DMC/DC/F.14/Comp.2500/2/2022/ 27th September, 2022

**O R D E R**

The Delhi Medical Council through its Disciplinary Committee examined a representation from Dy. Commissioner of Police, Central District, Delhi, seeking medical opinion in respect of death of Sh. Surat Singh, allegedly due to medical negligence, in the treatment administered to the deceased at BL Kapur Hospital, Pusa Road, Delhi.

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

The Disciplinary Committee of the Delhi Medical Council examined a representation from Dy. Commissioner of Police, Central District, Delhi, seeking medical opinion in respect of death of Sh. Surat Singh (referred hereinafter as the patient), allegedly due to medical negligence, in the treatment administered to the deceased at BL Kapur Hospital, Pusa Road, Delhi(referred hereinafter as the said Hospital).

The Disciplinary Committee perused the representation from Dy. Commissioner of Police, copy of complaint of Shri Harish Kumar, written statement of Dr. Sanjay Mehta, Head Medical Services, BLK Super Speciality Hospital enclosing therewith written statement of Dr. Satbir Singh, Consultant Cardiology, written statement of Dr. Subhash Chandra, HOD-Department of Cardiology, BLK Super Speciality Hospital, written submissions of Dr. Satbir Singh, copy of medical records of BLK Super Speciality Hospital, post mortem report No. 302/2018 dated 09.04.2018 and other documents on record.

The following were heard:-

1) Shri Harish Kumar Complainant

2) Dr. Satbir Singh Consultant, Cardiology, Super Speciality Hospital

3) Dr. Subhash Chandra HOD-Department of Cardiology, BLK Super Speciality Hospital

4) Dr. Suhas Parnami Medical Superintendent, Super Speciality Hospital

5) Dr. Dhirendra Kumar DMS, HOD-Department of Cardiology, BLK Super Speciality Hospital

It is noted that as per the police representation, it is averred that on 07th April, 2018, a PCR call was received at PS Prasad Nagar vide DD No. 21A, regarding the death of caller’s father due to medical negligence at BL Kapur Hospital, Pusa Road, Delhi. It was learnt that the patient (the deceased) Shri Surat Singh s/o Duli Chand r/o H.No.638, Ranthavala Road, Ishwar Colony, Bawana, Delhi was admitted in the BL Kapur Hospital, Pusa Road on 06th April, 2018 with complaint of breathlessness and blood-pressure problem, earlier diagnosed at Saroj Hospital, Rohini, Delhi. During the treatment, an angiography and angioplasty was done by the doctors, after which on 07th April, 2018, the patient collapsed. Son of the patient namely Shri Harish Kumar (the complainant) made a complaint vide DD No. 53-B, dated 07th April 2018, alleging medical negligence by the doctors and the management of the BL Kapur Hospital. Other family members of the patient also gave similar complaint in this regard. The post-mortem of the patient was conducted by the Board of three doctors at MAMC mortuary on 09th April, 2018 vide PM No.302. The videography of the post-mortem was prepared. Meanwhile, the treatment papers and death summary of the patient was obtained from the BL Kapur Hospital and Shri Harish Kumar (the complainant) also submitted the treatment papers of previous hospital. The viscera and histopathology samples were preserved by the Board during post-mortem of the patient and the same was sent to the competent authority for the examination. The post-mortem report of the patient has been received alongwith inquest papers. Since, the Delhi Medical Council is having the appropriate authority to decide such matters; it is requested to examine the present case regarding medical negligence.

The complainant Shri Harish Kumar alleged that on 06th April, 2018, they admitted the patient Shri Surat Singh (the complainant’s father), 66 years old with breathlessness problem at B.L. Kapoor Hospital. The blood-pressure measurement at that time was 90/60 mmHg and after admission, it reached 110/70 mmHg. Till the afternoon of 07th April, 2018, the condition of the patient was good, the patient ate well and slept well. The visiting doctor said the condition was good, no need to worry; they (the doctors) will discharge the patient. They just wanted to do angiography, so that they can assess, if there is any other problem. The pointed doctor (Dr. Satbir Singh) took the patient to operation-theater for angiography and after angiography, the doctor told that there is slight blockage in two arteries and they (the doctors) want to put two stents. The complainant gave his consent and asked if the heart is weak, is it safe to operate heart with stent; Dr. Satbir Singh said yes. Then after sometime, Dr. Satbir Singh came back and said, some complications occurred during the operation and the patient got heart attack and the patient was put on the ventilator. After sometime at 04.45, Dr. Satbir Singh declared the patient dead. They just came in B.L. Kapoor Hospital for review because the treatment was going on in Saroj Hospital, Rohini, Delhi and they discharged the patient from the Saroj Hospital on 05th April, 2018 (on second time) and from the Saroj Hospital, the doctor said, no need to worry, the blood-pressure will remain in between 85-90 or slightly low and there will be some breathlessness but he will recover in short time. The discharge was second time from the Saroj Hopspital, where the patient was readmitted second time for the breathlessness. First time on 27th March, 2018, the patient was admitted in Saroj Hospital where the heart was operated with angiography and angioplasty, and first time they discharge the patient in good condition on 31st March, 2018. But again, he readmitted the patient second time (01/04/2018) and then they clearly said now the patient is in stable condition and will recover in short time, but no need to worry. He requests the Delhi Medical Council to investigate the matter thoroughly/complete with depth investigation because, they are the victims of the hospital and the doctor negligence.

Dr. Satbir Singh, Consultant Cardiology, BLK Speciality Hospital in his written statement averred that the patient Shri Surat Singh (MRD : 594676 ; IP : 18/218291), a 66 years old gentlemen, was admitted to B.L. Kapur Memorial Hospital on 06th April, 2018 at 02.24 p.m. with complaints of breathlessness and orthopnea. The patient had been discharged from Saroj Hospital, one day earlier. The patient was initially admitted at the Saroj Hospital on 27th March, 2018 with acute anterior wall myocardial infarction with cardiogenic shock and the patient underwent primary Percutaneous Transluminal Coronary Angioplasty (PTCA) to Left Aanterior Descending (LAD). The patient was readmitted at Saroj Hospital on 01st April, 2018 with shortness of breath and hypotension, for which, the patient was managed conservatively and discharged on the same day. It may be noted that this was the third hospitalization with ongoing complaints of breathlessness and orthopnea within last twelve days. On evaluation, ECG revealed qRBBB pattern. Troponin he was 3760 pg/(normal range < 34.0 pg/ml) even after twelve days of index event indicating that a re-myocardial infarction might have occurred. The NT pro BNP was 16067 pg/ml (normal range < 376 pg/ml). Screening echocardiography done on 07th April, 2018 revealed that the degree of severity of mitral regurgitation was worsening as compared to earlier screening ECHO. In view of left ventricular dysfunction, worsening mitral regurgitation (MR) (? ischemic), persistently raised troponin I with signs of left ventricular failure(LVF) clinically and no improvement on medical management since index procedure on 27th March, 2018 at the Saroj Hospital, the decision of early invasive evaluation was discussed with the family and after the family consented for the procedure, the patient was taken-up for coronary angiography (CAG). CAG revealed significant stenosis in left circumflex artery(LCX) and right coronary artery (RCA) with the patient (angiographically and ECHO evaluation showed that LAD territory was akinetic and scarred). After discussion with family members of the patient and after proper consent, it was decided to vascularize the LCX and RCA with a hope that this will improve the LV functions and reduction in intensity of mitral regurgitation. In the Cath lab, the PTCA of LCX was done successfully with achievement of TIMI 3 flow. The patient, however, became increasingly tachypneic with pink froathy sputum. In view of the same, the patient was immediately placed on Intra-aortic balloon pump (IABP) support and was electively intubated and ventilated. The patient, however, did not improve and developed sudden bradycardia. Immediately CPR was started but the patient could not be resuscitated. The check angiography during CPR revealed that stent thrombosis of both LCX and LAD stents, the probable cause being low flow state following cardiac arrest. Plain optimal balloon angioplasty (POBA) to both vessels were done with ongoing CPR and flow was achieved (TIMI II). He would like to reiterate that the patient had a poor prognosis from the time of admission to Dr. B.L. Kapur Memorial Hospital due to elderly age group, recent MI with cardiogenic shock (approximately a fortnight ago), recent re-MI(raised Trop I after two weeks of index event), severe persistent heart failure (two readmissions after index admission of MI), worsening severe LV dysfunction (LVEF 25%) and persistently worsening mitral regurgitation (as compared to echo two days ago). In view of the above, it is submitted that the patient was managed as per the university standards of medical care.

He further stated that the patient Shri Surat Singh was initially admitted at Saroj hospital on 27th March, 2018 with acute anterior wall MI with cardiogenic shock and underwent coronary angiography, which revealed double vessel disease and primary percutaneous transluminal coronary angioplasty of left anterior descending artery. The patient was discharged on 31st March, 2018. The patient was readmitted at Saroj Hospital on the very next day i.e. 1st April, 2018 within hours of discharge with complaint of shortness of breath and hypotension (BP-70/40 mm Hg), where the patient was managed conservatively and was discharged on 5th April 2018. The patient, later came to the Department of Emergency of Dr. B. L. Kapur Memorial Hospital on 6th April 2018 with similar complaints of breathlessness and orthopnoea. On evaluation, the patient’s ECG revealed qRBBB pattern with persistent ST elevation, which signifies infarcted and aneurysmal LAD territory. Trop I was 3760 pg/mI(normal range is less than 34 pg per ml) indicates likely re- myocardial infarction. NT Pro BNP was 16067 pg per ml, (normal range was 376 pg/ml). Echo was done on 07 April, 2018, which revealed akinetic LAD territory and the degree of severity of mitral regurgitation, was worsening with LVEF of 25% (Severe LV dysfunction). Initially, the patient was managed conservatively in ICCU and after some improvement, the further possible treatment options were discussed with the family members. High risk nature of the disease, poor prognosis of the patient with myocardial infarction with cardiogenic shock, refractory heart failure and high risk cath procedure were discussed with the family members in detail and the informed consent was duly signed by Mr. Harish, son of the patient (the complainant). He (Dr. Satbir Singh) would like to reiterate that the patient had a poor prognosis from the time of admission to Dr. B. L. Kapur Memorial Hospital due to elderly age group, recent MI with cardiogenic Shock (approximately a fortnight ago), recent Re- MI(raised Trop I), severe persistent heart failure (two re-admissions after index admission of MI within a span of 12 days), worsening severe LV dysfunction (LVEF 25%) and persistently worsening mitral regurgitation. It is also submitted that the patient had severe recurrent refractory heart failure and the patient was admitted thrice to the hospital in two weeks’ time. This is further submitted that aggressive revascularization was the best possible solution to improve the outcome of the patient as per standard practice based on medical literature. Thus, in view of the risk factors and likely poor outcome without revascularization, an attempt to re-evaluate coronary anatomy was made and revascularization was attempted after detailed discussion of the risks with family and giving them an option of the conservative medical management. This procedure was undertaken only after the consent of family in writing. However, the patient developed acute de-compensation immediately after LCX angioplasty. The patient was started on intra-aortic balloon pump support and was electively intubated. While intubation, the patient had bradycardia and cardiac arrest, for which, CPR was started immediately in the cath lab itself. However, the patient succumbed and could not be revived. It may be noted that the findings of post mortem report on page no. 6 under the heading Heart shows around 300 ml of blood was present within pericardial sac. Heart appeared to be enlarged and globular in shape. A bulbous aneurysmal dilatation, of size 8 cm x 5 cm, was present over the anterolateral aspect of left ventricle situated 2.0 cm above apex." and page no. 8 under the heading opinion shows cause of death: on this case is due to cardiogenic shock due to cardiac tamponade as a result of left ventricular wall aneurysmal dilatation and rupture in a case of myocardial infarction consequent upon coronary artery disease. Hence, it is evident that revascularisation of the LCX was not responsible for terminal event of the patient, as the cause of death was aneurysmal dilatation and rupture which was present on the anterolateral wall above apex due to acute myocardial infaction with cardiogenic shock on 27th March, 2018 and findings of post mortem clearly shows that it was not related to revascularisation of the LCX. The reference from medical journal "The New England- Journal of Medicine" Functional left ventricular aneurysm formation after acute anterior transmural myocardial infarction. Incidence, natural history, and prognostic implications mentions natural history of LV aneurysms in the article by Dr. Jay L Meizlish et al.(1984 Oct 18;311(16):1001-6). One-year mortality was 61 per cent in patients with LV aneurysm (55 per cent of these deaths in this group of patients were sudden) and 3 percent in patients without LV aneurysm. The patients with a functional aneurysm appearing within 48 hours had the highest risk of dying (8 out of 10 i.e. 80%). Another article published in J Thorac Dis. 2021 Mar;13(3): 1706-1716. Predictors and long-term prognosis of left ventricular aneurysm in patients with acute anterior myocardial infarction treated with primary percutaneous coronary intervention in the contemporary era by Jieyun You et al which has given conclusion that LVA is still common in patients with acute anterior myocardial infarction in the contemporary PCI era, and the prognosis of these patients was significantly worse during the one-year clinical follow-up. Strategies of prompt reperfusion and complete revascularization may be helpful in preventing LVA formation and improving clinical outcomes. The patient Shri Surat Singh was a high-risk patient category and it was well informed to the family members that the patient was refractory to medical management, despite repeated admissions and only after detailed discussion with the family members, further procedure was decided post seeking high risk consent in writing. In view of the above, it is once again submitted that he has followed the Standard Operating Procedure and the patient was managed as per the established principles of medical care and had neither been deficient nor negligent in discharge of his duties.

Dr. Subhash Chandra, HOD-Department of Cardiology, BLK Super Speciality Hospital stated that the patient late Shri Surat Singh was admitted under Dr. Satbir Singh and all the treatment was provided by Dr. Satbir Singh. He, being head of department, only reviewed the line of treatment and the case was discussed with him alongwith all department cases.

He further stated that he agreed with the written statement and written submissions filed by Dr. Satbir Singh.

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

1. It is noted that the patient Shri Surat Singh, 66 years old male presented to the said Hospital on 06th April, 2018 with complaints of shortness of breath and suffocation since one week. The patient was known case of CAD (Coronary Artery Disease) recent anterior wall MI(Myocardial Infarction) with cardiogenic shock. The patient had undergone PTCA (Percutaneous Transluminal Coronary Angioplasty) to LAD(Left Anterior Descending Artery) at the Saroj Hospital on 27th March, 2018. All the investigations were done and the patient was found to be in acute left ventricular failure. The patient was maintained on anti-platelets, statins, diuretics and other supportive treatment. Review echo revealed LVEF (Left Ventricular Ejection Fraction) 25 % with mild to moderate MR (Mitral Regurgitation). Written consent of the patient was taken and the coronary angiography was done, which revealed critical LCX (Left Circumflex) and RCA (Right Coronary Artery) lesion with patent LAD stent. After discussion, the patient was taken-up for PTCA to LCX and RCA. Following LCX PTCA, the patient developed acute pulmonary edema, which was managed accordingly and IABP (Intra-Aortic Balloon Pump) was inserted, procedure for RCA was postponed. The patient suddenly developed pink frothy sputum fifteen to twenty minutes after the procedure and the patient was intubated and put on mechanical ventilator. The patient developed bradycardia and hypotension. CPR was initiated. Access for coronary angiography was taken from left groin with CPR continuing. Coronary angiogram done which revealed thrombus in LAD and LCX. POBA (Plain old Balloon Angioplasty) was done to LAD and LCX and finally TIMI 2-3 flow was achieved in both the arteries. TPI was inserted, CPR continued and the patient was shifted to ICCU. The patient was received in ICCU with blood pressure not recordable and the monitor showing HR (heart rate) 100/min on TPI. The CPR was continued for forty five minutes. Despite all resuscitative efforts, the patient could not be revived, hence, declared dead at 03.59 p.m. on 07th April, 2018. The cause of death as per postmortem report no. 302/2018 dated 09.04.2018 of Maulana Azad Medical College was cardiogenic shock due to cardiac tamponade as a result of left ventricular wall aneurysmal dilation and rupture in a case of Myocardial Infarction and coronary artery disease.
2. The patient late Shri Surat Singh had extensive anterior wall myocardial infarction. After MI (Myocardial Infarction), he was having recurrent LVF due to poor LV function. It is pertinent to note that the patient was advised only medical management during readmission at Saroj Hospital on 01st April, 2018. He presented to BLK Super Speciality Hospital with complaints of breathlessness and suffocation. It is noted that as per the informed consent dated 07th April, 2018 of BLK Super Speciality Hospital, the patient/attendant were briefed about the alternative management, however, it is apparent that they chose to undergo the surgical procedure of coronary angioplasty, as the consent for the same was given by the complainant Shri Harish Kumar. Dr. Satbir Singh that aggressive revascularization was the best possible solution to improve the outcome of the patient as per standard practice based on medical literature and thus, in view of the risk factors and likely poor outcome without revascularization, an attempt to re-evaluate coronary anatomy was made and revascularization was attempted after detailed discussion of the risks with family and giving them an option of the conservative medical management; in the facts and circumstances of this case, is found to reasonably acceptable.

In this particular case as per clinical symptoms and investigations mentioned in records, a clear indication to perform angioplasty could not be elucidated due to following reasons:-

1. There was no evidence of acute ischemia in other coronary territories at admission.
2. The Trop T may be raised due to severe LV dysfunction or as a result of recent MI.
3. NT ProBNP>16,000 pg/ml.

The patient might have benefited from intensive medical management with diuretics and other disease modifying medications. .

In light of the observations made herein-above, it the decision of the Disciplinary Committee that in the facts and circumstances of this case, Dr. Satbir Singh made an error in judgment in subjecting the patient Sh. Surat Singh to angiography and angioplasty, as under the prevailing medical condition of the patient, such a procedure was fraught with high risk of complications. He is, therefore, advised to exercise due diligence in selection of the cases, for performing angioplasty procedure, in future.

Matter stands disposed.

Sd/: Sd/: Sd/:

(Dr. Maneesh Singhal) (Dr. Anil Kumar Yadav) (Dr. G.S. Grewal)

Chairman, Eminent Publicman, Delhi Medical Association,

Disciplinary Committee Member, Member, Disciplinary Committee Disciplinary Committee

Sd/: Sd/:

(Dr. Vimal Mehta) (Dr. Bhagya Narayan Pandit)

Expert Member Expert Member,

Disciplinary Committee Disciplinary Committee

The Order of the Disciplinary Committee dated 29th March, 2022 was taken up for confirmation before the Delhi Medical Council in its meeting held on 29th April, 2022 wherein “*the Council observed that the matter be referred back to the Disciplinary Committee for re-consideration by observing “that as per records, the patient who had earlier undergone PTCA to LAD on 27th March, 2018 at Saroj Hospital and subsequently had to be readmitted on 01st April, 2018 with shortness of breathlessness and hypotension at Saroj Hospital; presented to B.L. Kapur Hospital on 06th April, 2018 with complaints of breathlessness and orthopnea, on investigations, ECG - qRBBB, Troponin T was significantly high 3760 pg/ml (normal range < 34.0 pg/ml), NT pro BNP 16067 pg/ml (normal range < 376 pg/ml), ECHO suggestive of worsening mitral regurgitation possibly ischemic; under these medical condition, can the possibility of re-myocardial infarction having occurred in the patient, be completely ruled out? Further, CAG reported on 07th April, 2018 revealed critical LCX and RCA lesion and the doctor having arrived at diagnosis of Acute Left Ventricular Failure, clinically, the decision to subject the patient to PTCA to LCX and RCA, under consent, after having discussed the alternative in form of medical management, as is evident from the Consent Form, to alleviate the condition of the patient; was it not within the clinical judgment of the treating cardiologist?*

*Once the Disciplinary Committee has determined the aforementioned issues, the matter be placed before the Council for consideration/confirmation”*

The Order of the Disciplinary Committee dated 29th March, 2022 in complaint No.2500 was taken up for re-consideration before the Disciplinary Committee of the Delhi Medical Council in its meeting held on 29th July, 2022 in terms of the Council minutes dated 29th April, 2022.

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

The Order of the Disciplinary Committee of the Delhi Medical Council dated 29th March, 2022 in complaint No.2500-a representation from Dy. Commissioner of Police, Central District, Delhi, seeking medical opinion in respect of death of Sh. Surat Singh, allegedly due to medical negligence, in the treatment administered to the deceased at BL Kapur Hospital, Pusa Road, Delhi, was taken up for re-consideration in terms of the Council minutes dated 29th April, 2022 wherein the Council observed that the matter be referred back to the Disciplinary Committee for re-consideration by observing “*that as per records, the patient who had earlier undergone PTCA to LAD on 27th March, 2018 at Saroj Hospital and subsequently had to be readmitted on 01st April, 2018 with shortness of breathlessness and hypotension at Saroj Hospital; presented to B.L. Kapur Hospital on 06th April, 2018 with complaints of breathlessness and orthopnea, on investigations, ECG - qRBBB, Troponin T was significantly high 3760 pg/ml (normal range < 34.0 pg/ml), NT pro BNP 16067 pg/ml (normal range < 376 pg/ml), ECHO suggestive of worsening mitral regurgitation possibly ischemic; under these medical condition, can the possibility of re-myocardial infarction having occurred in the patient, be completely ruled out? Further, CAG reported on 07th April, 2018 revealed critical LCX and RCA lesion and the doctor having arrived at diagnosis of Acute Left Ventricular Failure, clinically, the decision to subject the patient to PTCA to LCX and RCA, under consent, after having discussed the alternative in form of medical management, as is evident from the Consent Form, to alleviate the condition of the patient; was it not within the clinical judgment of the treating cardiologist?”*

On reconsideration, the Disciplinary Committee made the following observations.

1. In light of the prevailing medical condition of the patient at the time of admission in B.L. Kapur Hospital and investigations, the possibility of the patient having suffered re-myocardial infarction cannot be ruled out, and in view of the same, the significantly raised Trop T and NT pro BNP can also be attributed to the possible re-myocardial infarction.
2. In addition to medical management of this medical condition, the alternative method of treatment is Angioplasty (PTCA). It is apparent from perusal of the Consent Form that both the options were discussed and the PTCA procedure was done under consent.

In light of the observations made herein-above, the Disciplinary Committee expunges its following observations, as reflected in its earlier Order dated 29th March, 2022.

“*In this particular case as per clinical symptoms and investigations mentioned in records, a clear indication to perform angioplasty could not be elucidated due to following reasons:-*

1. *There was no evidence of acute ischemia in other coronary territories at admission. ii) The Trop T may be raised due to severe LV dysfunction or as a result of recent MI.*

*iii) NT ProBNP>16,000 pg/ml.*

*The patient might have benefited from intensive medical management with diuretics and other disease modifying medications.*

*In light of the observations made herein-above, it the decision of the Disciplinary Committee that in the facts and circumstances of this case, Dr. Satbir Singh made an error in judgment in subjecting the patient Sh. Surat Singh to angiography and angioplasty, as under the prevailing medical condition of the patient, such a procedure was fraught with high risk of complications. He is, therefore, advised to exercise due diligence in selection of the cases, for performing angioplasty procedure, in future.”*

It is, therefore, the opinion of the Disciplinary Committee that the decision to subject the patient to PTCA in this case, was well within the clinical judgment of the treating cardiologist, hence, no medical negligence can be attributed to him.

Matter stands disposed.

Sd/: Sd/:

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

Chairman, Delhi Medical Association,

Disciplinary Committee Member, Disciplinary Committee

Sd/: Sd/:

(Dr. Vimal Mehta) (Dr. Bhagya Narayan Pandit)

Expert Member Expert Member,

Disciplinary Committee Disciplinary Committee

The Orders dated 29th March, 2022 and 29th July, 2022 of the Disciplinary Committee, were placed before the Council in its meeting held on 10th August, 2022 for confirmation.

The Council after due deliberations, confirmed the Orders dated 29th March, 2022 and 29th July, 2022 of the Disciplinary Committee.

This observation is to be incorporated in the final Order to be issued. The Order of the Disciplinary Committee stands modified to this extent and the modified Order is confirmed.

 By the Order & in the name of

 Delhi Medical Council

 (Dr. Girish Tyagi)

 Secretary

Copy to :-

1. Shri Harish Kumar, 638, Ishwar Colony, Ranthavala Road, Bawana, Delhi-110039.
2. Shri Satbir Singh, Through Medical Superintendent, BL Kapur Hospital, Pusa Road, Delhi-110005.
3. Dr. Subhash Chandra, HOD, Cardiology, Through Medical Superintendent, BL Kapur Hospital, Pusa Road, Delhi-110005.
4. Medical Superintendent, BL Kapur Hospital, Pusa Road, Delhi-110005.
5. National Medical Commission, Pocket-14, Sector-8, Phase-1, Dwarka, New Delhi-110077-w.r.t. erstwhile Medical Council’s letter No.MCI-211(2)(Gen/)2018-Ethics/126609 dated 02.08.2018-**for information**.
6. Deputy Commissioner of Police, Central District, Delhi, Darya Ganj, New Delhi-110002-w.r.t. letter No.7148/SO/DCP/C(AC-II) dated Delhi the 27/06/2018-**for information.**

 (Dr. Girish Tyagi)

 Secretary