DMC/DC/F.14/Comp.2476/2/2022/ 21st November, 2022

**O R D E R**

The Delhi Medical Council through its Disciplinary Committee examined a complaint of Shri Ashish Bansal, r/o- 70-A, J & K Pocket, Dilshad Garden, New Delhi-110095, alleging medical negligence on the part of the doctors of St. Stephen’s Hospital, Tis Hazari, New Delhi-110054, in the treatment administered to complainant’s father Shri B.S. Bansal at St. Stephen’s Hospital, resulting in his death on 09.02.2018.

The Order of the Disciplinary Committee dated 23rd September, 2022 is produced herein-below :-

The Disciplinary Committee of the Delhi Medical Council examined a complaint of Shri Ashish Bansal, r/o- 70-A, J & K Pocket, Dilshad Garden, New Delhi-110095 (referred hereinafter as the complainant), alleging medical negligence on the part of the doctors of St. Stephen’s Hospital, Tis Hazari, New Delhi-110054, in the treatment administered to complainant’s father Shri B.S. Bansal (referred hereinafter as the patient) at St. Stephen’s Hospital (referred hereinafter as the said Hospital), resulting in his death on 09.02.2018.

It is noted that the Delhi Medical Council has also received a reference from the District Consumer Disputes Redressal Commission-I (North District), Govt. of NCT of Delhi in CC. No.274/2022 matter titled ‘Chandro Devi & Ors. Vs. St. Stephen’s Hospital & Ors.’’, whose subject matter is same as that of complaint of Shri Ashish Bansal; hence, the Disciplinary Committee is disposing both of these matters by this common Order.

The Disciplinary Committee perused the complaint, written statement of Dr. Ras Bage, Medical Superintendent, St. Stephen’s Hospital enclosing therewith joint written statement of Dr. Mathew Varghese, Dr. Mandeep Singh Bajaj, Dr. Abhishek Kaushik, Dr. Rajendra Kumar Gupta, Dr. Navjeet Singh Ahluwalia, copy of medical records of St. Stephen’s Hospital and other documents on record.

The following were heard in person :-

1. Dr. Ashish Bansal Complainant

2) Dr. Pawan Bhati Brother-in-law of the complainant

3) Dr. Mathew Varghese HOD, Orthopaedics, St. Stephen’s Hospital

4) Dr. Mandeep Singh Bajaj Consultant Orthopaedics, St. Stephen’s Hospital

5) Dr. Abhishek Kaushik Special Orthopaedics, St. Stephen’s Hospital

6) Dr. Rajendra Kumar Gupta Specialist Orthopaedics, St. Stephen’s Hospital

7) Dr. Navjeet Singh Ahluwalia HOD & Consultant, Cardiology, St. Stephen’s Hospital

8) Shri Jaideep Peters Asst. Records Officer, St. Stephen’s Hospital

9) Dr. Ras Bage Medical Superintendent, St. Stephen’s

Hospital

The complainant Shri Ashish Bansal alleged that on 22nd January, 2018, the patient Shri B.S. Bansal met with a serious road accident at 07.30 a.m. in front of J and K Pocket Society Gate, Dilshad Garden, Delhi-110095. The patient was badly hit by a motorcycle when the patient was crossing the road and after the accident, the patient lost his (the patient) consciousness but regained it after sometime. The patient was taken to the Guru Teg Bahadur Hospital in emergency for preliminary treatment where the patient’s initial condition was stabilized. There was no history of ENT bleeding, seizure and vomiting. After preliminary treatment given at G.T.B Hospital., the patient was then taken to St. Stephens Hospital, as the family thought Dr. Mathew Varghese, would have been a better option, as he (Dr. Mathew Varghese) is renowned in the field of orthopaedics. Therefore, the patient was taken to St. Stephens Hospital and admitted in emergency at 4.00 p.m. on 22nd January 2018. During examination at St. Stephens Hospital, it was found that the patient’s GCS scale was 15/15 with no disorientation. The patient was conscious and cooperative. The patient was later shifted to I.C.U. from emergency after consultation with Dr. Mandeep Singh for resuscitation. On diagnosis, the patient was found to have multiple fractures including fracture in bones of both the legs i.e., right leg bone (Tibia and Fibula} and segmental fracture left Tibia, fractured shaft ulna of right forearm, fractured pelvic girdle and small fracture on the face bones (Zygomatical orbital bones). After diagnosis, the patient was then shifted to general ward from I.C.U. after being stabilized on 23rd January, 2018 and the patient was planned to be operated on 24th January 2018. On 23rd night operation was cancelled, as the patient was not able to sleep due to severe pain but the patient was conscious, partially cooperative, irritated, restless and had a distressed look. During this time, Dr. Mathew Varghese was on ward rounds after having seen the patient in distressed and restless position he (Dr. Mathew Varghese) ordered to remove the bandages which were there to make him (the patient) stable to reduce further damage to the fractured site. On 24th January, his (the patient) O.T. was cancelled, as he (the patient) was restless and again shifted to I.C.U. for further treatment to stabilize his (the patient) condition. The patient was evaluated by the subsequent departments like ophthalmology, neurosurgery and pulmonology. Neurosurgery gave the report of small contusion which they question marked on right frontal region. Ophthalmology department gave their report for being completely stable. No ocular surgical intervention was required. Similarly, pulmonology department reported that the patient was normal and there was no fracture of the rib or no pulmonology contusion was seen. On x-r ray bilateral clear chest was seen. Considering his (the patient) problem of restlessness, the patient was then received by the psychiatry department and was put on sedatives to stabilize his (the patient) condition. On 27th January, the department of orthopaedic under which he (the patient) was admitted, shifted the patient to post-surgical or post-operative care. On the same day the DVT-prophylaxis was discussed with respect to the frontal lobe contusion the DVT prophylaxis was deferred. They also deferred any mechanical-prophylaxis or no mechanical prophylaxis to the B/L tibia. After this, his (the patient) psychiatric evaluation was going on regular basis and the patient was stable during this time. On 29th January 2018, department of respiration evaluated the patient’s condition and no fresh complaints were noticed. However, bilateral plural effusion was seen on x-ray with slight fever. Hence, further review with x-ray was requested. Even 2D echo was requested to rule out any cardiac anomaly. On 30th January 2018, the 2D-echo was done to rule out any cardiac anomaly and the x-ray was also done. Cardiac department ruled out any contraindication for surgery and permitted the surgery with(LVEF=60%). The patient was also again examined by the respiratory department and the patient was declared fit for the surgery. On the same day, they clearly stated to start the thrombo-prophylaxis post-operatively and Dr. Rahul from the orthopaedic department also emphasized to carry out the thrombo-prophylaxis post-operatively which is clearly stated in history notes of the patient but no thrombo-prophylaxis was carried out. On 31st January, his (the patient) first surgery i.e., CRIF (Right Leg) was done and his (the patient) condition was good. But neither thrombo-prophylaxis was started nor mechanical prophylaxis was given and then the patient’s condition was reviewed by Dr.Rajendra Kumar Gupta and Mandeep Singh on that day. The patient’s second surgery i.e. CRIF for left leg Tibia was done on 2nd February 2018, still no thrombo/mechanical prophylaxis was initiated and the patient was reviewed again by (Dr. Mathew Varghese/Rajendra Kumar Gupta/Mandeep Singh) on that day. The third surgery was done on right ulna on 05th February 2018 and the patient was shifted to ward. Again, no thrombo/mechanical prophylaxis was initiated and the patient was again reviewed by (Dr. Rajendra Kumar Gupta/Mandeep Singh). After the surgery, the patient’s liquid intake was good and was responding well. On 6th February 2018, the patient was well and had good liquid intake but only problem was that the patient was not able to sleep, as there was a development of stiffness in his (the patient) legs. Even by that time, there was no thrombo-prophylaxis was carried out which was the need of hour in his (the patient) case. On 07th February 2018, the patient was normal and doing well and was on normal diet. His (the patient) urine output was normal, till now no thrombo-prophylaxis or mechanical prophylaxis was done. In the evening, Dr. Mathew Varghese visited the ward and after consulting his (Dr. Mathew Varghese) team about the condition of the patient, he (Dr. Mathew Varghese) advised to discharge the patient next day. The patient was immobile for almost 16 days and was bed ridden, still Dr. Mathew Varghese did not notice that any thrombo-prophylaxis was done or not and advised for discharging the patient in hush-hush manner. On 8th February, 2018, Dr Mandeep visited the ward in the morning and after examining the patient, he(Dr. Mandeep) advised to remove the catheter to see whether patient will be able to pass the urine without it or not. The catheter was removed around 12.30 p.m. and after that the patient was easily passing the urine. The new discharge order released was that the patient to be discharged on 9th February, 2018. On 9th February, 2018 when the patient was about to be discharged from the hospital around 9.00 a.m., the patient complained of breathlessness to his (the patient) son (the complainant) then his son (the complainant) reported the same immediately to the resident doctor presented in the ward and then, the patient was immediately shifted to ICU by 9.30 a.m. In ICU, the patient was evaluated and found to have increased heart rate and breathing. On further examination, the patient’s SP02 was 70% without oxygen and with oxygen it was 72%. In ICU around 10.30 a.m., the patient’s SP02 was 67% and after that the patient was kept on bipap machine. Then, the patient was advised immediate cardiac consultation, ECG, venous Doppler, 2 D, echo and CT angio. Till 10.30 a.m., the patient was in ICU for almost one hour even after one hour, no test or examination was done then where was the urgency or emergency. At 11.30 a.m., the patient was intubated by Dr. Pooja due to high respiration rate and de-saturation. They knew that it was a case of pulmonary embolism. At 12.00 p.m. 2D echo was done; it showed the right auricle and right ventricular dilatation and pulmonary artery was dilated. Bilateral Venous Doppler was also done that showed extensive thrombosis in bilateral pelvic veins. After this, no CT angio was done, which was the need of the hour. On the basis of 2D echo report, the doctor started with injection Unfractionated Heparin i.e. 5000 I.U bolus was given, which was already too late as per the condition of the patient. At 1.30 p.m., the patient was taken to CT room for CT Angio and CT Angio was done, which clearly showed the massive pulmonary embolism and at 2.00 p.m., the patient came back to I.C.U. After returning from the CT Room to I.C.U., the patient went into cardiac arrest around 2.00 p.m. and immediately CPCR was given to revive the patient and the patient was revived. At 2.45 p.m., again the patient went into second cardiac arrest and immediately CPCR was started again to revive the patient and the patient revived again. Still, no thrombolysis was done to dissolve the clot to save the patient. At last around 3.00 p.m., the thrombolysis was started and Dr. Ahluwalia from cardiology, administered the injection but again around 3.15 p.m., the patient went into third cardiac arrest and CPCR was done to revive the patient, but the patient could not revived, as this is too late to save the patient and declared the patient dead at 4.00 p.m. by flat line E.C.G.

He further alleged that now from the above said facts, he would like to highlight the points which shows the negligence on the part of the doctors and they are as : why there was no thrombo-prophylaxis carried out on the patient during his stay in the hospital. On 30th, January 2018 when respiratory department clearly stated to start the thrombo-prophylaxis after the surgery which was even emphasised in return order by Dr. Rahul from ortho department to carry out the same but why this order was never carried out. Not carrying out thrombo-prophylaxis in multi trauma, bed-ridden and the patient who went under multiple surgeries was a Himalayan blunder which put the patient on risk of developing life threatening condition called pulmonary embolism, due to which, the patient died on the 9th, February, 2018. On 9th, February, 2018 when the patient developed breathlessness and shifted to ICU immediately around 9.30 a.m., when there was need to do a 2 D echo, Venous Doppler and cardiac consultation immediately why these all done after a delay of two hours at 11.30 a.m. When at 11.30 a.m., a 2D-Echo clearly showed the dilated pulmonary artery, right auricle and right ventricle which was clear signs of pulmonary embolism after this a immediate CTAngio should have been done but why this is done at 2 pm which a delay of 2.5 hours which clearly put a patient at life threatening risk. Why thrombolysis was done at 3.00 p.m. even after the diagnosis of dialated pulmonary artery/right auricle and right ventricle at 11.30 a.m. by 2D echo then what are the reasons of delay 3.5 hours. When there was urgent need of conducting 2D Echo and CT Angio at 10.00 a.m. which clearly stated in written orders then why they were done by delay of 2.5 and 5 hours, respectively. Why thrombolysis was done at 3.00 p.m. even after the diagnosis of confirmed pulmonary embolism through CT angio at 2.00 p.m. then what is the reason of delay of one hour. Now from the above mentioned facts, it shows that concerned doctors of the hospital did not discharge their duty properly and there was negligence on the part of the doctors who conducted the treatment of the patient. He (the complainant) has mentioned only the brief facts with regards to the treatment of the patient, however, some other facts with regard to the negligence on the part of the doctors will come to the light, if proper and systematic interrogation would be carried out either by the concerned officials of the investigation agency or responsible person of the hospital. The doctors had given the improper treatment, which resulted in the demise of the patient. Due to the demise of the patient, the wife of the patient as well as his other family members are facing very hardship and it is an unbearable loss for the family. The doctor concerned who were negligent and responsible for the improper treatment of the patient are liable to be prosecuted under the appropriate provisions of law as well as bear the losses which are facing by him (the complainant) and family members.

Dr. Mathew Varghese, Head of Dept. Orthopoaedics, Dr. Mandeep Singh Bajaj, Specialist, Dept. of Orthopaedics, Dr. Abhishek Kaushik, Sr. Specialist, Dept. of Orthopaedics, Dr. Rajendra Kumar Gupta, Sr. Specialist, Dept. of Orthopaedics and Dr. Navjeet Singh Ahluwalia, Head of Dept. of Cardiology, St. Stephen’s Hospital in their joint written statement averred that at the outset, it is submitted that the complaint is misconceived and makes incorrect allegations against the doctors who provided best possible treatment as per accepted medical practices and with full sincerity and devotion to the patient Shri B.S. Bansal. A perusal of the complaint, would reveal that considered decisions taken by the doctors in the best interest of the patient, having regard to the fact that the patient was also suffering from traumatic brain injuries (TBI), are now sought to be cited as indicative of negligence. The principal allegation made in the complaint is that thrombo-prophylaxis was not started though the patient had suffered trauma, was bed ridden and had undergone multiple surgeries. In making the said allegations, the complainant has completely ignored the fact that the patient was having traumatic brain injuries resulting in haemorrhage. The details of the injuries suffered by the patient are set out as : (a) Brain- haemorrhagic contusions with perilesional oedema in right basifrontal region, (b) fracture both bones right leg (tibia and fibula). Fracture left tibia(segmental), (d) Fracture right ulna, (e) Fracture right acetabulum, (f) Fracture ilium, (g) Fracture anterior and posterior walls of right maxillary sinus, (h) Fracture right orbit floor and lateral wall, (i) Fracture right lamina papyracea, (j) Displaced comminuted Fracture of Outer and Inner walls of bilateral frontal sinuses along-with fracture of intervening septum and (k) Air fluid levels in frontal and maxillary sinuses. Given the said injuries, the consequent three surgeries which the patient had to undergo over a short period and the episodes of haematuria on 2nd and 3rd February, there was always a risk of further haemorrhage in the event of thrombo-prophylaxis being carried out. The team of the doctors were confronted with a difficult choice, in that the patient had already suffered traumatic brain injury coupled with hemorrhage and the need for carrying out thrombo-prophylaxis which carried with it the attendant risk of causing major bleed. Based on the injuries, the symptoms that presented themselves and the overall condition of the patient, a considered decision was taken by the team of the doctors to defer thrombo-prophylaxis. In view of the nature of the injuries, mechanical prophylaxis was also not feasible. However, the patient was given physiotherapy on regular basis with ankle mobilization and calf pumping exercises. It is submitted that the decision to defer thrombo-prophylaxis was taken in the best interest of the patient and was consistent with accepted medical practices. A major challenge in the treatment of brain-injured patients is the decision on indication and timing of prophylactic anticoagulation. Despite evidence for an increased risk of venous thromboembolic events and pulmonary embolism in traumatized patients without prophylactic anticoagulation, there is a lack of distinct recommendations and standardized clinical practice guidelines. The start of pharmacologic thromboprophylaxis (PTP) and particularly the timing of initiation is a gray area. There is lack of evidence guiding thrombo-prophylaxis in traumatic brain injuries (TBI) and currently there is insufficient data to determine the appropriate timings of PTP. PTP can exacerbate intracranial haemorrhage in the patients with TBI. There are no standards for thrombo-prophylaxis in the patients with TBI and medical opinion is that till more robust data is available to guide decision making, clinicians have to use their judgment on individual basis to decide upon the timing and mode of thrombo-prophylaxis, taking into consideration the risk of worsening intracranial bleeding, the nature of injuries, timing of surgical intervention, predisposing risk factors etc. Certain studies have even found no evidence of effectiveness of either pharmacological or mechanical interventions and thrombo-prophylaxis has not been found to reduce the mortality or pulmonary embolism. Although some studies suggest an increased risk of bleeding complications when heparin products are administered pre-operatively or in the early postoperative period, there are conflicting opinions regarding ideal timing for perioperative pharmacologic prophylaxis. Certain institutions do not initiate pharmacologic prophylaxis within 72 hours of the procedure. In view of the above position, initiation of thrombo-prophylaxis in high risk patients with TBI is ultimately dependent upon the clinical judgment of the treating doctors. That judgment was duly exercised by the team of the doctors at St. Stephens’ Hospital and it was felt that the risks of not undertaking thrombo-prophylaxis were far outweighed by the risk of a major bleed that could be brought about if the patient was subjected to thrombo-prophylaxis at the times and stages as now being suggested by the complainant. More-so, in view of his (the patient) brain injury and oedema, the numerous fractures and the fact, that the patient had an episode of haematuria on 2nd and 3rd February. It is submitted that there was no negligence in the treatment of the patient. It is well settled that a doctor is guilty of negligence only if he fails to provide the treatment in accord with accepted medical practices. If out of the two modes of the treatment, a doctor adopts one, it cannot be said that he (the doctor) is guilty of negligence. Even an error of judgment does not qualify to term as act of negligence. While treating a seriously ill patient, the doctors are frequently confronted with situations where they have to quantify the risks and benefits associated with adopting or not adopting a particular line of the treatment. A considered decision taken by the treating team of the doctors in the best interest of the patient is being wrongly characterized by the complainant as an act of negligence. The detailed facts regarding the treatment given to the patient are as : - the patient was brought to the casualty with history of loss of consciousness following trauma for 30 minutes. Initially the patient was treated at GTB Hospital. As per history given by attendants, there was fall in the blood-pressure at GTB Hospital, for which, one packed cell (blood) transfusion and one normal saline infusion was given. The patient’s in the casualty of St Stephen's Hospital was not stable and the patient was transfused two units of normal saline in casualty and was shifted from there to surgical ICU. In surgical ICU, one unit blood transfusion was given and normal saline Ringer Lactate infusion was started at the rate of 75 ml/hour. Initially, the patient was hypotensive in ICU and subsequently stabilized with blood and IV fluids. After investigations including x-Rays and CT scan, the patient was diagnosed with injuries of Brain- Haemorrhagic Contusions with perilesional oedema in Right Basifrontal Region, fracture both bones right leg (Tibia and Fibula), fracture left tibia (Segmental), fracture right ulna, fracture right acetabulum, fracture right ilium, fracture anterior and posterior walls of right maxillary sinus, fracture right orbit Floor and lateral wall, fracture right lamina papyracea, displaced comminuted fracture of outer and inner walls of bilateral frontal sinuses alongwith fracture of intervening septum, air fluid levels in frontal and maxillary sinuses ? hemosinuses. The patient was seen by the general surgeon on 22nd January, 2018, who advised for ultrasound whole abdomen which was reported to be normal. Neurosurgeons also saw the patient in view of head injury. They advised for tablet Levetiracetam (Anticonvulsant) and Lasilactone. The patient was found to be stable in ICU on 23rd January, 2018 and was shifted to ortho ward. The patient showed episodes of intermittent irritable behaviour in the ward with normal vitals, and on close questioning the relatives disclosed that the patient had some psychiatric illness in the past, for which, the patient was on irregular treatment. A psychiatry opinion was then sought on 24th January, 2018. Psychiatrist advised for injection Lorazepam. Respiratory medicine opinion was also sought for the same reason. They saw the patient and as per their examination, no abnormality was detected in the respiratory system. The patient’s irritability and restlessness did not settle. Therefore, psychiatry opinion was again sought. They made a diagnosis of Delirium with benzodiazipine abuse and advised accordingly and advice was followed. Loosening of bandages (not removal) was suggested only to exclude any discomfort from any possible tight bandage. The surgery was deferred because of episodes of irritability and restlessness and repeated episodes of disorientation. The patient continued to be irritable and restless off and on the patient was shifted to the surgical ICU for observation on 24th January, 2018. Psychiatry opinion was sought after that on a regular basis in view of this and their advice was followed regularly. Neurosurgery opinion was again sought on 27th January, 2018 and they advised to stop Lasilactone and to continue Levetiracetam (Anticonvulsant). The patient was reviewed on 27th January, 2018 regarding the possibility of starting DVT prophylaxis, but in view of haemorrhagic contusions in the basifrontal region and his(the patient) continued irritability, restlessness and disorientation, DVT chemoprophylaxis was deferred. Mechanical prophylaxis for DVT was not feasible in view of bilateral tibial fractures. Though, the neurosurgeon had question marked the frontal lobe contusion, formal CT scan report showed few haemorrhagic contusions in basifrontal region, apart from other fasciomaxillary injuries as stated above. The patient was shifted to surgical post-operative ward on 27th January, 2018. The patient was cleared by the cardiologist on 30th January, 2018 for the surgical intervention. Cardiologist cleared the patient for the surgery after 2D echocardiography. On 30th January, 2018, the patient was seen by the respiratory medicine consultant and suggested for thromboprophylaxis after the surgical intervention is completed. The patients last surgery was done on 05th February, 2018, however, the advice for postoperative thromboprophylaxis could not be carried out in view of haemorrhagic contusions in basifrontal region and other injuries (head injury and various maxillofascial injuries, as noted previously and noted below).

1. Brain- Haemorrhagic Contusions with perilesional oedema in Right Basifrontal Region.
2. Fracture Anterior and Posterior walls of right Maxillary Sinus.
3. Fracture Right Orbit Floor and Lateral wall.
4. Fracture right Lamina Papyracea.
5. Displaced comminuted Fracture of Outer and Inner walls of Bilateral Frontal Sinuses along with Fracture of intervening Septum.
6. Air Fluid levels in Frontal and maxillary Sinuses.
7. Patient had Haematuria during course of treatment.

Of specific importance are the injuries to the brain, orbit and lamina papyracea, with a high risk of secondary haemorrhage. In the judgement of the treating doctors, with repeated episodes of altered sensorium, starting chemoprophylaxis could be risky with additional risk of increased bleeding. Mechanical prophylaxis was any way not possible because of his fractured limbs, however, the physiotherapist were regularly doing exercises to keep the limb mobile and muscles contracting which is also a mechanism for thromboprophylaxis. Literature is grey in this regard with no accepted definitive prophylactic guidelines regarding thromboprophylaxis in the patients with such multiple injuries and traumatic brain injuries. On 31st January, 2018, the first surgery (CRIF-Right Leg) was performed. The patient was regularly visited by the physiotherapist and was started on ankle mobilization and calf pumping exercises. Mechanical prophylaxis by using pneumatic pump could not be done in view of his (the patient) fractured limbs. The second surgery(CRIF for left leg tibia) was performed on 02nd February, 2018. As the patient was undergoing surgeries, the patient had an episode of haematuria on 2nd and 3rd February. This in addition to the contusion in the brain hindered the doctors from starting chemoprophylaxis apart from other injuries. Mechanical prophylaxis, like ankle mobilization and calf pumping exercises continued. The third surgery was performed (on right ulna) on 05th February, 2018. The patient was keeping well in the postoperative period; there was no fever tachycardia or breathing difficulty. The physiotherapist on 06th February, 2018 very clearly did all the prophylactic exercises to prevent DVT. Chemoprophylaxis was not started for reasons, as discussed above. Since the patient was apparently normal and was doing well on normal diet and all the exercises were continuing, the patient could be sent home on exercises at a convenient time, it was noted on 08th February, 2018 that discharge be planned. The patient was found to be stable in postoperative period for three days. The decision for discharge was taken in a formal round with the team members of the department (not in a hush-hush manner, as wrongly asserted in the complaint). However, the patient was not discharged on that day, as the patient was catheterized with indwelling urinary catheter. The hospital tries whenever possible to discharge the patient without in dwelling urinary catheter, as it is difficult to give catheter care at home. The discussion not to start chemoprophylaxis was already done and documented clearly in the case record. In Orthopaedic ward, the patient complained of breathing difficulty at 9:30 a.m. on 09th February, 2018. The patient was immediately seen by the doctor on duty, who checked the patient’s oxygen saturation by pulse oximeter, which was found to be low(70%). He (the doctor) advised for oxygen inhalation that was immediately started. The patient was also evaluated at 9:35 a.m. by the consultant on round who advised for arterial blood gas analysis and shifting of the patient to SICU for intensive care. The patient was shifted to SICU at 10:30 a.m. (and not at 9:30 a.m., as contended by the complainant). The patient was started on BIPAP and was intubated at 11:30 a.m. in view of deterioration of condition i.e. non-maintenance of oxygen saturation despite 100% oxygenation. There was a suspicion of thromboembolism/chest infection. Cardiology opinion was sought. Thus, the patient was immediately attended in ward as well as ICU. Initially, the patient was put on BIPAP and then on ventilator. Without wasting any time and side-by-side, the relevant investigations–2D echo, venous doppler and CT pulmonary angiography were ordered. The patient was examined by the cardiology department, who immediately advised for injection Heparin and it was given and planned for thrombolysis after CT pulmonary angio. CT pulmonary angio was arranged immediately, but the patient’s condition deteriorated further and was being actively managed in SICU for this. As soon as the patient’s blood-pressure stabilized, the patient was shifted for CT scan. The patient went for CT scan at 1:30 p.m. and returned after CT scan at 2:00 p.m., and CT scan confirmed bilateral pulmonary embolism. As the patient returned from CT scan, the patient had two cardiac arrests one at 2:00 p.m. and other at 2:45 p.m. The patient was successfully revived from those two cardiac arrests; the cardiac arrest patients need to be observed, to be certain that they do not have arrhythmias and other cardiac problems soon after revival. Thrombolysis at this stage could add to the risk, as the patient can start bleeding from all the injured sites including the brain and this could further compromise his revival.

In so far as the specific allegations of negligence are concerned, they further averred that on a review of the case it would be seen that on 30th January, 2018, the patient was seen by the respiratory medicine consultant and suggested for thromboprophylaxis, but their advice could not be carried out in view of the injuries (head injury and various maxillofascial injuries), as noted previously and noted as : Brain- haemorrhagic contusions with perilesional oedema in right basifrontal region, fracture anterior and posterior walls of right maxillary sinus, fracture right orbit floor and lateral wall, fracture right lamina papyracea, displaced comminuted fracture of outer and inner walls of bilateral frontal sinuses alongwith fracture of intervening septum, air fluid levels in frontal and maxillary sinuses. The patient had haematuria during the course of the treatment. Of specific importance are the injuries to the brain, orbit and lamina papyracia, with a high risk of secondary haemorrhage. In literature also there are no standard guidelines regarding chemo-thromboprophylaxis in the patients with such multiple injuries and traumatic brain injuries. The patient was shifted to SICU at 10:30 a.m. on 09th February, 2018and not at 9:30 a.m. as per the clinical records. Both venous Doppler and 2D echo were done at the earliest possibility in SICU and the patient was seen by the cardiologist department, who further advised for injection Heparin, which was given immediately, and CT pulmonary angiography was planned at the earliest. First of all, it is not two hours delay, as alleged and it was only one hour interval and that too the patient was very sick and was being resuscitated and in the hour, the patient was put on BIPAP, followed by the ventilator and 2D echo and venous Doppler were done without any delay. As the patient was critically ill, all these investigations were done bedside. The concerned doctors were all along at the bed site supervising and hastening procedures to the best of their ability and in the interest of the patient. There was no question of delaying anything. The patient needed to be shifted to CT scan room for CT; this was not possible immediately, as the patient had to be put on inotropic support to stabilize the patient before shifting the patient for CT. In addition, the patient was intubated and was on a ventilator, it was not easy to shift such a patient and after all precautions, the patient could only be shifted to CT scan at 01.30 p.m. and not at 02.00 p.m. as per clinical records. At 02.00 p.m., the patient was back from CT, after which the patient had two cardiac arrests and was revived from them soon after revival of two cardiac arrests, the patient was started on thrombolytic therapy. The 2D echocardiography criteria for the diagnosis of pulmonary embolism have differed in different studies. The signs of RV overload/dilatation may also be found in the absence of acute pulmonary embolism due to other cardiac or respiratory diseases. If immediate CT angiography is feasible then final confirmation of the diagnosis by CT angiography should be sought as soon as the patient can be stabilized by supportive treatment. Though 2D echo raised the suspicion of pulmonary embolism, confirmatory CT could not be done immediately, as the patient was unstable and was being stabilized. The patient was first on a BIPAP needed to be intubated subsequently and because of persistent hypotension needed to be started on inotropes. CT angiography is the method of choice for imaging the pulmonary vasculature in the patients with suspected PE. It allows adequate visualization of pulmonary artery down to the segmental level. In suspected pulmonary embolism with shock and hypotension, CT angiography should be done as soon as the patient is stabilized for confirmation of pulmonary embolism. If CT angiography is positive for PE then, PE specific treatment-thrombolysis/primary reperfusion is considered. Thromboprophylaxis is carried out by either injection Heparin or oral anticoagulant drugs. The thrombolysis is done with thrombolytic drugs. The risk of bleeding, due to thrombolytic drugs are much higher than heparin or oral anticoagulant drugs which are used for thromboprophylaxis. Thrombolytic therapy carries the risk of major bleeding, including the risk of intracranial haemorrhage. The patient being considered for thrombolysis required screening for contra indication. Intra-cranial haemorrhage is the most feared and severe complication. The symptom and signs of pulmonary embolism are nonspecific. In this case, addition of thrombolytic therapy carried with it a serious risk of secondary haemorrhage from sites, mentions as : brain haemorrhagic contusions with perilesional oedema in right basifrontal region, fracture anterior and posterior walls of right maxillary sinus, fracture right orbit floor and lateral wall, fracture right lamina papyracea, displaced comminuted fracture of outer and inner walls of bilateral frontal sinuses alongwith fracture of intervening septum, Air fluid levels in frontal and maxillary Sinuses. ? Haemosinus and the patient had haematuria during the course of the treatment. Recently operated site, last surgery was done on 05th February, 2018. The patient also had history of haematuria and blood transfusion for hemodynamic instability. The patient was shifted to ICU at 10.30 a.m., after which, the patient was put on BIPAP initially and then on ventilator because of non-maintenance of oxygen saturation, the patient was on ventilator at 11.30 a.m. By 11.30, the patient was on ventilator and his (the patient) 2D echo were done at the ealiest possible time. When those investigations raised, the suspicion for pulmonary embolism, CT pulmonary-angio ordered, which was subsequently arranged urgently but the patient developed hypotension and was put on inotropes to stabilize his (the patient) blood-pressure before shifting the patient for CT pulmonary-angio. The patient had to cardiac arrests one at 02.00 p.m. and second at 02.45 p.m., soon after, the patient came back from CT scan. The patient was being revived from those cardiac arrests. The priority was to revive the patient from cardiac arrest. Having regard to what has been stated above, it is submitted that there was no negligence in the treatment of the patient. It is well settled that a doctor is guilty of negligence only, if he fails to provide the treatment in accordance with the accepted medical practices. If out of the two modes of treatment, a doctor adopts one, it cannot be said that he (the doctor) is guilty of negligence. Even an error of judgment does not qualify to term as act of negligence. While treating a seriously ill patient, the doctors are frequently confronted with a situation where they have to quantify the risks and benefits associated with adopting of not adopting a particular line of treatment. A considered decision taken by the treating team of doctors in the best interest of the patient is being wrongly characterized by the complainant as an act of negligence. It is, submitted that the complaint is misconceived and merits for rejection.

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

1. The patient late Shri B.S. Bansal, age 60 years old male presented to the casualty of the said Hospital on 22nd January, 2018 with poly-trauma with alleged history of RTA (Road Traffic Accident) in Dilshad Garden Area in Delhi at 07.30 a.m. on 22nd January, 2018. He was taken to GTB hospital from where he was shifted to said Hospital. There was history of loss of consciousness for thirty minutes and regained consciousness in GTB Hospital. There was no history of ENT bleeding, seizure, vomiting. There was history of occasional restlessness, for which, the patient took antipsychotics drugs in the past. He was examined and investigated. He was diagnosed with fracture both bone right leg and segmental fracture left tibia, fracture shaft ulna right forearm, fracture. Acetabulum, right frontal lobe contusion, fracture of lateral wall of Right Orbit and Displaced fracture of Right zygoma, communited fracture of outer and inner walls of Bilateral Frontal sinus. The patient was shifted to surgical ICU in view of vitals monitoring, pulmonary embolism and shock. After twenty four hours (23-01-2018), the patient was stable, so the patient was shifted to ward. On 24th January, 2018 in the ward, the patient became restless with de-saturation and so shifted to surgical ICU. The patient was stabilized and, thus, shifted to surgical post ICU on 27th January, 2018 for vital monitoring. Then the patient was planned for CRIF right tibia and posted on 30th January, 2018. The patient was stable in recovery, so was shifted to ward. On 2nd February, 2018, the patient was posted for CRIF for left tibia and was stable in recovery room, so shifted in ward. Then the patient was posted for ORIF right ulna on 05th February, 2018 and was stable in recovery room, so shifted to recovery room. At the time of presentation in the casualty surgery, neurosurgery, ophthalmology consultation was done and advice followed. Psychiatry medicine consultation was done in view of ongoing psychiatric medications and advice followed. Respiratory medicine consultation was done on 24th January, 2018 and advised followed. Maxillofacial surgery consultation was done on 24th January, 2018 and advice followed. On 09th February, 2018 at around 09.00 a.m., the patient complained of restlessness and breathlessness and was evaluated, was found to have tachycardia, tachypnoea with falling saturation. The patient was shifted to SICU with O2. Following which, the patient was intubated and controlled ventilation was started via ventilator. The patient’s saturation was 70%, inspite of 100% O2. The patient was further evaluated with chest x-ray, 2D ehco and CT pulmonary angiography which showed massive pulmonary embolism. The patient went into cardiac arrest at around 02.00 p.m. and CPCR was initiated. The patient was revived after ten minutes with spontaneous circulation. On consultation with the cardiologists and the neurosurgeon, the patient was started on thrombolysis. The patient again went into third cardiac arrest at around 03.15 p.m. and CPCR was done for forty five minutes; the patient could not be revived and was declared dead at 04.00 p.m. on 09th February, 2018.

The cause of death as per the post-mortem report No.203/18 dated 10th February, 2018 of Department of Forensic Medicine, UCMS & GTB Hospital, was septicemic shock as a result of multiple organ failure as subsequent upon multiple bone fractures produced by blunt force impact.

1. We are of the considered opinion that in a case of poly-trauma where the patient had suffered multiple injuries including brain injury which had resulted in haemorrhagic contusions, had undergone three surgeries, suffered from hematuria which had compounded the risk of haemorrhage; the decision to not prescribed thrombo-prophylaxis initially, was within the clinical judgement of the doctor and in light of the prevailing condition of the patient, cannot be termed as an act of medical negligence.
2. The post mortem report opined the cause of death as ‘septicemic shock as a result of multi organ failure as subsequent upon multiple bone fractures produced by blunt force impact’ and further did not give any finding of the patient having suffered pulmonary embolism.

It is observed that on 09th February, 2018 when the patient’s condition deteriorated, C.T. pulmonary angiography was done; the same was suggestive of massive pulmonary embolism, for which, thrombo-prophylaxis was administered. Unfortunately, the patient could not be revived and succumbed.

1. The patient was examined, investigated and treated by the multi-disciplinary team as per accepted professional practice in such case. The patient died due to his underlying condition, inspite of being administered adequate treatment.
2. There was no definite clinical indication or suspicion of developing pulmonary embolism and prophylactic anticoagulation (heparin) was not started in view of underlying brain haemorrhage hematuria. Once detected, timely treatment was initiated.

In light of the observations made hereinabove, it is the decision of the Disciplinary Committee that no medical negligence can be attributed on the part of the doctors of St. Stephen’s Hospital, in the treatment administered to complainant’s father Shri B.S. Bansal at St. Stephen’s Hospital.

Complaint stands disposed.

Sd/: Sd/: Sd/:

(Dr. Maneesh Singhal) (Dr. Satish Tyagi) (Daljit Singh)

Chairman, Delhi Medical Association Expert Member,

Disciplinary Committee Member, Disciplinary Committee

Disciplinary Committee

Sd/: Sd/:

(Dr. Amitesh Aggarwal) (Dr. Ajay Bahl)

Expert Member, Expert Member,

Disciplinary Committee Disciplinary Committee

The Order of the Disciplinary Committee dated 23rd September, 2022 was confirmed by the Delhi Medical Council in its meeting held on 19th October, 2022.

By the Order & in the name of

Delhi Medical Council

(Dr. Girish Tyagi)

Secretary

Copy to :-

1. Shri Ashish Bansal, r/o- 70-A, J & K Pocket, Dilshad Garden, New Delhi-110095.
2. Dr. Mathew Varghse, Through Medical Superintendent, St. Stephen’s Hospital, Tis Hazari, Delhi-110054.
3. Dr. Mandeep Singh Bajaj, Through Medical Superintendent, St. Stephen’s Hospital, Tis Hazari, Delhi-110054.
4. Dr. Abhishek Kaushik, Through Medical Superintendent, St. Stephen’s Hospital, Tis Hazari, Delhi-110054.
5. Dr. Rajendra Kumar Gupta, Through Medical Superintendent, St. Stephen’s Hospital, Tis Hazari, Delhi-110054.
6. Dr. Navjeet Singh Ahluwalia, Through Medical Superintendent, St. Stephen’s Hospital, Tis Hazari, Delhi-110054.
7. Medical Superintendent, St. Stephen’s Hospital, Tis Hazari, Delhi-110054.
8. Reader, DCDRC-1 (North), Delhi, District Consumer Disputes Redressal Commission-I (North District), Govt. of NCT of Delhi, Ground Floor, Court Annexe-2 Building, Tis Hazari Court Complex, Delhi-110054-w.r.t. CC. No.274/2022 matter titled ‘Chandro Devi & Ors. Vs. St. Stephen’s Hospital & Ors-**for information.**

(Dr. Girish Tyagi)

Secretary