DMC/DC/F.14/Comp.2682/2/2023/ 20th February, 2023

**O R D E R**

The Delhi Medical Council through its Disciplinary Committee examined a complaint of Smt. Nirupama Dutta r/o A 98/1 SFS Flats, Saket, New Delhi-110017, forwarded by the Medical Council of India, alleging medical negligence on the part of doctors of Max Hospital, Saket, Delhi, in the treatment administered to complainant’s mother Smt. Kailash Puri.

The Order of the Disciplinary Committee dated 07th February, 2023 is reproduced herein-below :-

The Disciplinary Committee of the Delhi Medical Council examined a complaint of Smt. Nirupama Dutta r/o A 98/1 SFS Flats, Saket, New Delhi-110017 (referred hereinafter as the complainant), forwarded by the Medical Council of India, alleging medical negligence on the part of doctors of Max Hospital, Saket, Delhi(referred hereinafter as the said Hospital), in the treatment administered to complainant’s mother Smt. Kailash Puri (referred hereinafter as the patient).

The Disciplinary Committee perused the complaint, written statement of Dr. Sahar Qureshi Medical Superintendent of Max Hospital enclosing therewith written statement of Dr. Rajiv Agarwal, Dr. Ripen Gupta, Dr. Prashant Saxena, Dr. Anand Kumar Saxena, copy of medical records of Max Hospital and other documents on record.

The following were heard in person :-

1) Smt. Nirupama Dutta Complainant

2) Ms. Indu Puri Sister of the complainant

3) Dr. Rajiv Agarwal Cardiologist, Max Hospital

4) Dr. Ripen Gupta Cardiologist, Max Hospital

5) Dr. Anand Kumar Saxena Neurologist, Cardiologist, Max Hospital

6) Ms. Bhakti Arora Medical Adm., Cardiologist, Max Hospital

7) Dr. Sahar Qureshi Medical Superintendent, Cardiologist, Max

Hospital

Dr. Prashant Saxena failed to appear before the Disciplinary Committee, inspite of notice.

The complainant Smt. Nirupama Dutta alleged that complainant’s mother, Smt. Kailash Puri was admitted to the Max Smart Super Specialty Hospital, Saket, Delhi on three occasions :1st August, 2018 to 05th August, 2018, 31st October, 2018 to 02nd November, 2018 and 16th November, 2018 to 26th November, 2018. In the 1st hospitalization based on symptoms of breathlessness, apart from ECHO and HOLTER, a scan of the spine was done costing Rs. 23360 plus a brain scan costing Rs. 4300 besides other tests unrelated to the presenting symptoms. In the 2nd hospitalization (where patient was admitted on grounds of “ghabrahat and sweating associated with shortness of breath”) a coronary angiography was done on 31.10.2018 which revealed “non critical CAD.” The treating doctor has mentioned on the prescription dated 02.11.2018 that the diagnosis was “MINOCA”. In the 3rd hospitalisation dated 16th November, 2018, despite an angiography on 31st October, 2018 which did not show any blockages, a second angiography was done on an 89 plus year old lady which again showed “non obstructive coronaries.” Why was such an elderly patient subjected to a repeat invasive surgery within 15 days, when the earlier report had been normal ? The second report is similar to the first one and states “insignificant CAD.” At the time of admission on 16th November, 2018, the presenting symptoms were “Giddiness since one day.” All other parameters were normal, namely, BP -120/80, HR-80, SPO2-99% on room air, CNS-no focal neuro deficit, Afebrile. ECG showed elevation in anteriolateral leads and Trop I was raised. Under the given circumstances and considering the age of the patient, and the fact that her previous history of two hospitalizations in the same hospital were available, the patient should have been managed conservatively with appropriate medication. Instead, aggressive line of treatment was adopted, including invasive procedures resulting in the patient being reduced to a vegetative state. On 21st November, 2018, when she visited the ICU during visiting hours at 4.30 pm, she found her mother lying unconscious with her mouth open and there was an overwhelming stench of faeces. It is unclear as to how long she had been lying in her own faeces in this state. Upon her making a complaint to her primary doctor, she was shifted to a bed in front of the nursing station. This is the “intensive” care that one gets in an ICU of Max Smart Super Specialty Hospital. She was subjected to a minimum of 3-4 blood tests daily and the when her haemoglobin predictably came down, blood transfusion was given. Her arms were covered with needle marks and then bandaged to prevent him from seeing them. She was kept sedated throughout, pumped with medicines. In the ICU, she also developed bed sores. On 23rd November, 2018, they were asked to immediately sign the form for putting her on the ventilator. The same day they were called by the Pulmonary doctor to give their concurrence for pleural fluid aspiration. They were told to state their preference for either tapping or needle aspiration. This is a medical decision meant to be taken by a doctor or the relatives of a patient ??. When chest x-rays were being done daily and sometimes twice a day how come fluid was noticed only when the entire lung had filled up?. On 24th they were informed that only 10 ml of fluid could be taken out since it required to be ultra sound guided so it would have to be done again. Why was the patient being subjected to repeated procedures. Blood tests have been billed to them for as many as 3-4 times a day. Not a single blood sugar report has bee given to them on the same. Eventually, on 26th November, they decided to LAMA. She regained consciousness a few hours later at home. The medication sheet clearly shows gross over medication and at times contra medication. This complaint is based on documentary and other proof available with them, as well as what was told to them by the patient.

Dr. Sahar Qureshi, Medical Superintendent, Max Smart Super Specialty Hospital, in his written statement averred that the patient Mrs. Kailash Puri was an 89 year old lady, got admitted to and treated at the Hospital on three occasions: First Hospitalization: From 01/08/2018 to 05/08/2018, Second Hospitalization: From 31/10/2018 to 02/11/2018 and Third Hospitalization: From 16/11/2018 to 26/11/2018. First Hospitalization: From 01/08/2018 to 05/08/2018: The patient, an 89 years old lady was admitted to the Hospital as a referred patient from an outside hospital, with complaint of giddiness for past 1 week and hypertension. The patient was admitted under Dr. Rajiv Agarwal for further management and to rule out any cardiac cause including unstable angina for which cardiac enzymes, ECG and echo were done. ECHO and Holter monitoring was advised with Neurology reference as she also complained of imbalance, heaviness of head, burning sensation in BIL soles. NCCT Head and CT Spine screening was advised which revealed age related changes and Scoliosis. Her NTproBNP was elevated, Troponin-I was normal, and Echo showed no wall motion abnormality. Holter was done to rule out cardiac arrhythmia as cause of giddiness. Neurology advice was taken from Dr. Anand Kumar Saxena and, as advised, NCCT head and CT whole spine was done to evaluate neurological causes of imbalance and giddiness. She was discharged on 5/8/2018 in a clinically stable condition; after her giddiness improved with Holter report awaited. Subsequently Holter confirmed Sick Sinus Syndrome with minimum HR 44 bpm, no long pauses and insignificant arrhythmia for which medical follow up was advised with aspirin and anti-hypertensive drugs. Patient was told to review in cardiology OPD after 7 days with prior appointment or SOS. Second Hospitalization: From 31/10/2018 to 02/11/2018: On 31/10/2018*,* the patient came to emergency ward of the Hospital with complaints of ghabrahat and sweating associated with shortness of breath. The Patient was admitted under Dr. Ripen Gupta from *31/10/18* with suspected ST Elevation MI for which emergency coronary angiography was done by his team. The Coronary Angiogram revealed recanalised LAD and planned for further medical management. The procedure was tolerated by the patient well and the hospital stay was uneventful. Being a follow up case of Parkinsonism neurology consultation was taken and advice followed. On 2/11/2018 the patient was discharged in a clinically stable condition with discharge medication advice and to review within the Cardiology OPD after 7 days but she never came to Dr. Ripen Gupta's OPD for follow-up. The discharge medication advised, apart from others were: • Tab. Ecosprin Gold 20, 1 Tablet once daily (after dinner). Third Hospitalization: From 16/11/2018 to 26/11/2018: On 16/11/18*,* the patient came to the cardiac OPD and met Dr Rajiv Agarwal with chiefcomplaints of sudden onset of giddiness and ghabrahat and was sent to the Hospitalemergency; where her ECG showed fresh ST elevation in Antero-lateral leads andTROP-I was raised. Code STEMI was announced by the emergency doctors based on STelevation which was more than the previous discharge. The patient was admitted underDr. Rajiv Agarwal. The patient had runs of ventricular tachycardia for which she wasgiven Amiodarone bolus dose followed by infusion. Diagnosis of fresh acute MI withventricular tachycardia was made, for which the best course of action appeared to beimmediate high risk coronary angiography and revascularization along with concomitantmedical management. This was explained to relatives. After taking written high riskconsent from the patient relatives and after explaining the risks and benefits, emergency coronary angiography was done on 16/11/2018 itself; which revealed insignificant Coronary Artery Disease. Subsequently the patient was managed in the ICCU with amiodarone and heparin infusion apart from other medicines. Echo showed good LV function, EF 50-55% with no regional wall motion abnormality. Trop I was elevated 0.23. Patient was drowsy but arousable and was seen by Critical Care team who asked for blood and urine cultures and intravenous antibiotics. Patient was catheterized by Urology on *17/11/18* for urinary retention and required intermittent BIPAP for breathing support. Chest X-ray showed no significant effusion or infiltration. On 18/11/18, the patient developed Atrial Fibrillation with Fast Ventricular rate subsiding spontaneously. Serum pro-calcitonin was high suggesting possible sepsis for which presumptive antibiotics were continuing and cultures sent. Patient remained afebrile and in sinus rhythm on 20/11/18. In view of recurrent ST elevation episodes, the patient, a case of MINOCAwith suspected Prinzmetal angina was made and the patient was planned for ergonovine provocation test for coronary spasm once after the patient got stabilized. Heparin was changed to Enoxaparin. On 21/11/18, the patient was in altered sensorium responding to commands, afebrile, in sinus rhythm with normal labs. Neurology consultation was sought from Dr. Anand Kumar Saxena and medicines for Parkinsonism were resumed. On 22/11/18, the patient was unable to take fluids orally and needed Ryle's tube insertion. TLC (white cell count) was raised 18100/cu mm but cultures were sterile. Hb was 9 g/dland KFT was normal. Ergonovine provocation test was deferred in view of poor general condition of the patient. Patient was seen by internal Medicine for rising white counts and advice incorporated. On 23/11/18, the patient was conscious but not obeying commands with reduced urine output, Hb 8.5 and TLC showing falling trend. Patient had difficulty in breathing and Chest X-Ray showed left side complete opacity. HRCT chest was done and it was suggestive of bilateral pleural effusion left> right with collapse consolidation of left lung with secretions in left bronchus. Thus, Pulmonology consultation was sought from the team of Dr. Prashant Saxena and pleural tapping was done by them. Echo on 24/11/18 showed Regional Wall Motion Abnormality present in mid-level with anteroseptal and anterior segments being akinetic and all segments at apical level being akinetic with moderate LV systolic dysfunction, grade I LV diastolic dysfunction, LVEF-40%, moderate MR, mild PAH with IVC congested. Patient was given diuretics with diagnosis of CHF. She was drowsy and disoriented for which repeat neurology consultation was taken. In view of worsening clinical condition, the possibility of ventilator support in case of further worsening was discussed with relatives. In view of further fall in Hb level, patient was given 2 units packed RBC transfusion for anaemia and clopidogrel was stopped. Due to high stroke risk in view of recurrent episodes of atrial fibrillation and high CHA2DS2 VASc score of 7, it was decided to continue anticoagulation with enoxaparin. INR was not raised and stool for occult blood was negative. Repeat Pulmonology consult taken from Dr. Prashant Saxena and as advised USG guided diagnostic and therapeutic pleural tapping was done on 25/11/2018 with pig tail left in situ in right pleural space. Around 450 ml straw coloured fluid was tapped and sent for all relevant investigations. Pleural fluid analysis was suggestive of Transudative picture and NTproBNP was also very high (22100). Dopamine infusion was started on 25/11/18 in view of low BP and urine output, subsequently changed to Noradrenaline. Intravenous amiodarone bolus was given for recurrent AF. On 26/11/2018,the Patient was conscious and obeying commands with good urine output. However labs were suggestive of mild elevation of creatinine and nephrology consult was sought. In view of only 50 ml pleural fluid drained and having a haemorrhagic hue, pigtail was removed. Patient PT-INR was 1.34. Patient was critically ill and hence repeated blood tests needed to be done to monitor her renal function, infection status and coagulation profile. After 3 admissions with ICU stay each time she had multiple venous needling and difficult access. There was thrombophlebitis on both arms due to administration of IV fluids and drugs including intravenous antibiotics. MAGSULF dressing was applied for treatment of thrombophlebitis and this was explained to the attendants at that time. From time of admission the patient had small superficial wounds with peeling skin over sacrum for which Mepilex was applied. All due precautions for nursing care of this bedridden patient were taken, for prevention and treatment of bed sores. On 26/11/18*,* the patient was conscious and oriented but needed further hospital stay in view of Heart Failure with Acute Kidney injury and recurrent episodes of AF but patient and relatives were unwilling for further hospital stay despite explaining the risks. So, the patient was discharged as leaving against Medical advice (LAMA) on 26/11/2018. It is submitted that, on 16.11.2018*,* the patient presented to the cardiology OPD with chief complaints of sudden onset giddiness and ghabrahat and was sent to the emergency where her ECG showed fresh ST elevations in Antero-lateral leads. Code STEMI was announced by the emergency doctors based on ST elevation which was more than the previous discharge. Thereafter, the patient had runs of ventricular tachycardia (documented in their CPRS records) for which she was given Amiodarone bolus dose followed by infusion. In view of her previous history of coronary angiogram for suspected ST elevation MI on 31/10/18, which showed insignificant disease, that could have progressed to plaque rupture by the time of her third admission, and considering the fresh ST elevations and runs of ventricular tachycardia leading to electrical instability, the Patient was advised for immediate coronary angiogram in the third admission; which was done after taking written informed consent from the patient's relatives, after explaining the risks and benefits involved in the same. On the question of the line of treatment adopted by the treating doctors, it is submitted that the Patient was admitted with suspected ST elevation MI 3 weeks before the admission to the Hospital on her Third Hospitalization and discharged on medical management with dual antiplatelets and statin therapy viz Ecosprin Gold. Despite this the Patient developed fresh or aggravated cardiac symptoms in the third admission, which were considered life threatening due to ventricular tachycardia. Hence an aggressive line of treatment was adopted, in the best interest of the patient and after taking written informed consent. It is submitted that, urgent coronary angiography and possible angioplasty is the preferred modality for ST elevation MI even in elderly patients and is likely to save lives. It is wrong and denied that the patient was reduced to a vegetative state due to the aggressive line of treatment, including invasive procedure. It is submitted that, the patient was regularly observed by the team of doctors and nursing staff . On 21.11.2018at around 4:30 PM, the patient had passed stool in bed. Thus, while the nursing staffs were making the necessary arrangements to clean-up the Patient, the relatives came to see the patient just then. It is wrong and denied that the patient was lying unconscious with her mouth open and an overwhelming stench of faeces. The Patient was, in fact, conscious but with altered sensorium responding to commands on 21.11.2018, as per the medical records. It is submitted that, the Patient was critically ill and hence blood tests were needed to be done to monitor her renal function, infection status and coagulation profile. It is to be noted that her haemoglobin was 9.3 to start with on 16.11.19 on admission and 9.5 on 21.11.18. Thus, it is wrong and denied the allegation that, due to 3-4 blood tests daily, blood transfusion was given. Her haemoglobin continued to be more than 8 g/dl until 24.11.19 when blood transfusion was needed only after the pleural tap was done, which itself was necessary to make a diagnosis. Stool for occult blood was negative on 25.11.18 and no other obvious source of bleed was identified. It is wrong and denied that the patent's arms were covered up with needle marks and then bandage to prevent it from seeing by the relatives. It is also wrong and denied that the patient was kept sedated and the patient developed bed sores. It is submitted that, the patient was an elderly patient and had very fragile veins. After 3 admissions with ICU stay each time she had multiple venous needling and difficult access. There was thrombophlebitis on both arms due to administration of iv fluids and drugs including iv antibiotics. MAGSULF dressing was applied for treatment of thrombophlebitis and this was explained to the attendants at the time. The patient was not sedated as is being alleged, but had altered sensorium for which neurology consultation was taken. From time of admission the patient had small superficial wounds with peeling skin over sacrum for which Mepilex was applied. All due precautions for nursing care of this bedridden patient were taken, for prevention and treatment of bedsores. On 23.11.2018 patient had breathing difficulty with fast respiration and elevated White cell count in blood as well as decreased urine output. She was drowsy and disoriented. X-ray chest and HRCT chest showed collapse-consolidation and bilateral pleural effusion. Patient was seen by Pulmonologist. In view of worsening clinical condition, the possibility of ventilator in case of further worsening was discussed with relatives. No immediate consent for ventilator was asked for as is being wrongly alleged. The team of treating doctors of the Hospital were diligent in managing the Patient and how the relatives were kept informed about the diagnosis, prognosis and the line of treatments; involving them in every possible way/needed. It is very unfortunate on the part of the Complainant to wrongly infer and raise question on whom to make medical decision. In fact, it is submitted that, on 23.11.2018 the Patient was found to have large left sided pleural effusion with breathlessness. Thus, Pulmonology team was consulted and they, after evaluating the patient, advised to drain it. In view of the fact that the patient was an elderly Patient on antiplatelet drugs for suspected acute coronary event and low molecular weight heparin for stroke prevention in atrial fibrillation, and was deemed to be at high bleeding risk. Choice between one time needle aspiration or chest tube (ICD) insertion (more effective but with higher bleeding risk) was discussed with relatives. After, understanding all the benefits and risks involved in both the procedures. Informed Consent for Pigtail/pleural tapping was given by on 24/11/2018. Thereafter, ultrasound guided pigtail insertion was done by the Radiologist and 500 ml of pleural fluid was drained. It is wrong on the part of the complainant to allege that X-rays were done daily. As per records, it is submitted that, Chest X-ray was done on 17/11/2018; which showed no pleural effusion. Subsequently, the patient was monitored in CCU and maintained good respiratory parameters. On 22.11.2018 when the patient had high TLC of 18100, then X-ray chest was repeated, which showed large pleural effusion. Subsequently HRCT chest was done on 23.11.2018and chest X-ray was repeated once each on 23/11/2018 and 25/11/2018 to see the response to pleural aspiration. It is submitted that, Pleural aspiration was attempted by the Pulmonology team on 23.11.2018but only about 10 ml diagnostic pleural fluid was aspirated ,since the Patient became too irritable and uncooperative. Thus, the procedure was abandoned as a means of abundant pre-cautions, as continuation of the procedure became too risky of injuring the patient internally. And a USG guided therapeutic Tapping was advised. A pigtail insertion was hence done by intervention radiologist under USG guidance, after taking an informed consent, to relieve the pleural effusion and dyspnoea on 24.11.2018after giving 2 units packed cells and omitting clopidogrel on 24.11.2018*.* It issubmitted that, regular bed side Blood Sugar monitoring was required. Reports were daily monitored and entered into the Nursing Notes. It is submitted that, Blood sugar was recorded by glucometer 3 times a day because patient had altered sensorium with suspected sepsis and being on nasogastric feeds, patient had risk of both hyper and hypoglycemia and needed effective glycemic monitoring and control if needed. Later on, with patient developing renal impairment and reduced urine output it was even more essential to record blood sugars for early detection of hypoglycemia. It was recorded by their nursing staff and incorporated into daily computerized record charting which is attached. In fact, the recorded blood sugars showed significant variation and hence were regularly monitored in this critically ill patient. It is further submitted that, in critically ill patients, hyperglycemia is common and associated with adverse outcomes. Several studies showed that both hypoglycaemia and severe hyperglycemia increase in-hospital mortality. In particular they draw a J-curve relationship between blood glucose concentration and mortality. According to Balloni, A., Lari, F. and Giostra, F. (2017); "Evaluation and treatment of hyperglycemia in critically ill patients", Acta Bio Medica Atenei Parmensis 2017,87(3), pp. 329-333. It is submitted that the allegation of negligence and deficiency in service on the part of hospital and its doctors made by the Complainants is not admissible qua the answering Hospital and its treating doctors and its staff. It is further prayed that the Hon'ble DMC may be pleased to exercise its powers to ensure that clinicians and medical professionals are free to use their professional abilities and skills to successfully treat the general public, without being inhibited by the fear of unnecessary complaint/litigation. It is also submitted that, as the Hon'ble Supreme Court has added to its mandate and oversight obligations to ensure that its members are not needlessly victimized or harassed for providing urgent, high risk and essential medical treatment, the Hon'ble DMC plays an important role in ensuring that there is supervisory oversight over professionals in a manner consistent with law. Thus, it is prayed accordingly.

Dr. Rajiv Aggarwal, Senior Director and Unit Head, Cardiology, Max Smart Super Specialty Hospital, in his written statement averred that patient Smt. Kailash Puri was a 90 years old lady, referred from an outside hospital with complaint of giddiness for past 1 week and hypertension. She was admitted on 01.08.2018 to rule out any cardiac cause. NTproBNP was elevated Troponin-I was normal and Echo showed no wall motion abnormality. Holter was done to rule out cardiac arrhythmia as cause of giddiness. Neurology advice was taken from Dr. Anand Saxena and, as advised, NCCT head and CT whole spine' was done to evaluate neurological causes of imbalance and giddiness. She was discharged on 05.08.2018 after her giddiness improved with Holter report awaited. Subsequently Holter confirmed Sick Sinus Syndrome with Minimum HR 44 bpm, no long pauses and insignificant arrhythmia for which medical follow up was advised with Aspirin and anti-hypertensive drugs. Patient was told to follow up with Cardiologist and Neurologist. Subsequently patient was admitted under Dr. Ripen Gupta from 30.10.2018 to 02.11.2018with suspected ST Elevation MI for which emergency coronary angiography was done by his team: On 16/11/18Mrs Puri presented to the OPD with chief complaints of sudden onset giddiness and ghabrahat and was sent to the Hospital Emergency where her ECG showed fresh ST elevation in Antero-lateral leads. Code STEMl was announced by the emergency doctors based on ST elevation which was more than the previous discharge .. Thereafter patient had runs of Ventricular tachycardia (Documented in their CPRS records) for which she was given Amiodarone bolus dose followed by infusion. Diagnosis of fresh acute Ml with ventricular tachycardia was made, for which the best course of action appeared to be immediate high risk coronary angiography and revascularization along with concomitant medical management. This was explained to relatives. After taking written high risk consent from the patient relatives and after explaining the risks and benefits, emergency coronary angiography was done on 16.11.2018which revealed insignificant Coronary artery disease. Subsequently the patient was managed in the ICCU with amiodarone and heparin infusion ·and other medicines. Echo showed good LV function, EF 50-55% with no regional wall motion abnormality. Trop I was elevated 0.23. Patient was drowsy but arousable and was seen by Critical Care team who asked for blood and urine cultures and intravenous .antibiotics. Patient was catheterized by Urology on 17.11.2018 for urinary retention and required intermittent BIPAP for breathing support. Chest X-ray showed no significant effusion or infiltration. On 18.11.2018 patient developed Atrial Fibrillation with Fast Ventricular rate subsiding spontaneously. Serum pro-calcitonin was high-suggesting possible sepsis for which presumptive antibiotics were continuing and cultures sent. Patient remained afebrile and in sinus rhythm on 20.11.2018*.* In view of recurrent ST elevation episodes they planned to perform ergonovine provocation test for coronary spasm after patient stabilized, Heparin was changed to Enoxaparin. On21.11.2018patient was in altered sensorium responding to commands, afebrile, in sinus rhythm with normal labs. Neurology consultation was sought from Dr. Anand Kumar Saxena and medicines for Parkinsonism were resumed. On 22.11.2018 Patient was unable to take fluids orally and needed Ryle's tube insertion. TLC (white cell count) was raised 18100/cumm but cultures were sterile. Hb was 9 g/dl and KFT was normal. Ergonovine provocation test was deferred in view of poor general condition of the patient. Patient was seen by Internal Medicine for rising white counts and advice incorporated. On 23.11.2018the patient was conscious but not obeying commands with reduced urine output, Hb 8.5 and TLC showing falling trend. Patient had difficulty in breathing and Chest x-Ray showed left side complete opacity. HRCT chest was done and it was suggestive of bilateral pleural effusion left> right with collapse consolidarion of left lung with secretions in left bronchus. Pulmonology consultation was sought from the team of Dr Prashant Saxena and pleural tapping was done by them. Echo on 24.11.2018showed Regional Wall Motion Abnormality present in mid-level with antero-septal and anterior segments being akinetic and all segments at apical level being akinetic with moderate LV systolic dysfunction, grade I LV diastolic dysfunction, LVEF· 40%, moderate MR, mild PAH with IVC congested. Patient was given diuretics with diagnosis of CHF. She was drowsy and disoriented for which repeat Neurology consultation was taken. In view of worsening clinical condition, the possibility of ventilator support in case of further worsening was discussed with relatives. In view of further fall in Hb level. patient received 2 units packed RBC transfusion for anaemia and clopidogrel was stopped. Due to high stroke risk in view of recurrent episodes of Atrial fibrillation and high CHA2DS2 VASc score of 7, it was decided to continue anticoagulation with enoxaparin. INR was not raised and stool for occult blood was negative. Repeat Pulmonology consult taken from Dr Prashant Saxena and as advised USG guided diagnostic and therapeutic pleural tapping was done on 25.11.2018with pig tail left in situ in right pleural space. Around 450 ml straw coloured fluid was tapped and sent for all relevant investigations. Pleural fluid analysis was suggestive of Transudative picture and NTproBNP was also very high (22100). Dopamine infusion was started on 25.11.2018in view of low BP and urine output, subsequently changed to Noradrenaline. Intravenous amiodarone bolus was given for recurrent AF. On 26.11.2018 patient was conscious and obeying commands with good Urine output. However labs were suggestive of mild elevation of creatinine and Nephrology consult was, sought. Tn view of only 50 ml pleural fluid drained and having a haemorrhagic hue, pigtail was removed. Patient PT-INR was 1.34. Patient was critically ill and hence repeated blood tests needed to be done to monitor her renal function, infection status and coagulation profile. After 3 admissions with ICU stay each time she had multiple venous needling and difficult access. There was thrombophlebitis on both arms due to administration of IV fluids and drugs including intravenous antibiotics. MAGSULF dressing was applied for treatment of thrombophlebitis and this was explained to the attendants at the time. From time of admission this patient had small superficial wounds with peeling skin over sacrum for which Mepilex was applied. All due precautions for nursing care of this bedridden patient were taken, for prevention and treatment of bed sores. Patient was conscious and oriented but needed further hospital stay in view of Heart Failure with Acute Kidney injury and recurrent episodes of AF but patient and relatives were unwilling for further hospital stay despite explaining the risks. So, patient was discharged as leaving against Medical advice (LAMA) on 26.11.2018.

Dr. Ripen Gupta, Director, Cardiology, Max Smart Super Specialty Hospital, in his written statement averred that the patient, 90 years female, presented to emergency on 31.10.2018 at 4.25 am with sudden onset ghabrahat and sweating associated with shortness of breath since 3.30am. She was a follow up case of hypertension and Parkinsonism under care of Dr. Rajiv Agarwal & Dr. Anand Kumar Saxena from the Hospital. On presentation, her oxygen saturation at room air was 75 % which improved to 95% after oxygen, nebulisation and medical treatment. Her pulse rate was 86/min and blood pressure was 120/80 mmHg. She was initially nebulised with duolin and budecort and intravenous hydrocortisone was also given. Her ECG done in ER showed ST elevation in anterolateral leads. She was given loading dose of aspirin 325mg, clopidogrel 300mg and atorvastatin 80mg. After stabilization she was taken up for coronary angiography which revealed non-critical coronary artery disease (CAD). She was planned for medical management and shifted to CCU. Her cardiac enzymes were elevated (Troponin I-0.78 ng/ml) and NT Pro BNP was also elevated (29,200 pg/ml). 2D Echo done on 31.10.2018 showed mid and apical lateral wall hyperkinesias, concentric LVH, LEFT atrial enlargement, LVEF 55 %, Grade II left ventricular diastolic dysfunction, moderate mitral regurgitation, moderate tricuspid regurgitation, mild pulmonary artery hypertension (PAH). Her breathlessness & ECG changes settled down with conservative management. She was also seen by neurologist, Dr. Anand Kumar Saxena for Parkinsonism. She was discharged on 02.11.2018 in a stable condition on dual antiplatelets, statins, calcium channel blockers and parkinsonism treatment.

Dr. Prashant Saxena, Head Pulmonology & Sleep Medicine, Associate Director- Critical Care, Max Smart Super Specialty Hospital in his written statement averred that the patient, 90 years old, female was admitted to the Hospital under Dr. Rajiv Agarwal with a diagnosis of Paroxysmal Atrial Fibrillation Myocardial infarction with non-obstructive coronary artery disease. Moderate LV dysfunction LVEF-40%, B/L pleural effusion L>R, Acute kidney injury, Sick sinus syndrome, Parkinsons disease, Hypertension, Hypothyroidism. Pulmonology referral was give in view of HRCT chest findings on 23.11.2018. HRCT chest was suggestive of bilateral pleural effusion left > right with collapse consolidation of left lung with secretions in left bronchus. On 23.11.2018 from pulmonology side an USG guided diagnostic and therapeutic pleural tapping was advised. Family counseling was done by him and procedure was explained. Patient insertion and USG guided tapping on right side was done by radiology team under USG guidance. Pleural fluid was transudative in nature so conservative management was advised and BIPAP along with oxygen therapy was continued with diuretics. On 26.11.2018 from pulmonology side it was advised to remove pigtail as the drain was less in amount (100 ml).

Dr. Anand Kumar Saxena, Associate Director and HOD Neurology, Max Smart Super Specialty Hospital, in his written statement averred that the patient Smt. Kailash Puri, 90 years female was admitted to Hospital on 01.08.2018 under Dr. Rajiv Aggarwal with the diagnosis of Paroxysomal Atrial Fibrillation Myocardial infarction-Non obstructive moderate LV dysfunction. LVEF <40%, B/L pleural effusion L>R, AKI, Sick sinus syndrome, Hypertension, Hypothyroid. Patient was admitted with complaints of giddiness, gabhrahat and shortness of breath. On 02.08.2018 her neurology reference was taken from him, in view of imbalance, heaviness in head associated with burning sensation in both soles. Patient was thoroughly examined by him. The patient had lower limb in-coordination with tendency to fall backward and her romberg sign was present. NCCT head ad CT cervical spine and NCV all 4 limbs was advised from his side. Her nerve conduction study report was normal. Her CT head plain revealed cereberal atrophy and CT cervical spine showed scoliosis of spine. Patient was given symptomatic treatment. Patient was evaluated and treated for parkinsonism symptoms on OPD basis on various sittings from dated 07.08.2018. On 31.10.2018 patient was admitted under Dr. Ripen Gupta with complaints of gabhrahat and shortness of breath. Neurology consultation was taken in view of Parkinsonism and advise was given. On 16.11.2018 patient was again admitted under Dr. Rajiv Aggarwal with complaints of giddiness, gabhrahat and tremoulsness and on 21.11.2018 patient reference was taken from him for Parkinsonism and required drug modification done. Patient had gone LAMA on 26.11.2018 from the Hospital.

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

1. It is noted that the patient Smt Kailash Puri, an 89 years old female presented to the said Hospital on 01st August, 2018 with complaints of giddiness for one week. She was diagnosed case of type II diabetes mellitus, systemic hypertension, 2D Echo-NO RWMA, LVEF 60%, GRI diastolic dysfunction, mild PAH. All routine blood investigations were done. CT scan whole spine plain of 02.08.2018 revealed Kypho-Scoliotic deformity of the spine. Degenerative changes seen in the whole spine in form of decreased disc spaces, end plate sclerosis and marginal osteophytes at multiple levels. Vaccum phenomenon seen at multiple dorsal lumbar levels. No lytic or sclerotic lesion was seen. No obvious cortical break was seen. There was a 24 x 18mm iso-hypodense lesion in the spinal canal of S2 level causing bony remodelling Neurogentic cyst. Degenerative changes were also seen in the symphysis pubis. Paraspinal muscles appear normal. NCCT head/ brain done on 02.08.2018 revealed chronic ischemic changes and age related changes of cereberal atrophy. Holter monitoring was done. Patient was managed conservatively with the given treatment and responded well. Neurology consultation was taken from Dr. Anand Kumar Saxena and advice was incorporated. Patient was discharged on 05.08.2018 in a clinically stable condition on medication.

The patient subsequently was hospitalized in the said Hospital on 31.10.2018 with complaints of gabhrahat and sweating associated with shortness of breath. ECG done showed ST elevation in inferolateral leads. TROP I was elevated (TROP I-0.78). After informed written consent, coronary angiography was done on 31.10.2018 which revealed recanalised LAD and advice medical management. Patient tolerated the procedure well and Hospital stay was uneventful. 2D Echo (31.10.2018): CAD, Conc LVH, LAE, RWMA present, normal LV systolic function, Grade II LV diastolic dysfunction, moderate MR moderate TR, mild PAH and LVEF 55%. Neurology consultation was taken and advice followed. Patient was discharged on 02.11.2018 on medication with advice to review in cardiology OPD.

The patient, thereafter, again had to be admitted in the said Hospital on 16.11.2018 with complaints of giddiness since one day. ECG done showed ST elevation in ateriolateral leads and TROP-I was raised. She developed runs of VT for which I.V. Cordarone bolus and infusion was started. She was shifted to cath lab. After informed written consent, coronary angiography was done on 16.11.2018 which revealed insignificant CAD. Urology consultation was taken from urology team for retention of urine and advice incorporated. USG whole abdomen (17-11-2018) done was normal. On 19.11.2018, 2D Echo done which showed Conc LVH, No RWMA, LVEF-55-60%, non restrictive mitral inflow pattern. Labs showed TSH-11.3 and hence low dose thyroxine was started. Patient sensorium dropped and neurology consultation was taken from Dr. Anand Kumar Saxena for parkinsonism and advice incorporated. Ergonovine provocation test was planned to identify prinzmetal variant angina as a possible cause of minoca in view of transient ST elevation but due to neurological and respiratory instability, it was postponed indefinitely till patient condition improved. On 24.11.2018 due to tachypnea and high total counts, chest x-ray was done which showed left side complete opacity. HRCT chest done was suggestive of bilateral pleural effusion left > right with collapse consolidation of left lung with secretions in left bronchus. Internal medicine consultation was taken from Dr. Arun Dewan due to raised procalcitonin and advice followed. Echo repeated on 24.11.2018 showed RWMA present in mid level with antero sseptal and anterior segment being akinetic and apical level all segments being akinetic, moderate LV systolic dysfunction, Grade I LV diastolic dysfunction, LVEF -40%, moderate MR, mild PAH with IVC congested. Pulmonology consult was taken from Dr. Prashant Saxena and as advised USG guided diagnostic and therapeutic pleural tapping was done for the same on 25.11.2018 with pig tail left in situ in right pleural space. Around 450 ml straw coloured fluid tapped out was send for all relevant investigations. During hospital stay patient received 2 units PRBC transfusion for anaemia. Clopidogrel was stopped in view of non obstructive coronaries and pleural tapping. Pleural fluid analysis was suggestive of transudative picture. NT PROBNP was also very high. So patient was started on diuretic. Patient during hospital stay had 3 episodes of AF with FVR which terminated with loading dose of amiodarone. Her anti-arrythmic therapy was optimized. On 26.11.2018 patient was conscious and obeying commands with good urine output. However due to high negative fluid balance AKI developed. In view of only 50ml pleural fluid drained and having a hemorrhagic hue, Pigtail was removed. Patient PT-INR was 1.34 and due to high stroke risk in view of recurrent episodes of AF with FVR it was decided to continue anticoagulation. Patient needed more hospitalization in view of AKI and recurrent episodes of AF but patient and relatives were unwilling for further hospital stay despite the risks being explained to them. The patient was discharged on LAMA on 26.11.2018. The patient as per the complaint subsequently expired on 02.12.2018.

1. It is noted that at the time of second admission (31-10-2018 to 02-11-2018) in the said Hospital, the patient (89 years old) had presented with complaints of gabhrahat and sweating associated with shortness of breath. The TROP I level was elevated i.e. 0.78, hence, under Informed Consent, the CAG procedure was warranted; although, the CAG done on 31st October, 2018 revealed recanalised LAD and the patient subsequently was managed conservatively.

It is further noted that at the time of third admission (16-11-2018 to 26-11-2018), the patient had presented with complaints of giddiness since one day and even though, the TROP I levels had fallen from 0.78 to 0.23 and ST elevation was persistent from second to third admission, again the patient was subjected to CAG procedure. The CAG done on 16th November, 2018, albeit under Informed Consent, revealed insignificant Coronary Artery Disease.

We are of the considered opinion that in the facts and circumstances of this case and considering that patient was an 89 year old, subjecting the patient to second CAG, in view of ST segment elevation, which can be justified.

1. The explanation of the doctors that patient was elderly with fragile veins and had three admissions in ICU, she had multiple venous needling and difficult access, with thrombophlebitis on both arms due to administration of IV fluids and drugs; which were the reason for needle marks, is found to be reasonable. Similarly, in an ICU setting, the need/ frequency, the decision for blood tests, fall within the clinical judgement of the doctor.

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 part of the doctors of Max Hospital, Saket, Delhi, in the treatment administered to complainant’s mother Smt. Kailash Puri.

Complaint stands disposed.

Sd/: Sd/: Sd/:

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

Chairman, Delhi Medical Association, Expert Member,

Disciplinary Committee Member, Disciplinary Committee

Disciplinary Committee

The Order of the Disciplinary Committee dated 07th February, 2023 was confirmed by the Delhi Medical Council in its meeting held on 09th February, 2023.

By the Order & in the name of

Delhi Medical Council

(Dr. Girish Tyagi)

Secretary

Copy to :-

1. Smt. Nirupama Dutta r/o A 98/1 SFS Flats, Saket, New Delhi-110017.
2. Dr. Rajiv Agarwal, Through Medical Superintendent, Max Super Speciality Hospital, Saket, New Delhi-110017.
3. Dr. Ripen Gupta, Through Medical Superintendent, Max Super Speciality Hospital, Saket, New Delhi-110017.
4. Dr. Prashant Saxena, Through Medical Superintendent, Max Super Speciality Hospital, Saket, New Delhi-110017.
5. Dr. Anand Kumar Saxena, Through Medical Superintendent, Max Super Speciality Hospital, Saket, New Delhi-110017.
6. Medical Superintendent, Max Super Speciality Hospital, Saket, New Delhi-110017.
7. National Medical Commission, Pocket-14, Sector-8, Dwarka, New Delhi-110077-w.r.t erstwhile Board of Governors In Supersession of Medical Council of India’s letter No.MCI-211(2)(Gen.)/2019-Ethics./161363 dated 09.01.2019-**for information.**

(Dr. Girish Tyagi)

Secretary