfused without rechecking and re-screening for infection of hepatitis B. The blood was supplied by a blood bank in a well-known institution and screened for hepatitis B, etc. A certificate was issued along with the two pints. The patient developed hepatitis B, 10 days after transfusion, while the incubation period for hepatitis B virus is between 50 to 160 days. Also, it is known that hepatitis B may occur by other means too. The Commission held that when a disease can occur due to other causes as well it is for the complainant to prove that the particular act of the opposite party was the proximate cause of his ailment. Hence, the complaint was dismissed.

In another case a patient was operated for prostate by transurethral resection of prostrate (TURP), where blood transfusion was given during surgery. Later, patient developed hepatitis. Expert testified that incubation period of hepatitis is one month. Patient developed hepatitis earlier than incubation period. Therefore, blood cannot be source of infection. The case was dismissed as there was no evidence and nexus with blood transfusion.

Technical issues in blood banking, transportation and storage

- Whole blood can be stored for 35 to 42 days at 4 C.
- Platelets can be stored at 22 C with continuous agitation up to 5 days.
- FFP and plasma can be stored for 1 year at -30 or less

  Should be rapidly frozen and thawed just before use.
- Transportation should be temperature controlled.
- Should be transfused as early as possible. Whole blood/ RBC transfusion should be completed within 4 -6 hours of issuing.

General precautions

- A separate valid informed consent is a must for blood transfusion
- Consent has to be signed by the patient himself unless exempted as per rules of valid consent
- Doctor qualified nurse should check name, age of donor and recipient along with their respective blood groups before starting the transfusion. Treating doctor is not responsible for wrong cross matching or tests of Hepatitis B,HIV etc. But treating doctor is responsible to see that blood is transfused at a proper rate and proper volume. He must give proper written orders to watch pulse rate, temperature, Blood pressure and any signs of mismatched transfusion.
- For any wrong report of blood group or HIV, Hepatitis B etc pathologist is responsible.
- Any transfusion reaction or untoward reaction should be documented and reported to blood issuing blood bank.

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Ps. soon will start articles on medico-legal cases pertaining to various specialties. If you have any query related to your specialty please mail it to dr.arun.medicolegal@gmail.com or WhatsApp 9811106056