DMC/DC/F.14/Comp.2438/2/2022/ 19th September, 2022

**O R D E R**

The Delhi Medical Council through its Disciplinary Committee examined a complaint of Shri M.P. Bhatnagar, r/o- 161, Vigyan Vihar, Preet Vihar, Delhi-110092, alleging medical negligence on the part of the doctors of Max Healthcare Hospital, 108A, IP Extension, Patparganj, Delhi-110092, in the treatment administered to complainant’s wife Smt. Usha Bhatnagar, resulting in her death.

The Order of the Disciplinary Committee dated 29th July, 2022 is reproduced herein-below :-

The Disciplinary Committee of the Delhi Medical Council examined a complaint of Shri M.P. Bhatnagar, r/o- 161, Vigyan Vihar, Preet Vihar, Delhi-110092 (referred hereinafter as the complainant), alleging medical negligence on the part of the doctors of Max Healthcare Hospital, 108A, IP Extension, Patparganj, Delhi-110092 (referred hereinafter as the said Hospital), in the treatment administered to complainant’s wife Smt. Usha Bhatnagar (referred hereinafter as the patient), resulting in her death.

The Disciplinary Committee perused the complaint, joint written statement of Dr. Praveen Pandey, Dr. Y.P. Singh, Dr. Gaurav Jain and Dr. Nidhi Saxena, Medical Superintendent, Max Healthcare Hospital, rejoinder of Shri M.P. Bhatnagar copy of medical records Max Healthcare Hospital, Patparganj, Delhi and other documents on record.

The following were heard in person :-

1) Shri M.P. Bhatnagar Complainant

2) Dr. Praveen Pandey Pulmonologist, Max Healthcare Hospital

3) Dr. Y.P. Singh Anaesthetist, Max Healthcare Hospital

4) Dr. Gaurav Jain Pulmonologist, Max Healthcare Hospital

5) Dr. Saurabh Jain Anaesthetist, Max Healthcare Hospital

6) Jefin Mathews Nursing Supervisor, Max Healthcare Hospital

7) Shri Vishal Ahlawat Medical Admn., Max Healthcare Hospital

8) Ms. Anu C. Mathew Nursing ANS, Max Healthcare Hospital

9) Dr. Nidhi Saxena Medical Superintendent, Max Healthcare Hospital

The Disciplinary Committee noted the complainant Shri M.P. Bhatnagar sent a representation(e-mail) dated 30th May, 202 wherein he stated that he is 87 years old and not in position to walk at all and confined and requested that the matter be heard through video-conferencing. The Disciplinary Committee contacted the complainant telephonically and he was heard telephonically.

The complainant Shri M.P. Bhatnagar alleged that the deceased (the patient) Smt. Usha Bhatnagar was admitted to Max Hospital under the benefit of CGHS scheme and was treated with such utter negligence by doctors and nurses of the hospital that rather than coming out of her illness, she eventually lost her life as a direct result of the negligence and inaction of certain doctors, nursing staff and administration of the hospital. On 20.12.2017, the deceased was taken to Apollo Hospital for regular check up and thereafter she was shown to a pulmonologist in Apollo Hospital who recommended her to use Nebulizer. On 22.12.2017, the deceased complained of shortness of breath and cough with expectoration pursuant to which she was taken to the nearest Max Healthcare Hospital in Patparganj. The condition of the deceased at the time of being shown in the Emergency Room was deteriorating but to the shock of the family members who was attending her, no immediate attention was provided to her by the Hospital. After a lot of persuasion the deceased was intubated and put on IPPV support. After more persuasion by the family members, the preliminary diagnosis was found out to be of Viral Pneumonia. It is only after that, the deceased was put on antibiotics, but was not shifted to the ICU even when she was found to be in critical state. Apprehending that her situation will get worse, the family members of the deceased constantly requested the authorities of the hospital to shift her to ICU. After six hours, the patient was shifted to ICU on day of admission, her condition had worsened. From 22.12.2017 to 24.12.2017, the deceased was kept in ICU and after showing some response to the treatment; she was finally extubated on 24.12.2017 and put on NIV support. It is pertinent to mention here that despite the deceased being admitted for 48 hours in the ICU, the family members were not informed about the treating doctor of the deceased. It is only after much deliberation and using their own resources did the family members come to know that Dr. Praveen Pandey (Pulmonology) was looking after the case of the deceased. Also, the family members of the deceased had to wait outside the ICU since morning to somehow search for the treating doctor and take advice from him regarding the critical health of the deceased. On 26.12.2017, in the morning, the family members of the deceased were informed that the patient would be shifted to the High Dependency Unit (HDU) and they would be informed accordingly. The family members assessing the critical situation the deceased was in, requested that the deceased be shifted to isolation room in HDU since the regular HDU was appearing to be severely immune compromised. The family members of the deceased were also aware that the HDU was solely run by the nursing staff and there was no intensivist to monitor the patients. In fact, the doctors led by the treating physician of the deceased totally disregarded the suggestions of family members and told them it was against hospital policies. Thereafter, the family members along with the complainant waited in lobby of the hospital till 5 PM on 26.12.2017, waiting for the deceased to be shifted to HDU as told by the treating physician. But to their shock, the deceased was not shifted to the HDU and no response was given by the hospital authorities regarding the non-shifting despite the family members making various inquiry calls regarding the same. Around 5:30 PM when the complainant went to meet the deceased during visiting hours, he found her in a very deteriorated condition. On seeing her dilapidated condition, he tried to inquire about it from the hospital staff but was ignored blatantly by the staff. It is only after he was made to run from pillar to post that he was informed that the deceased had an episode of respiratory distress and de-saturation and hence was not shifted out. The said fact was deliberately hidden from the family members of the deceased for reasons best known to the hospital staff and doctors. Thereafter, the deceased was kept on NIV support for the next four days. On 30.12.2017, the deceased was again planned to be shifted to the HDU but again she was not shifted to the HDU citing the reason that the bed was unavailable. On 31.12.2017, in the evening, the deceased was finally shifted to HDU. After being shifted to HDU, the deceased looked frightened and complained to her family members she was being abused and harassed by nursing staff of the hospital. She also informed the family members that the nursing staff who was putting her hearing aid was mistreating her and had also hurt her while putting the aid. In such a hostile state, the deceased requested her family members to shift her out of the HDU. Thereafter, the family members made inquiries from the Nursing Superintendent present about such mistreatment of the deceased and other patients in the HDU who were also complaining of such mistreatment on part of the nursing staff. On the complaint of family members, a meeting was called for by the hospital authorities pursuant to which the authorities promised them to take appropriate action against their nursing staff but to the dismay of the family members, no action was taken by the hospital authorities and all pleas made were blatantly ignored. On 01.01.2018 morning, when the family members visited the deceased around 09:30 AM, they found the breakfast of deceased lying untouched and the deceased was sleeping. Since nobody had properly attended the deceased and she was not taken proper care of, the family members were compelled to approach hospital authorities again in a hope that reasonable care of the deceased should be taken by the hospital staff and doctors. Thereafter, a counselling session/meeting was held for the said reason and the hospital authorities assured the family members of the deceased that she would be taken proper care of. Additionally, the family members of deceased also found out that in the HDU, there were cupboards and shelves filled with files and documents which was completely laden with dust. The said cupboards and shelves were adjacent to the bed of the deceased. Since the deceased was a patient of COPD and allergic to dust, the family members apprehended that it would affect her further and hence requested the hospital administration to shift her to another bed in a properly immuno protected environment. On 02.01.2018, in the morning when the family member of the deceased visited her, she was appearing to be drowsy and exceptionally quiet. On inquiring, the nursing staff told the family member that the deceased had undergone a psychiatric evaluation and was advised HALOPERIDOL which happens to be a potent CNS depressant. On being further asked if a consultation had been taken from a clinical psychiatrist on the same, the nursing staff was silent. In fact, the medical records provided later to the family members also did not show any psychiatric evaluation of the deceased on 02.01.2018. It is pertinent to note that while in the HDU, the condition of the deceased had started to deteriorate. Her Total Leucocyte Count (TLC) had reached to alarming level. Her urine culture had started showing the growth of EColi bacteria. Such a deteriorating condition of the deceased had alarmed her family members hence they asked the visiting doctor Dr. Amitabh Banka (Pulmonology) to discuss such flare in infection, to which Dr. Amitabh Banka ignored the query by saying that he wasn't in a position to answer. Dr Amitabh Banka ordered for a repeat CT Chest and after the CT Chest Scan, the family members were informed by him that the deceased was fine and was responding well to the changed antibiotics. It is also pertinent to note that after the demise of the deceased, when her reports were handed over to her family members, it was only then it was discovered by them that the lung consolidation had significantly progressed and they were under a false impression that the deceased was slowly but surely improving. Such a false impression created by the doctor and not taking adequate steps to control the increasing TLC count, EColi etc showed negligent on part of the visiting doctor. On 04.01.2018, after much deliberation by the family members, the deceased was ultimately shifted to a private room bearing number 1512. Since the deceased was already immunocompromised owing to the negligent conduct of nursing staff and attending doctors as detailed above, the family members of the deceased were hopeful that after shifting to the private ward she would be handled more carefully. On the contrary, the family members noticed that the oxygen breathing apparatus with humidifier had stale water and the tubing was also not changed. It is also pertinent to mention here that the family members had been constantly attending the deceased throughout the day and no visiting doctor came for evening round to attend the deceased. On 05.01.2018, at night the deceased told her family member that she was not tolerating the use of BiPAP. Immediately a nurse was called for help who told the family member that the BiPAP was not so important as the deceased was already maintaining saturation. Thereafter, the deceased had a very uncomfortable night which the nurse did not report to the treating physician/pulmonologist the next morning. Also, regular nebulisation was advised to the deceased by the treating Doctor which was not appropriately taken care of by the nursing staff. It is only after being reminded again and again by the family members did the nurse nebulize the deceased. Further, the blood glucose level evaluation of the deceased was not done despite the deceased being a known case of Type II Diabetes Mellitus. Again, no doctor came for an evening visit to check the deceased despite she continued to be kept in a careless manner. On 06.01.2018, in the morning, when the treating doctor came for morning round, the family member of the deceased informed him that the deceased had been removing her catheter since past day without informing them and passing urine on bed. Surprisingly, the treating doctor told the family member that it was normal behaviour on part of deceased and she had been on catheter for so long and early ambulation will improve her condition. The treating doctor informed the family members that the blood reports of deceased were normal and also ordered for an ABG test to be done and told the family members that he was also planning to discharge the deceased soon. Despite repeated reminders the ABG was not done till 2 PM and later the family members were informed that the ABG report was absolutely normal. Further, the deceased was neither nebulized throughout the day nor the blood sugar test was conducted by the nursing staff. On being enquired about the blood sugar level, the nursing staff blatantly said that they forgot to measure the blood glucose level the entire day. It is only after the family members insisted on getting the blood glucose test done, the nursing staff opposingly did the same and the family members were shocked to see that her blood fasting glucose level was 300 mg/dl. On further inquiry, the nursing staff revealed that she has been giving the deceased some oral tablets for diabetes. It is pertinent to mention here that no endocrinologist was consulted to alter the medication and no such medication was reflected in the bills. On the same day, when routine sponging of the deceased was being done, the family members noticed that her gluteal region wasn't cleaned properly and faecal matter was stuck to skin and mucosa. It was also very evident that the deceased had developed a skin rash which when reported to nursing staff was said to be due to molini sheet. Also, no temperature was recorded of the patient and her vitals were blatantly ignored by the nursing staff. Further, after the treating doctor recommending the deceased to be discharged, the same was not done by the hospital and no doctor came for evening visit to check the condition of the deceased in the evening. On 07.01.2018 in the morning when Dr. Gaurav Jain (Pulmonology) came for a morning round, he found the breathing of deceased to be significantly abnormal. He advised for using a full face mask to control her breathing and ordered ABG to be done. A physiotherapist was also called for to suction the phlegm from the lungs of deceased which proved to be worthless. In the meanwhile, the family member of the deceased went to collect the ABG report and found out that the Oxygen saturation had remarkably dipped and the ABG report was worse than the day when the patient was admitted. Incidentally, Dr. Amitabh Banka was crossing the room the same time and was hence requested to look at the condition of the deceased since he was more experienced and knew the history of the case. To the requests made by the family members, Dr. Amitabh Banka evaded them by saying that he was not on call that day. Thereafter, the family members of the deceased were made to run from pillar to post to call for medical help pursuant to which Dr. Gaurav Jain informed the family members that the deceased had become critical and was immediately needed to shift to the ICU due to cardiac arrest. Thereafter, when the deceased started losing consciousness, the family members were informed that she was being shifted to Surgical ICU which procedure took almost one and a half hours during which no other medical aid was provided to deceased. It is pertinent to note here that the deceased was shifted in the SICU for critical treatment without her medical records and hence, the SICU critical team started inquiring about the details from the family members of deceased rather than the Pulmonology department of the hospital. Due to zero coordination among the departments of the hospital, the family members of the deceased noticed that no treatment was being given to the patient while she was in SICU and the nursing staff had also not handed over the deceased's treatment charts and records. Thereafter, realizing that her condition was deteriorating and she was being given no treatment in SICU, the family members of the deceased managed a bed for her in the MICU. Within 15 minutes of shifting her in MICU, at about 4 PM, the family member of the deceased was asked to give consent to put the deceased back on ventilator, the preparation of which had already been done by the hospital staff which consent was duly given. Thereafter, before taking the consent of the complainant, a meeting was called by the doctors in critical care unit and the team of doctors came out to talk to family members of deceased along with a bouncer and security guard with them. Despite the consent being taken at 4.00 PM, the deceased was not intubated till 10:30 PM. It is only around 10:00 PM, the family members were called to the ICU and informed by the doctors that the deceased had to be immediately put on ventilator in fear of imminent cardiac arrest. It is pertinent to mention here that despite the deceased being in such critical condition, the antibiotics were also not stepped up till next morning. On 08.01.2018 the treating doctor Dr. Pravin Pandey informed the family members that the condition of the deceased was very critical as she had developed septicaemia from Hospital Acquired Infection (HAI). It came as a big shock to the family members as they had been constantly requesting the hospital staff and doctors to take proper medical care of the severely immunocompromised deceased since the time when she was admitted to the hospital. Her blood culture reports demonstrated the presence of Acinetobacter Baumannii and urine culture also demonstrated the presence of Enterococcus faecium, both being fatal hospital acquired bacteria. Thereafter, the deceased remained on ventilator and her condition kept on deteriorating which was directly due to the negligence shown by the doctors and nursing staff of the hospital. On 11.01.2018 the granddaughter of the deceased met the intensivist, Dr. Pooja who was attending the deceased, it was informed to her that the deceased had three bacterias simultaneously growing within her and all her culture reports including the BAL culture demonstrated the presence of Acinetobacter baumannii. The intensivist also informed that the hospital staff had not changed the central line in 17 days which could have been a possible source of increasing bacterial load. It is pertinent to mention here that the family members had also observed that the local site of the central line was left undressed and the food being fed to her was dribbling and possibly locally infecting the central line as well. On 12.01.2018 the family members were informed that the renal functions had further deteriorated and a dialysis needed to be performed. The consent form for the same was signed at 2 PM on the same day but the dialysis was not started till 8 PM despite repeated requests by the family members. On 13.01.2018, in the morning when the family members of the deceased went inside the ICU, they realized that all reports and documents pertaining to the deceased had been removed. When one of the family members asked the nursing staff to show the reports, the said request was blatantly denied by the nursing staff. Around 3 PM the nephrologist told the family members that the serum potassium level had increased to 7.7 and the patient could end in a cardiac arrest anytime. The nephrologist also stated that the CRRT would have to be done which is a 24 hour procedure for which the payments were made by the complainant and the procedure started around 10:30 PM. Thereafter, at about 11:30 PM, family members went to the ICU and were told that the CRRT procedure was being stopped as the deceased was haemodynamically unstable and couldn't take the procedure any further. At about 11:45 PM the complainant lost his wife. It was shocking to see that the careless and negligent attitude of the hospital staff did not end even after the death of the deceased. The hospital had assured that the death summary of the deceased and other documents would be handed over to the family members in the night itself. Surprisingly the same was not done for the entire week. On 21.01.2018 the family member of the deceased went to the hospital to get the death summary and found out that the same had not been prepared. On persistent requests again, the death summary and other records was handed over to the family member and it was found out that the summary didn't even have a mention of the CRRT procedure. Later when the family member met Dr. Praveen Pandey, he showed his ignorance of any knowledge of the CRRT procedure being abandoned after the condition of the deceased had deteriorated. The perusal of the death summary and records given much later to the family members of the deceased showed that the records had been manipulated by the Hospital and the family members had been handed over altered/forged records in order to save their face from a medical negligence enquiry. Prima facie, the records seem to be tampered leaving very little scope with the complainants to give substantial documentary evidence for supporting their case. Such a conduct of the hospital on tampering the evidence shows malicious intent of the Hospital and other opposite parties and further supports the case of the complainants that there was gross medical negligence in treatment of the deceased. It would be evident by the fact that the nursing records and the treatment claimed by the doctors do not match. Secondly, the nursing record is nearly a repetition of vitals and other entries day by day. In fact, the hospital has failed to give the true nursing record and they have only given the nursing protocol that should ideally be followed hence it in no way highlights and brings forward what exactly has been given and what exactly was the condition of the patient. For e.g. in the nursing record submitted herewith, it has been mentioned "no oxygen" given while the saturation of oxygen was low and the deceased was actually on oxygen support. Hence, such nursing records provided are prima facie not reliable and only show medical negligence on part of Opposite Parties while treating the deceased.

As discussed in detail above, the deceased was immediately not shifted to ICU when she was admitted after her condition was getting critical. After being kept in ICU for four days, the deceased was not shifted to HDU for the reasons best known to the treating Doctor and his team and such reasons were not revealed to the family members of deceased. Finally after nine days in ICU, the deceased was shifted to a immunocompromised HDU which was only run by the nursing staff and it had no intensivist either. The deceased was ill treated in the HDU which fact was conveniently ignored by the Doctors. The deceased was negligently kept in the immune compromised HDU for almost four days due to which the condition of the deceased started to deteriorate, her TLC increased and urine culture started showing growth of Ecoli bacteria. Thereafter, when deceased was shifted to a private room, the treating doctor and his team showed negligence by not taking proper vitals of the deceased and not even making evening visits which are critical to the reasonable medical care to be given to the patients’ of a hospital. On various occasions as enumerated in the detailed out facts, the treating doctor and his team ignored the pleas of the deceased and her family members to give her proper attention and medical care which ultimately lead to development of hospital acquired infection and the resultant death of the deceased Mrs. Usha Bhatnagar. As laid out in detail in the paras above, the nursing staff mistreated the deceased while she was in HDU, kept her in an immunocompromised area and did not maintain the high standards of medical care to be given to patients that too who are in a critical condition. The nursing staff blatantly ignored the plight of the deceased and her family members and on numerous occasions acted negligently while keeping the deceased safe from bacterial and other infection which eventually lead to the deceased's health being deteriorated due to hospital acquired infections and her resultant death due to the same. The hospital administration and the critical care facility of the hospital while showing negligence in providing the degrees of medical care which a healthcare institution has to provide while admitting the deceased, mismanaging the overall healthcare schedule of the deceased, keeping its critical areas for e.g. HDU room immuno-compromised, not coordinating the inter departmental communication for critical as well as other healthcare has resulted in the deceased being found with hospital acquired infections and her eventual death.

Dr. Praveen Pandey, Pulmonologist, Max Healthcare Hospital stated the patient Smt. Usha Bhatnagar, 78 years old female, was brought to Emergency Department of Max Super Speciality Hospital on 22nd December, 2017 at 01.30 p.m. with complaints of shortness of breath and chest discomfort since one week which further worsened since last night. She was thoroughly assessed by the team of doctors of emergency department and was found to have labored breathing alongwith cough and expectoration present. SPO was 90% on room air and was 95% on oxygen. Pulse was 102 per minute. Blood-pressure was 160/100 mm of HG, temperature of 98 degree Fahrenheit. Systemic examination showed chest had bilateral crepts, soft distended abdomen, CGS of 15. The patient had a history of CAD, DM, COPD, adenocarcinoma of gall bladder. Immediately, the patient was started on BIPAP and oxygen support. The patient was started on IV antibiotics, IV steroids, bronchodilators and other supportive treatment. Baseline investigations were sent alongwith all relevant cultures. The clinical condition of the patient and requirement of ICU was explained to the attendants in detail. It was also informed to the attendant regarding the requirement of mechanical ventilation. At 01.50 p.m., the family was also briefed about the condition of the patient and the same has been documented and counter signed by the attendant (Ms. Sneha, Grand Daughter of the patient). Despite BIPAP support, the patient was not able to maintain oxygen saturation. Thereafter taking consent from the attendants of the patient, intubation was done. Since, the ICU bed was not available at the time of admission, the patient was kept in crash room and was given due care by the team of the doctors and nursing staff. The patient developed hypotension and vasopressors were started. As soon as the bed was arranged, she was shifted to medical ICU at around 06.00 a.m. 2D ECHO was done which revealed LVEF 55% with diastolic relaxation abnormality and raised RVSP. Gradually, the patient showed response to the given treatment and was extubated on 25th December, 2017 and put on NIV support. The patient was shifted to HDU on 31st December, 207 wherein she was under the supervision of intensivist round the clock. After initial improvement, her condition again deteriorated. Her TLC showed an increasing trend. It is also submitted that while the patient was in HDU, she was suffering from ? ICU delirium? septic encephalopathy and these patients may experience delusions or hallucinations. The same was explained to the attendants in MDT meeting (the patient’s husband and daughter were present in the meeting). CT chest was done which revealed Lobar consolidation with air bronchogram seen involving left lung lower lobe. Associated minimal to mild left pleural effusion was seen. Subsegmental areas of consolidation/air space opacificatoin are seen in right lower lobe at places with irregular nodular lesions scattered in adjoining right lower lobe. Another focal nodular lesion is seen in right lung upper lobe anterior segment. Her urine culture showed growth of E.Coli and antibiotics modified accordingly. As the patient had ? ICU delirium ? septic encephalopathy, psychiatric opinion was taken and advice incorporated in the treatment. Gradually, the patient showed response to the given treatment and was shifted to room. On 07th January, 2018, the patient was drowsy. ABG done which revealed acute on chronic respiratory acidosis. The patient was shifted to ICU and was initially managed on NIV support but her condition continued to deteriorate and she was intubated and also started on vasopressor support. Her repeat chest x-ray was done which revealed left lower zone collapse/consolidation. In view of chest x-ray findings, bronchoscopy was done, BAL taken and sent for detailed investigations. Antibiotics were upgraded empirically on clinical grounds and were continued as per culture and sensitivity report. Her intitial BAL gram stain showed few gram positive cocci seen in pairs and chains. Numerous gram negative cocco bacilli seen, AFB stain was negative, BAL culture showed growth of acinetobacter baumannii. The patient’s throat swab and blood culture showed growth of enterococcus faecium. Foleys catheter and central line were changed as per protocol. As the patient had history of diabetes mellitus, endocrinologist opinion was taken and advice incorporated in the treatment. In view of deranged kidney functions, nephrologist opinion was taken and SLED was done. IN view of unstable hemodynamics, CRRT was started but the patient had fall in blood pressure and CRRT was discontinued. Poor prognosis about the condition of the patient was explained to the attendants at each and every step. Time to time, the family was apprised of critical condition of the patient and they were provided with case summary and lab reports as and when asked by them. On 13th January, 2018 at 11.15 p.m., the patient developed bradycardia followed by asystole. CPR stated immediately as per ACLS protocol. Despite of all resuscitative efforts, the patient could not be revived and declared dead at 11.45 p.m. on 13th January, 2018. The patient was brought to emergency department around 01.30 p.m. with complaints of shortness of breath and chest discomfortness since one week which was worsening since last night. She was thoroughly assessed by the team of the doctors in emergency department and was found to have labored breathing alongwith cough and expectoration present. SPO2 was 90% on room air and was 95% oxygen. Pulse was 102 per minute. Blood pressure was 106/100 mm of Hg, temperature of 98 degrees Fahrenheit. Systemic examination showed chest had bilateral crepts soft distended abdomen, GCS of 15. The patient had history of CAD, DM, COPD, adenocarcinoma of gall bladder (operated few years back). Immediately, BIPAP and oxygen support was given and conservative treatment was started based on the condition of the patient. She was started on IV antibiotics, IV steroids, bronchodilators and other support was given conservative treatment. Baseline investigations were sent alongwith all relevant cultures. Clinical condition of the patient and requirement of ICU was explained to the attendants. It was also informed to the attendant regarding the requirement of mechanical ventilation. At 01.50 p.m., the family was also briefed about the condition of the patient and the same has been documented and counter signed by the attendant (Ms. Sneha). It is also submitted that there was no persuation for intubation by the family, infact the same was recommended by the doctors in emergency which is documented in the Family Meeting Form and counter signed by the attendant (Ms. Sneha). Despite BIPAP support, the patient was not able to maintain saturation. Thereafter taking consent from the attendants of the patient, intubation was done. Since the ICU bed was not available at the time of admission, the patient was kept in crash room and was given due care by the team of the doctors and nursing staff. The patient developed hypotension and vasopressors were started. As soon as the bed was arranged, she was shifted to Medical ICU at around 06.00 p.m. It is further submitted that the patient’s attendants were told about the treating doctor and line of treatment. 2D echo was done which revealed LVEF 55% with diastolic relaxation abnormality and raised RVSP. Gradually, the patient showed response to the given treatment and was extubated on 25th December, 2017 and put on NIV support. It is pertinent to mention herein that they follows very strict protocols in regard to the patients care and service.

It is submitted that the water used in the humidifier is sterile and they do not use any tap water. The water is changed every day or as it is required based on consumption of oxygen. As soon as the previous patient leaves the room, as a protocol water from humidifier is removed and cleaned. All protocols for infection control are followed and aseptic precautions are taken in handling the patients. It is also submitted that all bio medical equipments in the hospital are cleaned as per protocols. It is further submitted that the team of doctors has been very vigilant throughout the course of hospitalization. Numerous investigations were done; many doctors were involved in the case-from different specialist i.e. pulmonology, critical care, endocrinology, cardiology, nephrology, neurology, psychiatry and ophthalmology. It is further submitted that the patient was seen by the team of the doctors both in ICU and ward. She was admitted under pulmonology team and daily two rounds were taken and the patient was seen twice daily. Also the critical care team had round the clock coverage in ICU where in the patient was under their supervision. Assessments were done time to time and were also documented accordingly. It is submitted that the patient maintained SPO2>90% with low flow oxygen throughout the night. The patient was on BIPAP support intermittently and was receiving nebulisation therapy. Regular sugar charting was done during stay of the patient in the hospital. She was admitted under pulmonology team and daily two visits were done. As per infection control policy, it is always preferred to remove any invasive catheter as soon as possible if it is not further required and the same was done in this case. It is reiterated that the patient was also receiving nebulization therapy. Regular sugar charting was done during the stay of the patient in the hospital and the patient was given anti-diabetic medication (insulin as per sliding scale) as per requirement. It is also specifically denied that no endocrinologist had seen the patient. The patient was seen by endocrinologist on multiple occasions. It is also part of standard practice to provide bed care to each patient and the same was followed in this case diligently. It is specifically denied that the doctor ordered for the patient to be discharged. It is submitted that the patient had decreased urine output and deranged KFT, the patient was seen by the nephrologist on 11th January, 2018 and SLED was done on 12th January, 2018 after taking informed consent from the attendants, collecting viral markers report and putting dialysis catheter. It is submitted that CRRT was advised in view of hemodynamically instability. The death summary was prepared by the hospital within two hours of the patient’s death but it was not collected by the attendants. 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 patient, there is no question of negligence attributed to the hospital and the treating team of the doctors of whatsoever nature. In view of above submissions, he out-rightly denies all allegation of mis-management, medical negligence and any kind of malpractice or wrong doing by the hospital, doctors or any staff off the hospital in too, further, no action lies against the hospital or its doctors, the present complaint is devoid of merit and should be dismissed.

Dr. Y.P. Singh, Anaesthetist, Max Healthcare Hospital stated that the patient was shifted to HDU on 31st December, 2017 wherein she was under the supervision of intensivist round the clock. After initial improvement, her condition again deteriorated. Her TLC showed an increasing trend. It is also submitted that while the patient was in HDU, she was suffering from ? ICU delirium? septic encephalopathy and these patients may experience delusions or hallucinations. The same was explained to the attendants in MDT meeting (the patient’s husband and daughter were present in the meeting). CT chest was done which revealed Lobar consolidation with air bronchogram seen involving left lung lower lobe. Associated minimal to mild left pleural effusion was seen. Subsegmental areas of consolidation/air space opacificatoin are seen in right lower lobe at places with irregular nodular lesions scattered in adjoining right lower lobe. Another focal nodular lesion is seen in right lung upper lobe anterior segment. Her urine culture showed growth of E.Coli and antibiotics modified accordingly. As the patient had ? ICU delirium ? septic encephalopathy psychiatric opinion was taken and advice incorporated in the treatment. Gradually, the patient showed response to the given treatment and was shifted to room. The doctors are available in the HDU round the clock. Further, there is twenty four hours coverage by the intensivist in ICU. It is further submitted that the patient was planned to be shifted to HDU but was put on hold by the treating doctors, as the patient was drowsy and not fit to be shifted to HDU. It is submitted that as per the policy of the hospital, the patients who are prone to aerosol infections or who are infected with MDR bugs, are kept in isolation. Those with neutopenia/lekopenia are also considered for isolation. Eg: swine flu open case of Kochs, meningococcemia, MRSA, BMT patients. As this patient was not suffering from any of the above mentioned scenario and all intial cultures were negative she was not kept in isolation room. It is submitted that at no point of time, any issue regarding assault took place in the hospital. It is the basic ethics of nursing care and no staff can behave in that way and their hospital follows strict protocols in this regard. While the patient was in HDU, she was suffering from ? ICU Delirium and these patients may experience delusions or hallucinations. The psychiatrist opinion was also taken and advised was followed. It is again reiterated that while the patient was in HDU, she was suffering from ? ICU delirium and these patients may experience delusions or hallucinations. On 01st January, 2018, psychiatrist opinion was already taken and advised followed. It is further submitted that the TLC count of the patient showed rising trend. Her cultures were repeated and the antibiotics were upgraded empirically on clinical grounds and were continued and sensitivity report. Thereafter, gradually the condition of the patient improved and she was shifted to Ward on 04th January, 2018.

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

1. It is noted that the patient Smt. Usha Bhatnagar, 77 years old female presented in triage, Emergency Department of the said Hospital at 01.30 p.m. on 22nd December, 2017 with complaints of increased dyspnea, cough with whitish expectoration since past three-four days and drowsiness since that day. She had past history of DM, COPD, hypertension, and hypothyroidism. She also had adenocarcinoma of gall bladder, operated two years back. On examination, she was found to be dyspnoeic with pulse rate-102/min, blood pressure-160/100 mmHg, RR-22/min, SPO2-90 % on room air, temperature-98.6 degree F, chest-B/L Rhonchi, crepts(+), CNS-conscious/oriented, CVS-S1 S2 (+), PS-soft and BS was present. Initially, the patient was kept on BIPAP support at 12/6, but since she was not able to maintain saturation on BIPAP, she was intubated and put on IPPV support. All relevant investigations including cultures were done. She was started on IV antibiotics, IV steroids, bronchodilators and other supportive treatment. 2D-Echo done bedside revealed no obvious RWMA LVEF 55%. The ABG was 7.33/69.4/61.7/35.5. Chest x-ray was suggestive of bilateral LZ haziness. The patient was received in medical ICU at 06.57 p.m. on 22nd December, 2017, intubated and on ventilation on NORAD at 20 ml/Hr, injection Fentanyl @ 50 MCG/HR. Gradually, the patient showed response to the given treatment and was extubated on 24th December, 2017 and put on NIV support. The patient was shifted to HDU on 31st December, 2017. After initial improvement, the patient’s condition again deteriorated. Her TLC showed an increasing trend. The patient developed psychosis ? depression (? steroid ? ICU psychosis). The CT chest was done which revealed lobar consolidation with air bronchogram seen involving left lung lower lobe. Associated minimal to mild left pleural effusion was seen. Sub-segmental areas of consolidation/air space opacification were seen in right lower lobe at places with irregular nodular lesions scattered in adjoining right lower lobe. Another focal nodular lesion was seen in right lung upper lobe anterior segment. Her urine cultures showed growth of E. Coli and antibiotics were modified accordingly. As the patient had manic depressive episodes, psychiatric opinion was taken and advice was incorporated in the treatment. Her throat swab and blood cultures showed growth of acinetobacter bauannii and antibiotics were changed accordingly. The urine culture showed growth of enterococcus faecium and antibiotics was changed accordingly. Gradually, the patient showed response to the given treatment and was shifted to Ward on 04th January, 2018. On 07th January, 2018, the patient was drowsy. ABG done revealed acute on chronic respiratory acidosis (PH-7.268, PCO270, PO2-56, HCO3-31). The patient was shifted to ICU and was initally managed on NIV support but her condition continued to deteriorate and she was intubated and also started on vasopressor support. Her repeat chest x-ray done revealed left lower zone collapse/consolidation. In view of chest x-ray findings, bronchoscopy was done; BAL was taken and sent for detailed investigations. Her initial BAL Gram stain showed few gram positive cocci seen in pair and chains. Numerous gram negative cocco bacilli was seen, AFB stain was negative, BAL culture showed growth of acinetobacter baumannii and antibiotics were modified accordingly. As the patient had history of diabetes mellitus and hypothyroidism, endocrinologist opinion was taken and advice was incorporated in the treatment. In view of deranged kidney functions, nephrologist opinion was taken and SLED was done. Poor prognosis about the condition of the patient was explained to the attendants. On 13th January, 2018 at 1.15 p.m., the patient developed bradycardia followed by asystole. CPR was initiated; however, despite resuscitative efforts, the patient could not be revived and was declared dead at 11.45 p.m. on 13th January, 2018.

The cause of death as per the hospital records was COPD with acute exacerbation with type-II respiratory failure with septic shock with Acute Kidney Injury.

1. It is noted that the patient was initially managed in the emergency department of the said Hospital on 22nd December, 2017 from 01.30 p.m. to 06.57 p.m. (when she was shifted to Medical ICU) due to non-availability of ICU bed. The patient received adequate treatment akin to an ICU setting, as she was intubated put on IPPV support, started on IV antibiotics, IV steroids, Bronchodilators and other supportive treatment. Further, during this period, she was investigated :- 2D Echo, ABG, chest x-ray were done.
2. It is noted that as per the nurses note of 31st December, 2017 one Dr. Akhil had told that the patient was having ICU psychosis and had advised to give seranace (Haloperidol). Further, as per Dr. Priyanka Aggarwal’s 31st December, 2017 note, the patient was having manic depressive episodes, the attendants were counselled and psychiatry review was planned. Dr. Prashant Gupta, Psychiatry consultant notes of 01st January, 2018 revealed that the patient had been given Haloperidol and that she was in control with same. He, therefore, advised Haloperidol 25 mg on PRN (Pro re nata) basis.
3. As per ‘Family Meeting Record’ document of the said Hospital, the guarded prognosis of the patient was informed to the patient’s attendants on 22nd December, 2017, 23rd December, 2017 and 24th December, 2017 and thereafter almost on daily basis during the admission.
4. The probability of an immunecompromised, patient (as was the case in this patient) developing Hospital Acquired infection is very high, inspite of adequate precautions. Further, central line does not require routine change as per CDG guidelines and since in this case, culture of central line sent on 22nd December, 017 and 01st January, 2018 were negative and the third culture sent on 07th January, 2018, reported after forty eight hours was positive for Acenetobacter baumanni, the central line was changed.
5. It is noted that during admission, regular sugar charting of the patient was done and endocrinologist in his notes dated 12th January, 2018 and again at 13th January, 2018 prescribed injection Huminsulin R as per sliding scale, advised blood sugar four hourly and if blood sugar persistently greater than 200, shift to insulin injection as per ICU protocol.
6. The patient who was diagnosed with COPD with Acute Exacerbation with type-II respiratory failure with septic shock with AKI, was treated as per accepted professional practice in such cases by the multidisciplinary specialists which included pulmonologist, psychiatrist, nephrologist, endocrinologist, cardiologist. However, inspite of being administered adequate treatment, the patient succumbed due to her underlying condition which had guarded prognosis.

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 Max Healthcare Hospital, 108A, IP Extension, Patparganj, Delhi-110092, in the treatment administered to complainant’s wife Smt. Usha Bhatnagar.

Complaint stands disposed.

Sd/: Sd/: Sd/:

(Dr. Maneesh Singhal) (Dr. Satish Tyagi) (Dr. Ashwani Khanna)

Chairman, Delhi Medical Association Expert Member

Disciplinary Committee Member, Disciplinary Committee

Disciplinary Committee

The Order of the Disciplinary Committee dated 29th July, 2022 was confirmed by the Delhi Medical Council in its meeting held on 10th August, 2022.

By the Order & in the name of

Delhi Medical Council

(Dr. Girish Tyagi)

Secretary

Copy to :-

1. Shri M.P. Bhatnagar, r/o- 161, Vigyan Vihar, Preet Vihar, Delhi-110092.
2. Dr. Praveen Pandey, Though Medical Superintendent, Max Healthcare Hospital, 108A, IP Extension, Patparganj, Delhi-110092.
3. Dr. Y.P. Singh, Though Medical Superintendent, Max Healthcare Hospital, 108A, IP Extension, Patparganj, Delhi-110092.
4. Dr. Gaurav Jain, Though Medical Superintendent, Max Healthcare Hospital, 108A, IP Extension, Patparganj, Delhi-110092.
5. Medical Superintendent, Max Healthcare Hospital, 108A, IP Extension, Patparganj, Delhi-110092.

(Dr. Girish Tyagi)

Secretary