DMC/DC/F.14/Comp.2518/2/2023/ 02nd February, 2023

**O R D E R**

The Delhi Medical Council through its Disciplinary Committee examined a complaint of Shri Kripal Singh r/o 100-A, Shivam Enclave, Near Jhilmil Colony, Delhi-110032, forwarded by the Medical Council of India, alleging medical negligence in the treatment administered to the complainant’s wife Smt. Nirmal Kaur at Shanti Mukund Hospital, #2, Institutional area, Vikas Marg Extention, Karkardooma, Delhi-110092, resulting in her death on 30.03.2018.

The Order of the Disciplinary Committee dated 19th December, 2022 is reproduced herein-below :-

The Disciplinary Committee of the Delhi Medical Council examined a complaint of Shri Kripal Singh r/o 100-A, Shivam Enclave, Near Jhilmil Colony, Delhi-110032 (referred hereinafter as the complainant), forwarded by the Medical Council of India, alleging medical negligence in the treatment administered to the complainant’s wife Smt. Nirmal Kaur (referred hereinafter as the patient) at Shanti Mukund Hospital, #2, Institutional area, Vikas Marg Extention, Karkardooma, Delhi-110092 (referred hereinafter as the said Hospital), resulting in her death on 30.03.2018.

The Disciplinary Committee perused the complaint, written statement of Dr. Suneet Juneja Medical Superintendent of Shanti Mukund Hospital enclosing therewith joint written statement of Dr. K. K. Pandey, Sr. Consultant Pulmonary & Critical Care, Dr. K.C. Gupta, Consultant Medicine, Dr. Fateh Singh, Consultant Medicine Dr. Upendra Singh, Nephrologist, copy of medical records of Shanti Mukund Hospital and other documents on record.

The following were heard in person :-

1) Shri Kirpal Singh Complainant

2) Dr. Sumit Son of the Complainant

3) Dr. K.K. Pandey Consultant, Shanti Mukand Hospital

4) Shri Pawan Sharma Sr. Manager HR, Shanti Mukand Hospital

5) Dr. Fateh Singh Consultant, Shanti Mukand Hospital

6) Dr. Upendra Singh Consultant, Shanti Mukand Hospital

7) Dr. Amit Singh Sr. AMS, Shanti, Mukand Hospital

8) Dr. Sneh Jain Officiating Medical Superintendent, Shanti Mukand Hospital

Dr. Sneh Jain, Officiating Medical Superintendent, Shanti Mukand Hospital stated that the primary consultant in this case namely Dr. K.C. Gupta has expired.

The Disciplinary Committee noted that Shri Pawan Sharma Sr. Manager HR, Shanti Mukand Hospital presented before the Disciplinary Committee on behalf of Dr. K.C. Gupta (who was the primary consultant in this case), as Dr. K.C. Gupta has expired.

The complainant Shri Kripal Singh alleged that his wife (the patient) Smt. Nirmal Kaur, who was suffering from diabetes, hypertension was admitted to the Shanti Mukund Hospital on 19th March, 2018 with respiratory problems under the supervision of Dr. K.C. Gupta Unit. At the time of admission i.e. 19th March, 2018, all the vital parameters were normal viz. liver, kidneys, heart, as is evident from the hospital investigations. She was admitted in the ICU and put on BIPAP machine to exhale Carbone Dioxide retention in the body and for oxygen saturation. Her daily investigations indicated that her vital parts were normal. She was put on ventilator for one day on 20th March, 2018 and thereafter on BIPAP machine, till 28th March, 2018. During the course of the treatment, she was given antibiotics, which deteriorated her condition with the result that blood urea and S. creatinine got worsened day by day. He is of opinion that severe negligence occurred on 27th March, 2018 onwards, as a result of which, she expired on 30th March, 2018 with cardiac arrest. He also observed that blood started coming with urine output from 26th March, 2018, for which, no remedial actions were taken. He is also of the opinion that she suffered dehydration with undue antibiotics given caused her death.

Dr. Suneet Juneja, Medical Superintendent, Shanti Mukkand Hospital in his written statement averred that patient Smt. Nirmal Kaur was admitted in the hospital on 19th March, 2018 with the complaint of breathlessness since last night, one day cough, weakness, ghabrahat on admission. She had B/L crepts ++, rhonchi+, JVP, blood-pressure-310/130 mmHg, pulse-140/min, diagnosed with LRTI, pneumonia, LVF and ABG s/o CO @ retention (narcosis0 respiratory alkosis). The patient was a known case of hypertension; diabetes mellitus type 2 OSA with obsese, cellulitis leg, and chronic venous insufficiency. The patient continued to receive the treatment in the hospital up to 30th March, 2018. On perusal of the treatment record, as mentioned above, the Delhi Medical Council will kindly observe that the patient was provided all necessary treatment by a team of physicians, anaesthetist/intensivist pulmonologist/nephrologist all through during her stay in the hospital and based on necessary investigations, day to day treatment, as necessitated her medical condition was provided. Since the patient as was suffering DM type 2/DM type 2/HTN, cellulitis leg, LRTI, respiratory failure type 2 and being in critical condition, she was administered antibiotics in imperially and changed according to culture and sensitivity result. It is unfortunate that the patient could not be saved despite having provided all necessary treatment.

Dr. K. K. Pandey, Sr. Consultant Pulmonary & Critical Care, Dr. K.C. Gupta, Consultant Medicine, Dr. Fateh Singh, Consultant Medicine, Dr. Upendra Singh, Nephrologist, Shanti Mukund Hospital in their joint written statement averred that the patient Smt. Nirmal Kaur, age 68, female was admitted in Shanti Mukund Hospital on 19th March, 2018 with complaints of breathlessness since last night, cough, weakness, ghabrahat for one day. She is known case of DM type 2/HTN/morbid obesity, chronic venous insufficiency, cellulitis leg, OSA. She was admitted in hospital before also with same complaints. ON examinations, the pulse-104/min., blood-pressure-210/130 mmHg, JVP ↓, oedema feet +, chest-bilateral crepts was present, heart-S1 S2 (N), P/A-soft. In view of above findings, diagnosis of DM type 2, obesity, cellulitis leg, accelerated HTN with LVF/LRTI was made. The medicines were given as : O2 inhalation, injection Monocef 1 gm IV BD AST, injection Ondem 4 mg IV TDS, injection Pan 40 mg IV BD, injection lasix 40 mg IV stat, tablet Amlong 5 mg BD, tab. Arkamine 0.1 mg TDS, tab. Doxophyllin 400 mg BD, Duolin Resp. + Budecort Nebulization. On investigations, Hb was 10.4 gm%, TLC was 11.3, DLC N 86 L 7 M 6 E1, LFT was normal, urea was 29.1% mg%, S. creatinine-was 0.55, Na was 126, K-4.5, ECG-sinus tachycardia. On 19th March, 2018 at evening, the patient had loose motions and SPO2 was low. The patient was put on BIPAP and injection Monocef was stopped. Injection Tazar 4.5 gm IV TDS and injection Metrogyl were started. On 20th March, 2018, the patient’s general condition was poor,SPO2 was 82%, PCO2, 96 mmHg; the patient was intubated and put on ventilator with taking consent from the relatives. ECHO-LVEF was 55%, Hb was 9.8 gm%, TLC-12,200 and DLC N 89 L 7 E 0 M1. As the patient was serious went in type-II respiratory failure with increasing TLC count, antibiotics were changed, injection Tazar was stopped and injection Meropem 1 gm IV TDS was started. In the evening, the patient was on ventilator PCO2 46.5, SPO2-100% continue with same medicine. On 20th March, 2018, Dr. K.K. Pandey, Pulmonary Consulted and advised DVT prophylaxis injection Claxane was started and adjusted ventilator setting for type II respiratory failure. On 21st March, 2018, the patient’s general condition was better, the patient was conscious, blood-pressure was 130/80 mmHg. The patient was on RT feeding. Her potassium was 2.7 mg/lt, injection-kcl infusion was started. On 21st March, 2018, weaning from ventilator was started; PCO2 was started improving from 96 to 46, O2 was normal, PCO2 (N). The patient was extubated and put on BIPAP. The patient’s general condition was remained same. Intake/output was normal. On 22nd March, 2018, the general condition was same, the patient’s pulse-106/min, BP-150/90 mmHg, chest-rhonchi was present, and the patient was on BIPAP, tab. Claribid 500 mg BD added. Dr.K.K. Pandey saw the case and advised. BIPAP-AV APS, cap. Loftair OD, tab. Modalert. On 23rd March, 2018, the general condition was sick, weakness, on BIPAP 18.8, blood-pressure-160/90 mmHg, chest-rhonchi was present, PCO2 72.8, TLC 11,900/cmm, DLC-N 84 L 13 E1, temperature-100 degree F, as TLC was high and the patient was febrile. Changed the antibiotics to Polymixin B and injection Targocid, injection Meropenem was stopped. The attendant has been advised about critical condition of the patient. Intake was 1600 ml, output was 2000 ml. Pulmologist reviewed the patient SPO2 87 %, BP-120/80 mmHg. Changed BIPAP to ST mode ventilation and advised continue with chest physiotherapy and the same treatment. On 24th March, 2018, the patient was still serious, pulse-110/min, BP-140/80 mm Hg, chest-rhonchi + present. The patient was on BIPAP ventilator, NIV mode-PS NIV, urine output was good, NA-144, K-2.97 meq/lt. The patient had temperature 102 F, injection Paradrip was given. TLC justifies sepsis and need of higher antibiotics. On 25th March, 2018, the patient’s general condition was critical, the patient on BIPAP ventilator, NIV-PS NIV mode. Pulse was 96 min, BP was 120/80 mmHg, chest few rhonchi +, ABG PCO2-62.3. The patient had dark colour urine because of haematuria. Injection Claxane was stopped, bladder was done with 500 ml NS. The patient was injection Polymixin B, Claribid, injection Metrogyl and injection Targocid. Guarded prognosis was explained. On 26th March, 2018, the patient’s condition was still critical. The patient had fever, conscious following command, breathlessness, pulse-125/min, temperature-103 F, BP-130/80 mmHg, chest rhonchi + crepts present. The patient was on ventilator NIV, PSNIV mode, PCO2 60.1, PO2-60, TLC-7.3. Intake 2300 ml, output 2650. Urine colour was normal. The patient’s general condition was not improving, injection Magnex 3 gm IV BD was added, as the patient developing septicaemia. The blood C/S report, no growth. On 27th March, 2018, the patient’s general condition was same, the patient was conscious, following command, generalized weakness, pulse-113/min, BP-160/90 mmHg; oedema feet present temperature-101 F. The patient was ventilator BIPAP, Hb.-9.9 gm%, TLC-17,500/cmm. As the patient was on antibiotics as : injection Magnex Forte 3 gm IV BD, injection Polymixin B 5 lac units BD, tablet Claribid 500 mg and injection Targocid 200 mg BD. On 28th March, 2018, the patient’s general condition was poor, the patient was drowsy, respond to command, pulse-102/min, BP-160/80 mmHg, SPO2-90R% on BIPAP support connected with ventilator, chest-B/L basal crepts+, intake 2950, output 2100 ml. Urine colour was normal, injection Claxane was started as DVT prophylaxis. The pulmologist reviewed the patient. Prognosis guarded, advised injection Lasix, advised repeat blood C/S, urine C/S stop Candiforce and advised Voracanazole. The patient was on antibiotics as : injection Magnex Forte IV BD, injection Polymixin B, injection Targocid 200 mg BD and tablet Claribid was stopped. On 28th March, 2018 in the evening, the patient became more drowsy, SPO2 full to 75 %. The patient was intubated and put on ventilator by the anaesthetics team. ABG-pH-7.41, PCO2-75.3, PO2-46, injection-Hydrocortisone and Duolin, budecort nebulisation was given. On 29th March, 2018, the patient’s condition was critical, the patient was on ventilator, VCV mode, pulse-72/min, BP-90/60 mmHg, temperature-105 F, chest rhonchi +, Hb. 9.1 gm %, TLC-14,300/cmm, DLC- P 87 l10 M 2 E 1, urea-153, S. creatinine-2.72, Na-162, K-3.28. Injection Noradrenaline infusion was started. Chest physiotherapy, injection Paracetamol 1 gm IV stat, cold sponging injection Metrogyl, claribid was stopped. The patient was on antibiotics as : - injection Magnex 1.5 gm IV BD, injection Targocid 200 mg IV BD, injection Polymixin B. The patient developed septicaemia and acute kidney injury. The patient was reviewed by the pulmologist. Explain poor prognosis to the relatives. On 30th March, 2018, the patient’s general condition was critical, unconscious, pulse-88/min, BP-120/70 mmHg on nonadrenaline infusion, temperature-104 F, chest rhonchi was present. The patient was on ventilator PRVC mode. Intake 2300 ml/output was 1200 ml. Critical condition of the patient was explained to the relatives. ET trips C/S pseudomonas aeruginosa sensitive to colistin. Catheter tip C/S proteius mirabilis was grown. Blood C/S mixed growth of coagulase negative, staphylococci. X-ray chest-lungs haziness of both lower zones. Injection-Colistin advised and after reviewing the C/S reports. Urea-208.5, S. creatinine -4.4, Na-164, K-3.04, Hb.-8.9 gm% TLC-10,700/cm. Dr.Upendra Kumar, Nephrologist had seen the case and advised continue with injection Colistine 2 m.u. IV BD, injection Magnex 1.5 gm IV BD, injection Cefaperezone 1.0 gm IV BD, tablet Febutaz 40 mg BD. On 30th March, 2018 at 05.20 p.m., the patient had cardiac arrest, the patient was on ventilator, CPR was started and continued for 35 minutes. The patient could not be revived and declared dead at 05.55 p.m. It is unfortunate that the patient died inspite of all possible effort to save her. On 25th March, 2018, the patient had dark urine for that bladder wash was given and injection claxane was stopped, which was started for DVT prophylaxis. Later urine colour was normal and urine output was adequate. Her blood urea and S. cretinine start rising 28th March, 2018 onwards because the patient developed septicaemia and acute kidney injury. Through out the course of the treatment, the patient was in ICU, under care of Dr. K.C. Gupta and Dr. Fateh Singh, department of anaesthesia/interventionist, which are covering ICU round the clock. The patient was reviewed by the pulmologist Dr. K.K. Pandey and its unit. Dr. Upendra, Nephrologist was consulted, as she developed acute kidney injury. They have done every possible treatment to save the life of the patient. The patient was suffering from DM type 2/HTN, cellulitis leg, LRTI, respiratory failure type II. She was on ventilator, ryles tube feeding and for urination-foley’s cathether. Her general condition deteriorated day by day. She was in critical condition. She was given antibiotics imperially and changed according to culture and sensitivity result. The allegation that her condition deteriorated because of antibiotics is false and baseless. Their team did every possible effort to save the life of the patient. On 19th March, 2018, x-ray chest was normal. On 23rd March, 2018, portable film-both CP angle was blunted. On 26th March, 2018, (L) CP angle obscured. On 28th March, 2018, (L) CP angle was blunted, subtle haziness (R) lower zone and central venous line was in situ. On 19th March, 2018, USG whole abdomen-liver was medley enlarged. and fatty changes liver, GB post-op status. On 19th March, 2018, Echo-LVEF was 55%. On 28th March, 2018, procalcitonin level was 0.67 ng/ml. On 23rd August, 2018, blood culture and sensitivity: sterile after two days of incubation at 37 degree C and Final report : mixed growth of coagulase negative staphylococci and diplitheriods. On 30th March, 2018, catheher tip C/S-organism proteins mirabilis, ET trip culture and sensitivity-organism isolated-pseudomonas aeruginosa.

It is further averred that D-dimmer assary was not done. The patient was already on LMWH (injection Clexane). D-dimmer is a non-specific test, the patient with sepsis can have positive D-dimmer assay. Their clinical assessment was in favour of type respiratory failure due to COPD and OSA HS rather than PE. On 21st March, 2018, venous Doppler request for venous Doppler B/L lower limb was sent. The radiologist came and did venous Doppler but due to poor visualization on portable machine due to obesity, it could not be done and it was advised by the radiologist to send the patient to radiology department, if the condition permits. Since the patient had already been started on Clexane (DVT prophylaxis) and DVT pump and her general condition was poor, so she was not sent next day for Doppler. CP angio for pulmonary embolism was not done because the patient was critically ill and she was not position for shifting to CT scan department, the patient was on DVT prophylaxis. The patient was also admitted in the hospital in September, 2017 from 27th September, 2017 to 12th October, 2017. Diagnosis was : diabetes mellitus type 2 2/HTN/obesity/cellulitis both legs, chronic venous insufficiency, OSA, anaemia. The patient had swelling leg, breathlessness. Venous Doppler was done, it was normal. The details of medicines are as : -Cap. Loftair (Indacaterol 110 mcg + glycopyrronium 50 mcg) by inhaler, tab. Modalert (Modafinil), these are given for COPD and OSA. The patient was on injection Meropenem IG IV TDS. It was stopped on 23rd March, 2018. The patient was running temperature and had leucocytosis; the above antibiotics were changed to injection Polymixin B and injection Targocid. The patient was put on ventilator on 20th March, 2018 when PCO2 was 96. On 21st March, 2018, PCO2 decreased from 96 to 46, so it was justified to extubate the patient and put her on BIPAP to prevent VAP (Ventilator Associated Pneumonia) and, therefore, was maintaining PCO2 of 60, which is acceptable for COPD and OSA patient. The patient was a known case of COPD with OSA and she was on NIV support, she showed good response clinical and biochemical ↓ PCO2 after augmenting NIV setting. She did not require elective ventilator support, however, ventilator was kept stand by. She was on a BIPAP and chest physiotherapy from 22nd March, 2018 to 27th March, 2018, she was maintaining PC02 of around 60. On 28th March, 2018 when PCO2 rose to 75, she became drowsy; she was again intubated and put on ventilator support. All these were done, according to protocol and they did not deviate from the standard method of ventilatory management.

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

1. It is observed that the patient Smt Nirmal Kaur, 68 years old female, was admitted in the said Hospital on 19th March 2018 with complaint of breathlessness, cough, weakness and ghabrahat. She was a known case of hypertension, diabetes mellitus type 2, OSA with morbid obesity, cellulitis leg and chronic venous insufficiency. She was critically ill and was managed in ICU by a team of physicians, anaesthetist/intensivist pulmonologist/nephrologist all through during her stay in the hospital and based on necessary investigations. The guarded prognosis was explained. During the course of management, she was administered antibiotics empirically and they were changed according to culture and sensitivity result. She also had an episode of haematuria, for which, injection Clexane was promptly stopped and bladder wash was given. Subsequently, the patient developed sepsis along with renal failure and could not be saved.
2. It is observed that the patient was examined, investigated and treated as per accepted professional practices in such cases. The patient died due to her underlying condition, which carried a poor prognosis, inspite of being administered adequate treatment.

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 Shanti Mukand Hospital, in the treatment administered to the complainant’s wife Smt. Nirmal Kaur.

Complaint stands disposed

 Sd/: Sd/: Sd/:

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

Chairman, Delhi Medical Association Expert Member,

Disciplinary Committee Member, Disciplinary Committee

 Disciplinary Committee

 Sd/:

(Dr. Vishnu Datt),

Expert Member,

Disciplinary Committee

The Order of the Disciplinary Committee dated 19th December, 2022 was confirmed by the Delhi Medical Council in its meeting held on 21st December, 2022.

 By the Order & in the name of

 Delhi Medical Council

 (Dr. Girish Tyagi)

 Secretary

Copy to :-

1. Shri Kripal Singh r/o 100-A, Shivam Enclave, Near Jhilmil Colony, Delhi-110032.
2. Dr. K.K. Pandey, Through Medical Superintendent, Shanti Mukund Hospital, #2, Institutional area, Vikas Marg Extention, Karkardooma, Delhi-110092.
3. Dr. K.C. Gupta, Through Medical Superintendent, Shanti Mukund Hospital, #2, Institutional area, Vikas Marg Extention, Karkardooma, Delhi-110092.
4. Dr. Fateh Singh, Through Medical Superintendent, Shanti Mukund Hospital, #2, Institutional area, Vikas Marg Extention, Karkardooma, Delhi-110092.
5. Dr. Uprendra Singh, Through Medical Superintendent, Shanti Mukund Hospital, #2, Institutional area, Vikas Marg Extention, Karkardooma, Delhi-110092.
6. Medical Superintendent, Shanti Mukund Hospital, #2, Institutional area, Vikas Marg Extention, Karkardooma, Delhi-110092.
7. National Medical Commission, Pocket-14, Sector-8, Phase-1, Dwarka, New Delhi-110077-w.r.t. erstwhile Medical Council of India’s letter No.MCI-211 (2) (Gen.)/2018-Ethics./123456 dated 16th July, 2018-**for information.**

 (Dr. Girish Tyagi)

 Secretary