DMC/DC/F.14/Comp.2832/2/2024/ 15th July, 2024

**O R D E R**

The Delhi Medical Council through its Disciplinary Committee examined a complaint of Smt. Meena Jha, r/o- 1/3640, Gali No.01, Ram Nagar, Loni Road, Shahdara, Delhi-110032, made to office of the Deputy Commissioner of Police, Shahdara District, Bholanath Nagar, Shalimar Park, Delhi-110032, forwarded by the Medical Council of India, alleging medical negligence on the part of the doctors of East Delhi Medical Centre and doctors of Max Super Specialty Hosptial, Patparganj, Delhi, in the treatment of the complainant’s husband Shri Ram Pratap Jha, resulting in his death on 19.12.2018.

The Order of the Disciplinary Committee dated 29th May, 2024 is reproduced herein-below:-

The Disciplinary Committee of the Delhi Medical Council examined a complaint of Smt. Meena Jha, r/o- 1/3640, Gali No.01, Ram Nagar, Loni Road, Shahdara, Delhi-110032 (referred hereinafter as the complainant) made to office of the Deputy Commissioner of Police, Shahdara District, Bholanath Nagar, Shalimar Park, Delhi-110032, forwarded by the Medical Council of India, alleging medical negligence on the part of the doctors of East Delhi Medical Centre and doctors of Max Super Specialty Hosptial, Patparganj, Delhi, in the treatment of the complainant’s husband Shri Ram Pratap Jha (referred hereinafter as the patient), resulting in his death on 19.12.2018.

The Disciplinary Committee perused the complaint, written statement of Dr. Pankaj Kumar Goel, Dr. Ajay Bedi Director of East Delhi Medical Centre, joint written statement of Dr. Y. P. Singh, Dr. Vijay Arora, Dr. Anil Bhat, Dr. Akhil Taneja, Dr. Rahul Puri, Dr. Nidhi Saxena, Medical Superintendent of Max Super Specialty Hospital, copy of medical records of copy of medical records of East Delhi Medical Centre and Max Super Specialty Hospital and other documents on record.

The following were heard in person :-

1) Dr. Pankaj Kumar Goel Consultant, East Delhi Medical Centre

2) Dr. Ajay Bedi Director, East Delhi Medical Centre

3) Dr. Y. P. Singh Anaesthetist, Max Super Specialty

 Hospital

4) Dr. Akhil Taneja Anaesthetist, Max Super Specialty

 Hospital

5) Dr. Anil Bhat Consultant Cardiologist, Max Super

 Specialty Hospital

6) Dr. Saurabh Anaesthetist, Max Super Specialty

 Hospital

6) Dr. Vijay Arora Consultant Medicine Max Super Specialty Hospital

7) Dr. Gaurav Mittal AMS, Medical Administration, Max

 Super Specialty Hospital

8) Dr. Vishal Ahlawat Manager-Administration, Max Super

 Specialty Hospital

9) Dr. Nidhi Saxena Medical Superintendent, Max Super

 Specialty Hospital

The Disciplinary Committee noted that the notice sent to the complainant Smt. Meena Jha returned undelivered in the office of the Delhi Medical Council with noting from the postal department ‘no such person’.

In the interest of justice, the Disciplinary Committee decided to proceed with the matter in order to determine it on merits.

It is noted that the complainant Smt. Meena Jha in her complaint alleged that on 11th December, 2018 at around 08.00 p.m. her husband Late Shri Ram Pratap Jha (the patient) went to East Delhi Medical Centre for a normal checkup for fever and cough. Dr. Pankaj Goel attended him and advised for an ECG and x-Ray. Thereafter, Dr. Pankaj Goel suggested that the patient was suffering from either dengue or chikungunya and asked him to get admitted. The patient and she (the complainant) were being repeatedly told that the patient’s platelet count is low and; hence, he is being treated or monitored for the same. The patient was made to undergo multiple tests every morning and evening for number of days; however, no improvement was seen. Rather his condition continued to deteriorate and it was only on 17th December, 2018 when his condition deteriorated to such a great extent that East Delhi Medical Centre and its doctors simply shirked off their responsibility from further treatment and told her to take her husband to a higher centre. Hence, East Delhi Medical Centre and its doctors were not only negligent by resorting to experiment upon her husband’s body but further giving wrong treatment and letting condition deteriorate to such an extent that his case was no longer manageable by them. Further, on being taken to Max Super Speciality Hospital, Patparganj on 17th December, 2018 at around 11.30 p.m., Max Hospital admitted her husband under observation and conducted few tests in Emergency or Triage only. She was initially told that they do not have a bed in ICU and also that her husband will recover, though, the treatment may take about two weeks. On 18th December, 2018, she again insisted upon the doctors to shift her husband to the ICU but the doctors kept on maintaining that they do not have a bed in ICU. Also, to her utter surprise, the doctors changed their stand started saying that next seventy two hours are critical for her husband. No proper concern, due care or heed was paid to her persistent requests made in great pain and with much persuasion. At about 09.00 p.m. on 18th December, 2018 after she had dinner with her husband in the hospital, she was suddenly called out by the doctors and told that they are shifting him to the ICU. Thereafter, neither the complainant nor any other family member were allowed to meet the patient and further, the doctors told them that next twenty four hours are critical for him, which shocked her totally. In the meantime, despite raising queries about her husband’s health, no answers were given by the doctors. Finally, on 19th December, 2018 at 09.00 p.m. at Max Super Speciality Hospital, the doctors declared the death of her husband, citing septic shock. It is evident that conduct of the doctors at Max Super Speciality Hospital had caused her husband’s death, as they were negligent in not only diagnosing the condition of her husband and providing effective treatment, but also negligent in gauging the seriousness of the patient’s condition and continued to ignore the need of shifting him to an ICU, which, if they had diagnosed properly, then, they would have either shifted him to the ICU immediately, or if they actually did not have any bed, then, they would have shifted him to another Max Hospital in Delhi where they had a bed in ICU or to another hospital nearby, which, if it was done timely, would have saved his life. Hence, both East Delhi Medical Centre and Max Super Speciality Hospital, Patparganj and their doctors named above were negligent and caused death of her husband.

Dr. Pankaj Kumar Goel, Consultant Specialist Physician, East Delhi Medical Centre in his written statement averred that the patient named Shri Pratap Jha, 54 years old gentleman, presented to the emergency room on 11th December, 2018 at 09.00 p.m., the patient was immediately attended by Dr. Pankaj Kumar, Specialist Physician (MD, Medicine). The patient’s presenting complaints were high grade fever with chills, polyarthralgia with severe joints pain involving both small and large joints of upper and lower limbs. The pain was incapacitating and the patient was not able to move his extremities because of excruciating pain. The patient also complained of headache, generalized body-ache, nausea and poor oral acceptance and prostration. The patient also had cough without expectoration. The patient denied history of loose stool, rash over body, burning micturition, oliguria, jaundice, blurring of vision, alteration in consciousness, malena, hemoptysis or bleeding manifestations, wound, abscess or any apparent focus of infection elsewhere in the body. The patient denied any past history of DM, hypertension, heart disease, chronic kidney disease, CVA, rheumatological illness, other chronic illness or major surgery. The patient had a history of chronic alcoholism; there was no history of any drug allergy. On examination, the patient was conscious and oriented but febrile with a temperature of 101 degree F, pulse of 110/minute regular, blood-pressure of 130/70 mm Hg, respiratory rate of 24/minute and SPO2 was 95% on room air. The patient did not have pallor, cyanosis icterus, and pedal edema. The patient had B/L wheeze in chest, there was no murmur on cardiac auscultation. Abdominal examination revealed splenomegaly, liver was also palpable. The patient was again probed as to whether he had any liver disease in the past, to which, the patient denied having so. The patient was admitted with provisional clinical diagnosis of acute febrile illness with severe polyathralgia and splenomegaly with possible etiology of dengue or chikungunya like illness with lower respiratory tract infection. It is strongly denied that the patient was brought by the attendants for normal checkup for fever and cough. The fact is that the patient was brought by the attendants in the emergency room at 09.00 p.m. (on 11th December, 2018) with profound and debilitating symptoms and not for any normal check up for fever and cough. If the patient were to be brought for normal or routine health check-up, then, he would not have been brought in the emergency room at 09.00 p.m. in the night; rather, he would have been brought in the OPD during daytime. The patient was not brought in the OPD. The patient was brought in the night at 09.00 p.m. in the emergency room. Further, the patient did not come walking by himself at the time of presenting in the emergency, the patient was brought in a wheel chair to the emergency room of the hospital. It is for the complainant to explain the reasons for calling her husband’s condition, who was brought to the emergency in a wheel chair at 09.00 p.m. in the night, as normal check-up for fever and cough and to also explain as to why she has hidden this fact in her written complaint. However, in actuality, the patient had presented to the emergency room with complaints of high grade fever with chills with severe joint pain with breathing discomfort with coughing with poor oral intake with extreme restlessness (as per Referral Summary) for the past four days. This condition of the patient is self-explanatory. Further, in the emergency room itself, investigation including CBC, liver function tests, kidney function tests, serology for common and prevalent infectious agent and cultures (blood and urine) were sent. He was initiated on necessary treatment for above clinical presentation, which included I.V. fluids, I.V. Antimalarial-Artesunate , broad spectrum I.V. antibiotic third generation Cephalosporin- Ceftrixone with Tazobactum, Azithromycin and symptomatic and supportive treatment including antipyretics, nebulization with bronchodilators, antiemetic and Proton-pump inhibitors. The patient’s investigations revealed – Hb (16.5 g%), TLC (10.9), DLC (N-80, L-17) with thrombocytopenia (Platelet count-78,000/mm3), SGOT/SGPT (63/40), GGTP (47), ALKP (77), Bilirubin (Total/Direct 0.58/0.13), total protein (6.1) with Albumin and Globulin (3.27/28)with AG ratio of 1.16:1, Blood Urea (41.7), Creatinine (1.18), Uric acid (9), Calcium(8.4), mild hyponatremia (Sodium and Potassium-129/4.4). Urine R/M showed 10-12 pus cells/HPF. Investigation also showed malaria antigen (NR), typhoid(negative), dengue serology and NSI antigen (negative), chikungunya serology (negative), HBSAg (NR) and HIV (NR). Ultrasonography showed splenomegaly, mildly thickened gall-balder wall, small right kidney with lower pole calculi and small right lobe liver hemangioma, x-ray was unremarkable except for subtle haze in left lower zone. There was no evidence of pulmonary edema, effusion or infiltrates.ECG showed sinus rhythm. An individualized protocol was followed for evaluation of the patient’s illness for diagnostic workup and therapeutic measures the patient was regularly monitored for vitals, any bleeding manifestations, joint effusion, oxygen saturation and other clinical parameters. The patient was also monitored for worsening of thrombocytopenia, renal function, and electrolytes. In view of pus cells in urine, another antibiotic I.V. Aminoglycoside – Amikacin was also added along with oral urinary alkalizer solution. Doses of Ceftriaxone and Tazobactam were enhanced. The patient was also started on tablet Oseltamivir on empirical bases for possible H1, N1 infection. The patient was regularly monitored by round the clock duty Resident Doctors; Specialist Physician Incharge Dr. Pankaj Kumar, and ICU Intensivist Dr. Ajay Bedi (MD, Anaesthesia). The patient had symptomatic improvement with treatment; his fever started settling and joint pain although persistent but lessened in intensity. The patient had thrombocytopenia, which had later improved to 108,000/mm3. It is true that the patient’s platelet count was low and that he was regularly monitored for the same. His platelet counts were 78,000/cu.mm on 11.12.2018, 70,000/cu.mm on 13.12.2018, 92,000/cu.mm on 15.12.2018 and 104,000/cu.mm on 16.12.2018. This is standard medical management protocol in such situations. This is also true, as alleged by the complainant, that they were being informed repeatedly about the same. On 13th December, 2018 at 05.00 p.m., the patient developed shortness of breath and cough. Immediately, nebulization was repeated and the patient improved. However, the patient also complained of Orthopnea. To rule out any cardiac involvement 2D Echo was advised. Echo study revealed dilated cardiac chambers with gross left ventricle dysfunction with left ventricular ejection fraction of 30 to 35%. The patient was immediately advised for Trop-T test, to rule out acute coronary event, and Pro-B type Natriuretic Peptides (NT-pro BNP) test was also advised. The patient was then shifted to HDU at 11.00 p.m. on 13.12.2018, and subsequently to ICU at 02.00p.m. on 14.12.2018 itself, intensive care and haemodynamic monitoring. He was put on treatment for congestive heart failure including diuretics, oxygen therapy, I.V. fluids were restricted. The attendants were explained about his cardiac illness; need to shift to ICU and bad prognosis of the cardiac condition. The patient Trop-T test result was negative but NT pro BNP test results were markedly elevated (1485 pg/ml). In light of this event, and given the fact that such an event does not occur without previous history of heart disease, the patient’s attendants were again inquired about any history of heart failure or cardiac illness in the past. It was at this moment that the patient’s attendants informed that the patient has had some cardiac illness and liver related illness in the past and that he had received treatment for these illnesses at tertiary care centre (Sir Ganga Ram Hospital, New Delhi). The patient’s attendants were then advised to bring all the relevant documents related to his past illness. It is pertinent to note that the patient and his attendants did not divulge this important information at the time of admission, and kept it hidden from the treating physicians for reasons best known to them. On screening, the patient’s previous documents related with treatment in past at Sir Ganga Ram Hospital, it was revealed that the patient had Dilated Cardiomyopathy(DCMP) and Alcohol Related-Chronic Liver Disease (AL-CLD) and had a history of hospitalization for the same. There was no record of further follow-up for these illnesses. The patient was not in continuous treatment for his chronic illnesses. The patient’s ttendants were then briefed about chronic nature, poor outcome of these medical conditions as well as the need for continued medical follow up for these illnesses. In ICU with treatment, the patient showed improvement on the very next day in symptoms of Orthopnea. With improvement in clinical status, the patient he was shifted again in the ward on 15th December, 2018 afternoon with the combined opinion of specialist physician Incharge and ICU Intensivist. It is again denied that no improvement was shown in the patient’s condition. The patient was brought in an incapacitating condition and poor overall health, when he was shifted to ICU, but after treatment at their hospital, the patient’s condition had shown initial improvement and the patient was shifted from ICU to ward on 15th December, 2018. On 16th December, 2018, the patient again developed high grade fever despite being on antibiotics, and anti-malarials. In view of this new situation, the patient’s antibiotics were revised to Carbapenem- I.V. Meropenem on empirical basis. Although, cultures were sterile. CBC was repeated, which showed HB (17), TLC (11.3), PC (108), DC (N-80, L-15) on 17th December, 2018. On 17th December, 2018, in the evening around 04.00 p.m. the patient developed extreme restlessness and diaphoresis. On examination, the patient had tachycardia (150-160/minute) with irregular pulse and hypotension with systolic blood pressure of 70mmHg. The patient was immediately brought to ICU where ECG showed atrial fibrillation with fast ventricular rate and frequent ventricular ectopics. IV inotropes (noradrenaline) was started to sustain blood pressure and maintain systematic perfusion. Injection Amiodarone was also started to reverse the arrhythmia and restore sinus rhythm. The patient also received I.V. steroid-Hydrocortisone and bolus of normal saline. The attendants were explained about these clinical events and consequent hemodynamic instability in a patient who already has gross Left Ventricular Dysfunction (Cardiac Dysfunction). They were also informed about the critical status of the patient and need to shift the patient to tertiary care centre urgently for further evaluation and management. Without wasting time, the patient was referred and shifted on a same day at 17th December, 2018 itself to a tertiary care centre (to Max Hospital, Patparganj, as learnt from records provided by the Delhi Medical Council) in cardiac ambulance with continued treatment and supervision. It is pertinent to note that the cardiac ambulance had a duly qualified doctor to accompany with the patient. It is strongly denied that the treating doctors shirked off their responsibility from further treatment of the patient at the hospital. In contrast to the allegation, the fact is that the patient was duly treated with the best available facilities, equipment and the staff (as highlighted in the above), and then, referred to a tertiary care centre for further evaluation and management, as theirs is not a tertiary care medical centre. In fact, all due responsibilities of transfer of the patient were fulfilled by them, and the patient was shifted in a cardiac ambulance, alongwith a Resident Doctor in the ambulance itself. It is strongly denied that their hospital doctors resorted to experimenting upon the patient. It is again strongly denied that any of the doctors gave wrong treatment to the patient. It is humbly submitted that no facts alleging either experimentation or wrong treatment has been submitted by the complainant in her complaint. The nature of experimentation or wrong treatment has not been divulged by the complainant, and this remains merely a generalized complaint of the complainant. It may be noted that in the complaint of the complainant, the complainant has not named their hospital, East Delhi Medical Centre, for not diagnosing the condition of the patient and for not providing effective treatment. It is another hospital which has been so named, sparing the name of East Delhi Medical Centre. Also, the complainant has not named their hospital for being negligent in gauging the seriousness of the patient’s condition. Their hospital has also not been named for any delay in shifting the patient to ICU. Again, it is another hospital which has been so named, sparing the name of East Delhi Medical Centre. It is most unfortunate that the patient Shri Ram Pratap Jha succumbed to his illness at a tertiary care centre ,later in the course of his illness. They share their grief with their family. They strongly deny any negligence, whatsoever, in the care and treatment of the patient. During the entire course of hospitalization and at no point of time, the patient’s complaints were ignored. He was regularly and, as when required, visited by the specialist and the resident doctors. He was personally visited and consulted by the specialist physician, ICU intensivist and Resident Doctors for a total of twenty three times for his (the patient) entire hospital stay. The patient was constantly and regularly monitored for his vital signs. This can be corroborated by the vitals monitoring chart in the case file. The patient was repeatedly and regularly enquired about his symptoms, and any fresh complaints if any. The patient underwent all relevant investigations for his symptomatology as medically deemed necessary. The patient was provided due medical care and attention in all the circumstances during entire course of hospitalization. The attendants were regularly explained about his evolving clinical status, diagnosis, and outcome from time to time. This fact has been cited by the patient’s wife in her complaint letter. They were also informed about his investigation reports, and ongoing and required treatment, the patient’s underlying chronic illness i.e. dilated cardiomyopathy and chronic liver disease(alcohol related) and poor outcome of these conditions. It is to be noted that at no point of time, did the patient or his attendants made any complaint to any of the treating physicians (either specialist physician or ICU intensivist), resident doctors, nursing staff or administration of the hospital for want of care and attention during the patient’s entire hospital stay of six days. The patient was managed with utmost sincerity with best of their intentions and to the best of their knowledge and efforts. It is reiterated that the unfortunate death of the patient did not take place at East Delhi Medical Centre. The event of death was declared at the tertiary care centre (Max Hospital, Patparganj, as learnt from records provided by Delhi Medical Council).

Dr. Ajay Bedi, Director, East Delhi Medical Centre in his written statement averred that the patient named Shri Pratap Jha, 54 years male, presented to the emergency room on 11th December, 2018 at 09.00 p.m. The patient was immediately attended by Dr. Pankaj Kumar, M.B.B.S. M.D, Consultant Internal Medicine. The patient complained of high grade fever with chills, polyarthralgia with severe joints pain involving both small and large joints of upper and lower limbs. The pain was incapacitating and the patient was not able to move his extremities because of excruciating pain. The patient also complained of headache, generalized body ache, nausea and poor oral acceptance and prostration. He also had cough without expectoration. The patient denied history of loose stool, rash over body, burning micturition, oliguria, jaundice, blurring of vision, alteration in consciousness, malena, hemoptysis or bleeding manifestations, wound, abscess or any apparent focus of infection elsewhere in the body. The patient denied any past history of DM, hypertension, heart disease, chronic kidney disease, CVA, rheumatological illness, other chronic illness or major surgery. The patient had a history of chronic alcoholism; there was no history of any drug allergy. On examination, the patient was conscious and oriented but febrile with a temperature of 101 degree F, pulse of 110/minute regular, blood-pressure of 130/70 mm Hg, respiratory rate of 24/minute and SPO2 was 95% on room air. He did not have pallor, cyanosis icterus, and pedal edema. The patient had B/L wheeze in chest, there was no murmur on cardiac auscultation. Abdominal examination revealed splenomegaly, liver was also palpable. The patient was again probed as to whether he had any liver disease in the past, to which, the patient denied having so. The patient was admitted with provisional clinical diagnosis of acute febrile illness with severe polyathralgia and splenomegaly with possible etiology of dengue or chikungunya like illness with lower respiratory tract infection. It is strongly denied that the patient was brought by the attendants for normal checkup for fever and cough. The fact is that the patient was brought by the attendants in the emergency room at 09.00 p.m. (on 11th December, 2018) with profound and debilitating symptoms and not for any normal check up for fever and cough. If the patient were to be brought for normal or routine health check-up, then, he would not have been brought in the OPD during daytime. The patient was not brought in the OPD. Further, the patient did not come walking by himself at the time of presenting in the emergency, the patient was brought in a wheel chair to the emergency room of the hospital. This condition of the patient is self-explanatory. Further, in the emergency room itself, investigations including ECG, chest x-ray, CBC, liver function tests, kidney function tests, serology for common and prevalent infectious agent and cultures (blood and urine) were sent. He was initiated on necessary treatment for above clinical presentation, which included I.V. fluids, I.V. Antimalarial-Artesunate, broad spectrum I.V. antibiotic Cephalosporin- Ceftrixone with Tazobactum, Azithromycin and symptomatic and supportive treatment including antipyretics, nebulization with bronchodilators, antiemetic and Proton-pump inhibitors. The patient had symptomatic improvement with the treatment; the patient’s fever started settling and joint pain although, persisting but lessened in intensity. The patient had thrombocytopenia, which had later improved to 108,000/mm3.  It is true that the patient’s platelet count was low and that he was regularly monitored for the same. This is standard medical management protocol in such situations. This is also true, as alleged by the complainant, that they were being informed repeatedly about the same. On 13th December, 2018 at 05.00 p.m. the patient developed shortness of breath and cough. Immediately, nebulization was repeated and the patient improved. However, the patient also complained of orthopnea. To rule out any cardiac involvement, 2D echo was advised. Echo study revealed dilated cardiac chambers with gross Left Ventricle Dysfunction with Left Ventricular Ejection Fraction of 30 to 35%. The patient was immediately advised for Trop-T test, to rule out acute coronary event, and Pro-B type Natriuretic Peptides (NT-pro BNP) test was also advised. The patient was then shifted to HDU at 11.00 p.m. on 13.12.2018, and subsequently to ICU at 02.00 p.m. on 14.12.2018 itself, intensive care and hemodynamic monitoring. The patient was put on treatment for congestive heart failure including diuretics, oxygen therapy, I.V. fluids were restricted. The attendants were explained about his cardiac illness; need to shift to ICU and bad prognosis of the cardiac condition. His Trop-T test result was negative but NT pro BNP test results were markedly elevated (1485 pg/ml). In light of this event, and given the fact that such an event does not occur without previous history of heart disease, the patient’s attendants were again inquired about any history of heart failure or cardiac illness in the past. It was at this moment that the patient’s attendants informed that the patient has had some cardiac illness and liver related illness in the past and that he had received treatment for these illnesses at tertiary care centre (Sir Ganga Ram Hospital, New Delhi). The patient’s attendants were then advised to bring all the relevant documents related to his (the patient) past illness. It is pertinent to note that the patient and his attendants did not divulge this important information at the time of admission, and kept it hidden from the treating physicians for reasons best known to them. On screening the patient’s previous documents related with treatment in past at Sir Ganga Ram Hospital, it was revealed that the patient had Dilated Cardiomyopathy (DCMP) and Alcohol Related-Chronic Liver Disease (AL-CLD) and had a history of hospitalization for the same. There was no record of further follow up for these illnesses. The patient was not in continuous treatment for his chronic illnesses. The patient’s attendants were then briefed about chronic nature, poor outcome of these medical conditions as well as the need for continued medical follow up for these illnesses. In the ICU with treatment the patient showed improvement on the very next day in symptoms of Orthopnea. With improvement in clinical status, the patient he was shifted again in the ward on 15th December, 2018 afternoon with the combined opinion of specialist physician incharge and ICU intensivist. It is again denied that no improvement was shown in the patient’s condition. The patient was brought in an incapacitating condition and poor overall health, when he was shifted to ICU, but after treatment at their hospital, the patient’s condition had shown initial improvement and he was shifted from ICU to ward on 15th December, 2018. On 16th December, 2018 the patient again developed high grade fever despite being on antibiotics, and anti-malarials. In view of this new situation, the patient’s antibiotics were revised to Carbapenem- I.V. Meropenem on empirical basis. Although, cultures were sterile. CBC was repeated, which showed HB (17), TLC (11.3), PC (108), DC (N-80, L-15) on 17th December, 2018. On 17th December, 2018, in the evening around 04.00 p.m. the patient developed extreme restlessness and diaphoresis. On examination, the patient had tachycardia (150-160/min) with irregular pulse and hypotension with systolic blood-pPressure of 70mmHg. The patient was immediately brought to ICU where ECG showed arterial fibrillation with fast ventricular rate and frequent ventricular ectopics. IV inotropes (Noradrenaline) was started to sustain Blood Pressure and maintain systematic perfusion. Injection Amiodarone was also started to reverse the arrhythmia and restore sinus rhythm. The patient also received I.V. steroid- Hydrocortisone and bolus of normal saline. The attendants were explained about these clinical events and consequent hemodynamic instability in a patient who already has gross Left Ventricular Dysfunction (Cardiac Dysfunction). They were also informed about the critical status of the patient and need to shift the patient to tertiary care centre urgently for further evaluation and management. Without wasting time, the patient was referred and shifted on a same day at 17th December, 2018 itself at a tertiary care centre (to Max Hopital, Patparganj as learnt from records provided by Delhi Medical Council) in a cardiac ambulance with continued treatment and supervision. It is pertinent to note that the cardiac ambulance had a duly qualified doctor to accompany the patient. It is strongly denied that the treating doctors shirked off their responsibility from further treatment of the patient at the hospital. In contrast to the allegation, the fact is that the patient was duly treated with the best available facilities, equipment and the staff (as highlighted in the above paras), and then referred to a tertiary care centre for further evaluation and management, as theirs is not a tertiary care medical centre. In-fact, all due responsibilities of transfer of the patient were fulfilled by them, and the patient was shifted in a cardiac ambulance, along with a resident doctor in the ambulance itself. It is strongly denied that their hospital doctors resorted to experimenting upon the patient. It is again strongly denied that any of the doctors gave wrong treatment to the patient. It is humbly submitted that no facts alleging either experimentation or wrong treatment has been submitted by the complainant in her complaint. The nature of experimentation or wrong treatment has not been divulged by the complainant, and this remains merely a generalized complaint of the complainant. It may be noted that in the complaint letter of the complainant, the complainant has not named their hospital, East Delhi Medical Centre, for not diagnosing the condition of the patient and for not providing effective treatment. It is another hospital which has been so named, sparing the name of East Delhi Medical Centre. Also, the complainant has not named their hospital for being negligent in gauging the seriousness of the patient’s condition. Their hospital has also not been named for any delay in shifting the patient to ICU. Again, it is another hospital which has been so named, sparing the name of East Delhi Medical centre. It is most unfortunate that the patient Shri Ram Pratap Jha succumbed to his illness at a tertiary care centre later in the course of his illness. They share their grief with their family. They strongly deny any negligence, whatsoever, in the care and treatment of the patient. During the entire course of hospitalization and at no point of time, the patient’s complaints were ignored. The patient was regularly and, as when required, visited by the specialist and resident doctors. He was personally visited and consulted by the specialist physician, ICU intensivist and the resident doctors for a total of twenty times for his entire hospital stay. The patient was constantly and regularly monitored for his vital signs. This can be corroborated by the vitals monitoring chart in the case file. The patient was repeatedly and regularly enquired about his symptoms, and any fresh complaints if any. The patient underwent all relevant investigations for his symptoms as medically deemed necessary. The patient was provided due medical care and attention in all the circumstances during entire course of hospitalization. The attendants were regularly explained about his evolving clinical status, diagnosis, and outcome from time to time. This fact has been cited by the patient’s wife(the patient) in her complaint. They were also informed about his investigation reports, and ongoing and required treatment, his underlying chronic illness i.e. Dilated Cardiomyopathy and Chronic Liver Disease (Alcohol related) and poor outcome of these conditions. It is to be noted that at no point of time, did the patient or his attendants made any complaint to any of the treating physicians (either specialist physician or ICU (intensivist), resident doctors, nursing staff or administration of the hospital for want of care and attention during the patient’s entire hospital stay of 145 hours. The patient was managed with utmost sincerity with best of their intentions and to the best of their knowledge and efforts. It is reiterated that the unfortunate death of the patient did not take place at East Delhi Medical Centre. The event of death was declared at the tertiary care centre (Max Hospital, Patparganj as learnt from records provided by Delhi Medical Council).

Dr. Y. P. Singh, Dr. Vijay Arora, Dr. Anil Bhat, Dr. Akhil Taneja, Dr. Rahul Puri, Dr. Nidhi Saxena, Medical Superintendent of Max Super Specialty Hospital in their joint written statement averred that the patient late Shri Ram Pratap Jha, 54 years old male, came to the emergency department of their hospital on 17th December, 2018 at about 11.15 p.m. and was referred from the East Delhi Medical Centre where the patient was admitted with the complaints of high grade fever associated with chills since 11th December, 2018. There the patient was managed as case of dengue with thrombocytopenia with UTI. On 17th December, 2018, the patient developed new onset shock, for which, the patient was started on inotropes and was shifted to Max Hospital, Patparganj on O2 and inotropic support. On arrival in their hospital, the patient was looking sick, in hypotension on inotropic support. The patient had cold clammy skin with blood pressure 89/62 on NORAD support (20 ml/hour), pulse rate was 76/minute and SPO2 was 96%. On reviewing old records, the patient also had history of right ureteric calculi- post PCNL with DJ stenting done on 2015 and alcoholic liver disease with ascites, AKI recovered on 2015. Inotropes and Antibiotics were started and his preliminary workup showed evidence of cardiac dysfunction with EF was 20 to 25% raised Troponin I, CKMB, NT-pro-BNP. The patient had leuccocytosis and raised procalcitonin in view of which cultures were also sent. The patient was also found to have deranged liver and kidney functions. Vitamin K and FFP was given in view of coagulopathy, which was likely secondary to sepsis. Thereafter, urgent Cardiology and Gastro opinion was sought and screening echo was done, which was suggestive of DCMP with low EF (-20-25)%. The patient was diagnosed as a case of Septic Shock, UTI with AKI, DCMP, AF with FVR and CLD. The critical care team consult was also taken and guarded prognosis was explained to the attendants or the family by the doctors. On 18th December, 2018 within ten hours of hospitalization, biochemical reports showed raised cardiac enzymes which as per the cardiology team could be a part of sepsis/AKI when the serum procalcitonin is 36.3, NTproBNP is markedly high and the patient had very poor LV function (-20-25)%. The patient was also found to be in Low SID Metabolic Acidosis according to the VBG done on 18th December, 2018 at 06:56 a.m. The patient’s attendants were repeated explained by the ER team about the non-availability of beds. The patient was on moderate dose of Noradrenaline vasopressor since arrival in the hospital. The detailed 2D ECHO was done on the noon of 18th December, 2018 which confirmed the finding of EF 20 to 25% with severe MR. The patient was regularly being reviewed by the respective teams in the ER. Nephrology opinion was also taken and the advice was incorporated in the treatment plan. The patient was consistently being monitored in the ER by the treating team and necessary measures according to the plan of treatment were being taken. Repeat ABG at 05.52 p.m. was suggestive of compensated metabolic acidosis. On 18th December, 2018, CVP line and arterial line insertion were done in the ER after taking informed consent from the patient’s wife and then the patient was transferred to the medical ICU on vasopressor support (5ml/hour). At around 01.40 a.m., the patient was not maintaining saturation alongwith being tachycardiac and tachypneic even on non-invasive ventilator Support; and was put on mechanical ventilatory support at higher settings. Repeat ABG was done at 04.57 a.m. and was suggestive of severe respiratory acidosis. The patient was then managed accordingly and again the vassopressor support was increased. The patient continued to deteriorate with requiring high O2 and high dosage of vassopressors. The patient’s attendants wanted case summary for second opinion which was provided to them. The patient had an episode of bradycardia and hypotension. The pulse and blood-pressure were un-recordable. CPR was started according to ACLS protocol; however, the patient could not be revived and was declared dead at 09.51 p.m. after one hour of resuscitation. It is pertinent to mention that the attendants of the patient were regularly informed and explained about the medical condition of the patient by the staff of the hospital and the allegation made by the complainant is false and denied. It is denied that any timelines were given to the patient or the attendants regarding the treatment or stay in the hospital at the time of admission or during the course of hospitalization. It is also pertinent to mention that the attendants on multiple occasions explained in detail about the condition of the patient and every time all their queries were addressed and replied by the hospital staff in detail. The treatment administered to the patient while admission during their hospital was in line with set medical practice in India or globally under the facts and circumstances and conditions of the patients, there is no question of negligence attributed to the hospital and treating team of doctors of whatsoever nature. In view of the above submissions, they out-rightly deny all allegations of mismanagement, medical negligence and any kind of malpractice or wrong doing by the hospital, doctors or any staff of the hospital in toto, further, no action lies against the hospital or its doctors, the present complaint is devoid of merit and should be dismissed.

In view of the above, the Disciplinary Committee makes the following observations:-

1. It is observed that the patient Shri Ram Pratap Jha, 54 years old male, was admitted in East Delhi Medical Centre on 11th December, 2018 at 09.00 p.m. with complaints of high grade fever and polyarthralgia and was managed accordingly. During the course of treatment, the patient developed shortness of breath and on further investigation was found to have LV Dysfunction EF (30 to 35%). The patient was shifted initially to HDU and then to ICU. On further enquiry, the patient attendants informed about his previous illness of heart and liver, for which, he was managed at Sir Ganga Ram Hospital and the previous treatment records showed that he was a patient of CLD ( Chronic Liver Disease) with DCMP (Dilated Cardiomyopathy) and was hospitalized for same. The patient showed improvement and shifted to ward on 15th December, 2018. The patient again developed fever on 16th December, 2018 and antibiotics were escalated. The patient had restlessness and diaphoresis on 16th December, 2018 and was shifted to ICU. The ECG showed arterial filtration. The patient developed shock. The patient was ­­­­­­­­­­­­­­­­­­­­on antiarrhythmic and vasopressors. The patient was shifted to Max Super Specialty Hospital, Patparganj, Delhi in cardiac ambulance with accompanying doctor. The patient was managed in Max Super Specialty Hospital, Patparganj initially in ER and later in ICU. The patient was treated as a case of Septic Shock, UTI with AKI, DCMP, AF with FUR and CLD. Regular briefing of the family members was done as per records provided by Max Super Specialty Hospital.
2. The patient was treated and managed as per the treatment protocol and considering his chronic illness of CLD and DCMP; he was a critical case due to these co-morbidities, which was not disclosed at the time of admission to East Delhi Medical Centre. The patient was referred to Tertiary Care Centre Max Super Specialty Hosptial, Patparganj for further management and treatment provided as per his condition was adequate as per records.
3. Despite the patient's complex medical history, which wasn't initially disclosed, both East Delhi Medical Centre and Max Super Specialty Hospital, Patparganj provided appropriate care based on the available information and standard protocols. The treatment was reasonable considering the patient's critical condition and co morbidities.

In light of the observations made herein-above, it is the decision of the Disciplinary Committee that no medical negligence can be attributed on the part of the doctors of East Delhi Medical Centre and the doctors of Max Super Specialty Hosptial, Patparganj, Delhi, in the treatment of the complainant’s husband Shri Ram Pratap Jha.

Complaint stands disposed.

 Sd/: Sd/: Sd/:

(Dr. Maneesh Singhal), (Dr. Alok Bhandari) (Dr. Sumit Vats)

Chairman, Delhi Medical Association, Expert Member,

Disciplinary Committee Member, Disciplinary Committee

 Disciplinary Committee

The Order of the Disciplinary Committee dated 29th May, 2024 was confirmed by the Delhi Medical Council in its meeting held on 24th June, 2024.

 By the Order & in the name

 of Delhi Medical Council

 (Dr. Girish Tyagi)

 Secretary

Copy to:-

1. Smt. Meena Jha, r/o- 1/3640, Gali No.01, Ram Nagar, Loni Road, Shahdara, Delhi-110032.
2. Dr. Pankaj Kumar Goel, Through Medical Superintendent, East Delhi Medical Centre, 1/550, Mansarovar Park, Grand Trunk Road, East Ram Nagar, Shahdara, New Delhi 110032.
3. Medical Superintendent, East Delhi Medical Centre, 1/550, Mansarovar Park, Grand Trunk Road, East Ram Nagar, Shahdara, New Delhi 110032.
4. Medical Superintendent, Max Super Specialty Hospital, 108A, Indraprastha Extension, Patparganj, New Delhi-110092,
5. Deputy Commissioner of Police, Office of the Deputy Commissioner of Police, Shahdara District, Bholanath Nagar, Shalimar Park, Delhi-110032- (w.r.t. letter No.3326/Complt.(DA-IV)/Shahdara District, Delhi dated 04.06.2019)- **for information.**
6. Ethics & Medical Registration Board, National Medical Commission, Pocket-14, Phase-1, Sector-8, Dwarka, New Delhi-110077- (w.r.t. letter to erstwhile Medical Council of India’s letter No. MCI-211(2)(Gen.)/2019-Ethics/125709 dated 21.06.2019)**-for information.**

 (Dr. Girish Tyagi)

 Secretary