DMC/DC/F.14/Comp.2594/2/2022/ 18th November, 2022

**O R D E R**

The Delhi Medical Council through its Disciplinary Committee examined a complaint of Shri Pradeep Kumar, s/o Shri Jagmohan Lal, r/o 1595, Pana Mamurpur, Narela, Delhi-110040 alleging medical negligence on the part of Dr. K.K. Jindal of Maharaja Agrasen Hospital, West Punjabi Bagh, New Delhi-110026, in the treatment of the complainant’s wife, resulting in her death.

The Order of the Disciplinary Committee dated 04th October, 2022 is reproduced herein-below :-

The Disciplinary Committee of the Delhi Medical Council examined a complaint of Shri Pradeep Kumar, s/o Shri Jagmohan Lal, r/o 1595, Pana Mamurpur, Narela, Delhi-110040 (referred hereinafter as the complainant) alleging medical negligence on the part of Dr. K.K. Jindal of Maharaja Agrasen Hospital, West Punjabi Bagh, New Delhi-110026(referred hereinafter as the said Hospital), in the treatment of complainant’s wife Smt. Nisha Mittal, resulting in her death.

It is noted that the Delhi Medical Council has also received a representation from the Dy. Commissioner of Police, West District, Delhi, whose subject matter is same as that of complaint of Shri Pradeep Kumar, hence, the Disciplinary Committee is disposing both of these matters by this common Order.

The Disciplinary Committee perused the complaint, written statement of Dr. Mamta Jain Medical Superintendent of Maharaja Agrasen Hospital enclosing therewith written statement of Dr. K.K. Jindal, copy of medical records of Maharaja Agrasen Hospital and other documents on record.

The following were heard in person :-

1) Shri Pradeep Kumar Complainant

2) Shri K.K. Jindal Director Neurology, Maharaja Agrasen Hospital

3) Shri K.D. Sharma Record Clerk, Maharaja Agrasen Hospital

4) Dr. S.S. Srivastava Jt., Medical Superintendent, Maharaja Agrasen Hospital

The complainant Shri Pradeep Kumar alleged that on 15.08.2018, his wife late Smt Nisha Mittal (the patient) complained of sudden onset of facial deviation towards left side and slurring of speech, pursuant to which, he got his wife admitted in Maharaja Agrasen Hospital. The patient got admitted in the Hospital, under the supervision and care of Dr. K.K. Jindal and the doctor advised him and his family members that the patient should undergo tests including but not limited to MRI, Biochemistry, Haematology1, Clinical Pathology etc., to better understand the condition of the patient. Subsequent to the tests conducted by the hospital, the MRI suggested that the patient is having Hyperacute infarct right parietal and acute infarct left parietal region, due to which, the left side of her body was under paralysis. Further, the NCCT Head Test report conveyed “III defined hypodense areas are seen in right cerebelium and bilateral parietal lobes” and the same implied that the condition of the patient was critical and she was in need of immediate medical attention. Considering the situation, the doctor advised them to get the patient admitted in Intensive Care Unit (ICU) at the earliest and the needful was done on 15.8.2018 itself. It is pertinent to mention that he gave an advance of Rs.20,000/-at the time of admitting the patient in the hospital. It is submitted that he alongwith his family members represented to the Hospital that they belong to economically weaker section(EWS) of the society and hence, would not be able to bear all the expenses charged by the hospital for the treatment of the patient. Therefore, he requested for waiver*/*reduction in the said expenses. Thereafter, on 16.8.2018, more tests were conducted in the hospital and the report pertaining to Echocardiography and Colour Doppler suggested that the patient is having normal size LV with no LV regional Wall Motion abnormality with LVEF of 60% with LV Diastolic Dysfunction, therefore, the doctor conveyed him that the health of the patient is extremely critical and is deteriorating. The doctor further told him that the patient is required to be kept in ICU, till her condition improves. Since, there was no improvement in the health of the patient, the doctor gave direction to the hospital to put the patient on ventilator. Irrespective of heavy doses of medicines being administered to the patient, the condition of the patient worsened. Thereafter, the doctor advised the patient to undergo more tests in the Hospital. Pursuant to the same, MRA of Brain and Neck was conducted on 17.8.2018 and it showed that there exists no Definiate Vascular Abnormality. It is submitted that irrespective of the treatment administered by the doctor, his wife was still under immense pain. Therefore, he alongwith his family members went to another doctor namely Dr. S.K. Sogani, Sr. Consultant (Neurosurgery) in Institute of Neurosciences on 17.8.2018, to take second opinion. It is submitted that Dr. S.K. Sogani opined that since the patient is not recovering, she may be given Clexane Injection and Homocheck tablet and it was further advised that the patient should undergo CT Scan*/*MRI at the earliest. Subsequently, he alongwith the family members of the patient met the doctor and shared with him the opinion/suggestions as was put forward by Dr. S.K. Sogani. On hearing the same, the doctor lost his temper and stopped attending to the patient. Further, the doctor got furious and told him that the patient will pay the price of taking second opinion. The doctor thereafter became extremely insensitive and started claiming that the patient is fit to be discharged. The doctor further claimed that certain tests would be conducted before the patient is discharged from the hospital. It is submitted that he was shocked to hear the statement made by the doctor that patient is fit to be discharged, as on the contrary the patient was not responding and was on ventilator. Therefore, considering the situation, it is impossible to comprehend as to how doctor could even think of discharging the patient in such condition. He requested the doctor that since the patient is not fit, therefore, she should not be discharged. Further, he alongwith his family members were already in trauma because of the medical condition of the patient and by the acts and deeds of the doctor, the situation became more traumatic. On 17.8.2018, certain tests i.e. Haematology1, Biochemistry etc. were conducted. The former test reflected that the Lymphocytes and Eosinophilis were low, thereby implying that the patient was still weak. However, the doctor refused to pay any heed to his request and was hell bent on discharging the patient. The condition of the patient was not stable and since his financial condition is not good, therefore, he sought waiver under EWS category and on hearing this, the doctor and the hospital staff shifted the patient to general ward on 17.8.2018. At the time when the doctor intended to discharge the patient, the doctor again asked the patient to undergo more tests and few tests were conducted on 18.08.2018 in the hospital itself, however, there were other tests for which the doctor stated that since the facilities pertaining to the same were not available in the hospital, therefore, he should take the patient and get the said tests conducted at Dr. Lal Path Labs. It is pertinent to mention that the doctor and the administrative staff of the hospital were aware about his financial condition and yet, the doctor and the administrative staff of the hospital in collusion with each other, made attempts to create situation whereby, he alongwith the patient leave the Hospital. He was unable to pay for the tests and had consulted another doctor for second opinion; the doctor became adamant and persuaded his to get the patient discharged as soon as possible. It is submitted that doctor conveyed to the administrative staff of the Hospital that the patient had fully recovered and in view of the same, get the patient discharged immediately. However, the condition of the patient was not stable and she had already spoken to doctor that she was feeling extremely unwell. Irrespective of the health of the patient, the doctor forced the patient to get discharged from the Hospital, as according to the doctor, the health of the patient had improved and her condition was stable. He made repeated request to the doctor and the administrative staff of the Hospital to attend to the patient and not to discharge her, as one could see that she was not in a condition to get discharged. The repeated requests fell on deaf ear and the Hospital discharged the patient on 20.8.2018. Pursuant to the same, the doctor said that they may now get the treatment done by Dr. S.K. Sogani, as she would be able to bear your tantrums. He further said that the Hospital does not cater to patients, who are unable to bear the expenses for the treatment. It is to be noted that the doctor in connivance with the administrative staff of the hospital had discharged the patient on 20.8.2018 and the same is evident vide bills dated 20.8.2018 which bears the time of discharge i.e. 9:28 a.m., however, the discharge report/summary issued by the hospital shows the date of discharge to be as 17.8.2018. It is reiterated that the doctor and the administrative staff of the Hospital were aware about the condition of the patient and knew that there were chances that if the patient is not treated properly, then, she may not survive, as her condition was extremely critical. It is reiterated that the patient got discharged on 20.8.2018 at about 10.45 a.m. even when patient had already suffered an attack on 19.8.2018, but the staff of the hospital did not attend to the patient as the doctor had endorsed on papers to discharge the patient. Since the condition of patient was not stable and she was finding it difficult to breathe, repeated request were made to provide ambulance but it was denied to him. At the time of discharge, the hospital made a bill of Rs. 1,35,725/-*,* which was duly paid by him. It is reiterated that he was not in a condition to pay the said amount; however, the same was done after taking loan/loans from other members of the family. The entire process was extremely harassing for him and his family members. It is submitted that pursuant to her discharge from the hospital, the health of the patient worsened as she felt extremely uneasy and for the same reason was rushed to another hospital (Janakpuri Super Speciality) on the same date of her discharge i e. 20.08.2018*.* The patient midway stopped reacting*/*responding. Since the patient was not responding, the doctors in the Janakpuri hospital stated that there has been negligence on part of the hospital, as she was not fit and/or in a condition to be discharged. It is pertinent to mention that the patient after getting discharged expired within one hour. It is to be noted that the doctor behaved in most rude and unethical manner as he forced him to take his wife in his car to another hospital i.e. Janakpuri Super Speciality Hospital without even considering the fact that without an ambulance, the conditions of the patient will deteriorate further. The act of discharging the patient by the doctor and the administrative staff of the hospital was unprofessional as both were aware that the patient was not fit to be discharged, as her condition had deteriorated over a period of time. The negligence on the doctor is apparent, as the patient after getting discharged expired within one hour. It is stated that the doctor did not follow the standard procedure and failed in performing his duties diligently. It is pertinent to mention that the doctor treated the patient differently and did not pay requisite attention to her. It is stated that it is the duty of the doctor to give his best and save lives, however, the doctor behaved in a most unethical manner and the same reflects that the doctor has no respect for the Nobel profession and for himself. It is because of the conduct of the doctor that great loss occurred to his family. It is submitted that he have one school going child, aged about thirteen years and will now be deprived of love and affection of his mother. It is submitted that the untimely demise of his wife has created void in his family. The acts and deed of the doctor has caused immense pain to their family members and the loss cannot be compensated in any manner. He would like to state that the doctor should not have handled the present case so casually, as the act of the doctor led to untimely demise of his wife. It is the responsibility of the doctor to ensure that patients are discharged only after they have fully recovered. The basic principle was not applied in the given situation and it must always be considered that diligence does not equal perfection but it can help doctors to save lives. In view of the above, strict action may kindly be taken against Dr. K.K. Jindal, whereby, his license should be cancelled, as he has acted in a most unethical negligent manner thereby, reflecting that he has no respect for his profession or himself.

Dr. K.K. Jindal, Consultant, Neurologist, Maharaja Agrasen Hospital in his written statement averred that as per hospital record patient namely Smt. Nisha Mittal aged 37 years, female was admitted in the Maharaja Agrasen Hospital, Punjabi Bagh, New Delhi 110026 on 15.08.2018 vide IP No. 1832693 as General patient in economy category on payment mode of cash basis. At the time of admission, the complainant declared their family income Rs.25,000/- per month in admission details form. The patient was admitted with complaints of sudden onset of facial deviation and left sided weakness and she was a known case of Type 2 Diabetes Mellitus for last two years. At the time of admission in the hospital, on examination, the patient was found to have left sided hemiparesis with facial palsy. Power was 3/5 in left upper and lower limb, the patient was conscious and oriented but speech was dysarthric, so clinical diagnosiss of acute stroke was made and as she was in window period so according to stroke protocol, immediately, all necessary investigations including CT scan and Magnetic Resonance Imaging (MRI) was done. MRI showed hyper acute infarct in right MCA territory & acute infarct in left parietal lobe, as she was required for Intravenous (IV) thrombolytic therapy, the family members of the patient were counseled and consent was taken and IV thrombolysis was done and she was managed in ICU according to stroke protocol of IV thrombolytic therapy. The patient was advised ICU admission as per stroke protocol. The patient got admitted in ICU according to admission process of hospital. The complainant has complained that he requested for waiver under EWS category. In this respect, it is submitted that the complainant himself filled the details of the patient at the time of admission, and family income of Rs. 25,000/- and other column in the admission form. It is submitted that the complainant opted economy category for admission in the hospital. The treating doctor(s) as per the protocol for Acute Ischemic Stroke managed the patient in ICU (Intensive Care Unit). Some more investigations were conducted in the hospital on 16.08.2018. 24 hours after thrombolysis, repeat NCCT head was done which was showing infarct without any bleed or mass effect, so accordingly antiplatelet drugs were started as per protocol. Simultaneously the patient was investigated for the cause of stroke (2 D Echo, Carotid Doppler, Lipid Profile, HBA1C, Vitamain-B12, Serum Homocycteine) and following investigations were done as a protocol for Ischemic Stroke. The complainant and other family member of the patient were explained in details about the short term and long term prognosis in vernacular language and need of the investigations. It is further submitted that work up for hypercoagubility and vaculitic profile (ANA, C-ANCA, P-ANCA, Protein -C, Protein -S, Anti thrombin -Ill, Factor V leiden, Antiphospholipids antibody) was also advised as patient was a case young stroke but, the same was denied by the complainant/family member/attendants and negative consent was given for the same. Further, it is submitted that the complainant mentioned wrong averments before the Delhi Medical Council. It is submitted that the patient was never put on ventilator at any point of time during stay in the hospital. The complainant has complaint that patient underwent more tests in the hospital on 17.08.2018. It is submitted that on 17.08.2018 the patient was evaluated on morning rounds, showed improvement in power of left side & Dysarthria was better, was hemodynamically stable & blood sugar was also controlled. Physiotherapy and DVT prophylaxis was going on as per ICU protocol and advised mobilization out of bed on same day. Further test like MRA Brain and neck vessels were advised as routine workup for young stroke. It is further submitted that the complainant and/or family member of the patient on their own wished to get the second opinion, they agreed for that in view of complicated nature of illness which she suffered and provided them the case summary for second opinion on same day. It is further submitted that the patient’s attendant obtained second opinion from Neuro Surgeon, Dr. S.K. Sogani on 17.08.2018 and the said doctor also agreed that treatment which has been provided to the patient in the hospital is according to Standard Medical Protocol. It is incorrect that the doctor stopped attending to the patient. The allegation regarding doctor got furious and told to the complainant that patient will pay the price of taking second opinion is vehemently denied and allegations are levelled afterthought.The patient got LAMA (Left Against Medical Advice) on 17.08.2018 around 05.10 p.m. The complainant has paid a total sum of Rs.1,35,725/- against bill no 18020345 dated 17.08.2018 towards the treatment charges of the patient. It is submitted that a discount of Rs. 30,674.28 was allowed in the final bill. It is further submitted that the patient again came to casualty of the hospital and patient was admitted in the hospital on 17.08.2018 vide IP No. 1833100 as EWS patient & the complainant declared his Family Income Rs.7,000/- per month in the admission details form this time. The complainant declared his family income as Rs.25,000/- per month on 15.08.2018 in the admission detail form. It is submitted that work up for hypercoagubility and vaculitic profile (ANA, C-ANCA, P-ANCA, Protein -C, Protein -S, Anti thrombin-III, Factor V leiden, Antiphospholipids antibody) was also advised, as the patient was a case of young stroke. Further, it is, specifically submitted that some tests are not available in the hospital lab and as per hospital protocol the tests which are not available in the hospital lab, the blood samples for these tests are sent to Dr. Lal Path Lab and patients have to get these tests done on their own cost. They asked for the consent to the attendant of thepatient for the same. Further, it is submitted that the treating doctor did all the treatment as per the protocol of the hospital. It is further submitted that the tests to be done in the Dr. Lal Path Lab were denied by the complainant/family members/ attendants and negative consent was given for the same on 18.08.2018 at 10:30 a.m. It is specifically denied that administrative staff of the hospital was in collusion with the treating doctor/undersigned. On 18.08.2018 at morning rounds in ICU, the patient was found to be clinically stable assessed by treating doctor and ICU team of the hospital. The patient was advised normal diet, Intravenous fluids were stopped and mobilization out of bed and on same day ward shifting was advised. It is further submitted that on 19.08.2018 on morning rounds in the ward, the patient was clinically stable. MRA Brain and Neck vessels reports were also normal, hence, discharged was planned for coming morning. This is to emphasize that this is with complete compliance of hospital protocol wherein the patients are planned to discharge one day prior if patient is fit for that; so as to smoothen the process of discharge without any delay. This protocol also helps family members to be well informed and prepare for discharge. It is further submitted that on 20.08.2018, the patient was assessed on morning rounds and found to be clinically stable and was discharged. It is specifically denied that the hospital does not cater to the patients, who are unable to bear the expenses for the treatment. Infact, the hospital management provides free treatment to the large number of eligible patients who are unable to bear the expenses for the treatment in view of its charitable hospital. It is submitted that the patient was discharged on the basis of the medical reports/tests and the clinical condition of the patient was stable. It is incorrect that patient suffered an attack on 19.08.2018 and staff of the hospital had not attended the patient. These allegations are false and concocted. Infact, the patient was treated according to standard medical protocol and all available facilities provided to the patients. It is specifically denied that the treating doctor discharged the patient as per the connivance of the administrative staff of the hospital. It is specifically submitted that the patient was discharged as per the protocol after observing overall clinical condition of the patient. Further, at the time of the discharge, the patient was in stable condition. It is also emphasized that the view of the complainant that the patient was not fit for discharge because she was on ventilator is totally false and baseless as patient was never put on ventilator throughout the hospital stay. It is submitted that the patient was discharged on 20.08.2018 and being a EWS patient and the patient has not paid any amount to the hospital during the period 17.08.2018 to 20.08.2018. Further, the date on the discharge summary was correctly mentioned as 20.08.2018. It is strongly denied that the treating doctor treated the patient differently and did not pay requisite attention. It is also submitted that it is the duty of the doctor to give his best and save lives and treating doctor has done best for the patient according to standard stroke protocol. It is further submitted that the hospital is run and managed by a charitable society known for the quality treatment provided to the patients at affordable costs. Further, it is strongly denied that the death of the patient was due to the act of treating doctor and the hospital staff. Infact, the patient was treated as per the standard medical protocol the complainant is trying to create an emotional uproar by raising the concerns in the name of family and children. The emotional overtones have been abundantly overstated which have nothing to do with any alleged medical negligence. It is submitted that the patient was treated according to standard medical protocol and allegations mentioned in the complaint are false, frivolous and afterthought. In view of the above, the complaint of the complainant is liable to be dismissed by the Delhi Medical Council.

Dr. Mamta Jain Medical Superintendent of Maharaja Agrasen Hospital in her written statement averred that Maharaja Agrasen Hospital is a multi-disciplinary, super specialty hospital having accreditation of JC, NABH, NABL and ISO certification. It is bounden duty and obligation of the civil society including family of the patient to ensure that the medical professionals are not unnecessary harassed or humiliated, so that they can perform their professional duties without fear and apprehensions. In view of the facts and circumstances mentioned above, the complaint of Shri Pradeep Kumar is liable to be dismissed against the hospital and the treating doctor.

In light of the above, the Disciplinary Committee makes the following observations.

1. The patient Smt. Nisha Mittal was admitted in Maharaja Agrasen Hospital under case of Dr. K.K. Jindal, Consultant Neurologist. She had acute ischaemic stroke on background of DM II (Diabetes Mellitus II). She was managed as per standard protocol in window period and was given intravenous Thrombolysis with informed consent. She was thoroughly investigated to find mechanism of right MCA (Middle Cerebral Artery) stroke in young female including vessel imaging by MRI and MRA Brain. She was under treatment from 15th August, 2018 to 20th August, 2018 and was discharge in stable condition.
2. The patient was given treatment as per standard practice with informed consent before thrombolysis and was prognosticated time to time. As per records and statements from the patient and clinician, there appears no negligence on the part of or hospital staff.

In light of the observations made hereinabove, it is the decision of the Disciplinary Committee no medical negligence can be attributed on the part of the Dr. K.K. Jindal of Maharaja Agrasen Hospital, in the treatment of complainant’s wife Smt. Nisha Mittal.

Complaint stands disposed.

Sd/: Sd/: Sd/:

(Dr. Maneesh Singhal) (Dr. Satish Tyagi) (Dr. R.K. Dhamija)

Chairman, Delhi Medical Association Expert Member

Disciplinary Committee Member, Disciplinary Committee

 Disciplinary Committee

The Order of the Disciplinary Committee dated 4th October, 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 Pradeep Kumar s/o Shri Jagmohan Lal, r/o 1595, Pana Mamurpur, Narela, Delhi-110040.
2. Dr. K.K. Jindal, Through Medical Superintendent, Maharaja Agrasen Hospital, West Punjabi Bagh, New Delhi-110026.
3. Medical Superintendent, Maharaja Agrasen Hospital, West Punjabi Bagh, New Delhi-110026.
4. ACP/PG, For Dy. Commissioner of Police, West District Rajouri Garden, New Delhi-110027-w.r.t. no. 12873/Compt.(w)/DA-VI(Misc) dated 18.10.2019- **for information.**

 (Dr. Girish Tyagi)

 Secretary