DMC/DC/F.14/Comp.2793/2/2023/ 23rd November, 2023

**O R D E R**

The Delhi Medical Council through its Disciplinary Committee examined a complaint of Shri Piyush Chandra r/o 11 Floor B-56, Vasant Kunj Enclave, New Delhi-110070, alleging medical negligence on the part of Dr. Rajkumar of Indian Spinal Injuries Centre, Sector-C, Vasant Kunj, New Delhi-110070, in the treatment of complainant’s mother Smt. Pramila Srivastava, resulting in her death on 23.3.2019.

The Order of the Disciplinary Committee dated 31st October, 2023 is reproduced herein-below:-

The Disciplinary Committee of the Delhi Medical Council examined a complaint of Shri Piyush Chandra r/o 11 Floor B-56, Vasant Kunj Enclave, New Delhi-110070 (referred hereinafter as the complainant), alleging medical negligence on the part of Dr. Rajkumar of Indian Spinal Injuries Centre, Sector-C, Vasant Kunj, New Delhi-110070 (referred hereinafter as the said Hospital), in the treatment of complainant’s mother Smt. Pramila Srivastava (Referred hereinafter as the patient), resulting in her death on 23.3.2019.

The Disciplinary Committee perused the complaint, written statement of Dr. H.P. Singh, Chief of Medical Administration, Indian Spinal Injuries Centre enclosing therewith written statement of Dr. Raj Kumar, NCCT Films dated 08.03.2019, x-ray films dated 28.02.2019, 02.03.2019, 03.03.2019, 05.03.2019, 06.03.2019, 07.03.2019, 08.03.2019, 09.03.2019, 10.03.2019, 11.03.2019, copy of medical records of Indian Spinal Injuries Centre and other documents on record.

The following were heard in person :-

1) Dr. Raj Kumar Consultant Medicine, Indian Spinal Injuries Centre

2) Dr. (Col) Vijay Dutta Consultant, Indian Spinal Injuries Centre

3) Dr. Smita Morde Consultant ICU, Indian Spinal Injuries Centre

4) Shri Anoop Kaushik Sr. Manager MRD, Indian Spinal Injuries Centre

5) Dr. Nishith Mittal Medical Superintendent, Indian Spinal Injuries Centre

The Disciplinary Committee noted that the complainant Shri Piyush Chandra failed to appear before the Disciplinary Committee, inspite of notice.

In the interest of justice, the Disciplinary Committee decided to proceed with the matter in order to determine it on merits.

The Disciplinary Committee noted that the complainant Shri Piyush Chandra in his complainant has raised the following queries regarding the treatment of the patient Smt. Pramila Srivastava at Indian Spinal Injuries Centre.

1. Why was the patient admitted in isolated ICU, even when the attendants requested to either manage with oral antibiotic or to admit in ward but not in ICU? Even when H1N1 test came negative, why she was still kept in isolation? Why was the doctor adamant on admission in isolated ICU? The patient had the history of CHF (Congestive Heart Failure) and COPD. So why the opinion of pulmonologist/respiratory medicine and cardiologist was not taken to rule out the cause of breathlessness CHF and Respiratory failure? First ABG was done on 02nd March, 2019 while the patient was admitted on 28th February, 2019.
2. Why was the only consideration given to raise the Haemoglobin by blood transfusion and cause of its drop not investigated? Did the patient bleed from any side? Why iron profile and B12 and folate level was not done? There was a rise in creatinine and TLC.
3. When coughing with sputum was prevailing and the blood urine and sputum cultures all came negative, why was the pulmonologist respiratory opinion not considered to check the lungs condition or any infection in lungs.
4. How can anyone expect such a casual treatment from a doctor who is supposed to treat critical patients? Either the doctor is incompetent, still given authority to treat critical patients or there are targets to achieve by admitting in ICU and giving high end medications. Why was analysis not done to understand the bacteria which led to septic shock. There is no comment on inotropes, whether the blood pressure was maintained on inotropes or not. Because inability to maintain the blood pressure, can lead to AKI on CKD, which actually happened with the patient?
5. Cause of dip in saturation is not ruled out, the pulmonologist opinion was still not taken.
6. Creatinine level was fluctuating, why nephrologist was not taken into consideration.
7. Why was reason for not maintaining saturation investigated and just corrective action of putting on 2 lit/min oxygen given? How can he prescribe for long term oxygen therapy without consulting pulmonologist and they were not even told for how many hours per day oxygen should be given. The patient was at the risk of developing oxygen toxicity.
8. Why were repeated episodes of breathlessness not taken into consideration, inspite of the patient going through septic shock week before?
9. Why pinkish cough was not taken into consideration and informed to doctor? High BNP level was highly suggestive of cardiac failure but still the patient was discharged and the patient had symptoms of pink frothy sputum. Within thirty minutes of discharge, the patient was again breathless and the attendants of the patient had to immediately transfer the patient in tertiary care centre. Did they not evaluate the patient before discharge?

Dr. Raj Kumar, Consultant Internal Medicine, Indian Spinal Injuries Centre in his written statement averred that the patient Smt. Pramila Srivastava, 69 years old female, had fever with productive cough for four to five days. The patient was a known case of rheumatoid arthritis (on immune-suppressive medication), hypertension, chronic kidney disease, osteoporosis and hypothyroidism. She had a history of bilateral total hip replacement, cholecystectomy and hiatus hernia repair and was earlier admitted in their hospital between 25th July, 2016 and 14th August, 2016. On examination in emergency, her general condition was very sick, her respiratory examination showed bilateral rhonchi and bilateral basal coarse crepts. The treatment for respiratory infection was started, as per standard guidelines. She improved slightly, after the initial treatment in emergency. But in view of multiple co-morbid conditions like rheumatoid arthritis, chronic kidney disease, lower respiratory tract infection and left ventricular failure, which tend to complicate the hemodynamic stability of a patient; she was admitted in ICU, for close monitoring and vigilant care. This was done after explaining the details to the available family members. In the ICU, she was kept in isolation room in view of suspicion of H1N1 pneumonia, as per standard guidelines. H1N1 report was received as negative on 01st March, 2019 in night. As she was on immune suppressive medications, she was highly prone to acquiring secondary bacterial infections. Therefore, after discussing with the available family members, she was treated in isolation ICU for some more period. The patient was admitted on 28th February, 2019 in ICU. On the basis of clinical history and clinical examination, she was diagnosed as a case of lower respiratory tract infection (suspected H1N1 pneumonia) and left ventricular failure. On 02nd March, 2019, SPO2 was 90, PO2 was 56% and she further improved in the next twenty-four hours. The patient was advised to be shifted to ward on 03rd March, 2019 in afternoon. She gradually improved, with some waxing and waning of her condition. Her last investigation report before discharge showed a TLC 6270, creatinine 1.07, procalcitonin 0.11. As per their clinical finding, she was stable and fit for discharge. She was discharged from hospital in stable condition on 13th March, 2019, with proper advice to take medications, as listed in the Discharge Summary. The diagnosis at discharge was septic shock, bilateral pneumonia, LVF, COPD, oral candidiasis, rheumatoid arthritis, CAD and hypothyroidism. The patient was advised to consult in medical OPD after seven days. She was also advised to contact ISIC casualty in case of any fever, breathing difficulty, vomiting. The contact numbers were also given. The history and clinical examination suggested that there was infection in the lungs. Since the patient had multiple co-morbidities and was on immuno suppressants, it was considered appropriate to keep her in the ICU isolation room. It is also pertinent to state that the clinical presentation had features of H1N1 infection. The treating physician did not want to take any chances. The details were adequately discussed with the family members including the complainant. They were convinced by the decision of the treating physician then. Now, as an afterthought, the complainant was trying to invent an allegation. Similarly, the complainant is raising the question of consultation by the cardiologist and pulmonologist. The treating physician is a senior internal medicine specialist of eleven years standing. Consultations (pulmonologist and cardiologist) are taken from other specialists as and when required. ABG was done on 01st March, 2019 on 03:36 a.m. The drop in HB, mild rise in creatinine, were attributed to sepsis and the source of sepsis was lungs. The blood transfusion was given not to raise the HB but to improve the oxygen carrying capacity of the blood. The patient did have infections in the lungs and she was being treated for the same. As far as culture reports are concerned, these help in selecting antibiotics, if bacteria are grown. However, the negative culture report, by itself, does not rule out the infection. Moreover, viral infections cannot be grown on such culture tests. When the patient developed bradycardia, she was resuscitated successfully by the competent team of the doctors and nurses. Resuscitation following a code blue necessitates monitoring and caring such a patient in the ICU. That is what was done. The irresponsible allegations such as ‘incompetent doctor’ or ‘there are targets to be achieved by admitting in ICU and giving high end medications’ are too intimidating to be responded to. The patient was treated and cared as per standard guidelines. The treating physician is a senior internal medicine specialist of eleven years standing and with his efforts the patient had come out of a critical condition. The doctors do consult other experts as and when needed but merely to trace specialists for all symptoms related to different symptoms, is neither medical feasible or desirable nor legally mandatory. Initially, serum creatinine level was 1.43 and on 05th March, 2019 it was 1.17. It shows that it was marginally raised and even that was improving. Last two creatinine levels before discharge were 1.08 and 1.07. Moreover, she was a known case of chronic kidney disease and her urine output volume remained adequate (day 1 -590 ml in 7 hours, day 2 -1850 ml, day 3 -1950 ml). So, the nephrologist opinion was not necessary by any standards. The patient had responded and improved. She was stable enough to be shifted to the ward. Being a senior and experienced physician, he made his own clinical assessment. There was no need to consult a pulmonologist for this. The treatment was detailed to the patient’s attendants every day. The patient had compromised systems because of septic shock. The patient was recovering. The recovery in such cases does not happen instantly. The body systems take their own time, with some waxing and waning, for their recovery. The immune suppression status of this patient was an additional factor. Therefore, some breathlessness did occur. It was certainly not ignored. It was immediately and appropriately addressed by the duty doctor and the patient soon became comfortable. The patient was stable at the time of discharge. There was no pink or frothy sputum and there was no breathlessness. The patient was comfortably breathing and her vital signs were normal. After her discharge, if she had developed breathlessness, she should have contacted him or brought her to the casualty department of their hospital. They chose to take the patient to another hospital. We respect their freedom of choice. However, the complainant, as an afterthought, appears to be inventing deficiencies where none exist. In view of the above, it is requested that this forum may be pleased to dismiss this complaint in the interests of justice and fair play.

On enquiry by the Disciplinary Committee to explain as to why in the progress notes dated 13th March, 2019 09.45 a.m. when it has been written that the patient can be discharged, it is also mentioned that shifted to ICU in view of breathlessness and was put on diuretics and injection Meropenem; Dr. Raj Kumar stated that since in his clinical judgement, the patient was fit to be discharged, so he had advised discharge. Further, the other observations in the progress notes, were actually his dictation regarding the Discharge Summary to be prepared by the Resident doctor.

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

1. It is noted that the patient Smt. Pramila Srivastava, 69 years old female, presented in the said Hospital on 28th February, 2019 with history of being apparently asymptomatic four-five days back when she had fever, no chills and rigors. She was admitted with complaint of fever and productive cough sputum of four-five days duration. She had history of rheumatoid arthritis(on medications), known case of COPD, CAD and hypothyroidism on medications. Her vitals at the time of the admission were : Blood pressure-120/80mmHg, pulse rate-105/minute, respiratory rate-21/minute, SPO2-95% on room air, chest-bilateral occasional ronchi +, CVS-S1S2 present, non- tender, P/A-soft, non-tender, bowel sounds present and CNS-NFND. She was admitted in the ICU with above complaints. The patient was evaluated and investigated. The investigations revealed-HB was 09.1, TLC was 16070, ESR was 108, magnesium was 02.04, calcium was 09.4, phosphorus was 03.33, blood urea nitrogen was 19.2, creatinine was 01.43, sodium was 135, potassium was 03.5, chloride was 104, uric acid was 06.8, procalcitonin was 0.36, INR was 01.2, blood glucose random was 116.9 mg/dl, SGOT/SGPT was 25.4/19.1, NT-PRO BNP was 277.2, INR was 01.17, TSH was 0.63. Urine routine was done, which showed sterile. H1-N1 was negative. She was shifted to ward on 04th March, 20198. In view of acute onset breathlessness, she was again shifted to ICU on 05th March, 2019. TLC increased to 13660 and she was put on diuretic and injection Meropenem. The patient become better and stable and shifted back to ward on 11th March, 2019. The patient was managed with IV antibiotics (injection Meropenem), antipyretic, PPI, antiemetic, IV fluids, nebulization and other supportive measure. She was considered fit to be discharged on 13th March, 2019; hence, discharged on medication.

The patient on the same day; however, had to be admitted in Fortis Flt. Lt. Rajan Dhall Hospital, Vasant Kun, New Delhi-110070 on 13th March, 2019 with complaints of worsening of breathlessness, cough and chest discomfort. The patient’s initial ABG showed type II respiratory failure (pH-07.16, pCO2-81.9, pO2-29.5), put on non-invasive ventilation. IV antibiotics (Meropenem, colistin, teicoplanin, fluconazole), inhaled bronchodilator was started. Cardiac medications were continued. Initial reports were HB-09.5, TLC-21000, platelets-211, serum creatinine-01.28, BUN-24, LFT grossly normal. Trop I-0.17, CPK-69, CK-MB-41, procalcitonin-07.80, NT pro BNK->35,000. Decongestive therapy was started. HRCT chest done was suggestive of infective etiology with fluid overload segmental collapse/consolidation of right lower lobe. VQ scan was suggestive of low probability of pulmonary thromboembolism. The patient was having difficulty in expectoration and bilateral conducted sounds were there. So, bronchoscopy done, which was suggestive of right lower lobe inflamed, bleeds on touch. BAL was collected and sent for the investigations. The patient continued to be breathless, dull and drowsy, so was electively intubated and mechanically ventilated. The cardiology opinion was taken and advice was followed. 2D echo was suggestive of mild AR, trace TR, RWMA (+), mild posterior, distal, inferior, apex, distal IVS, distal lateral wall hypokinesia with LVEF-35-40%. H1N1 PCR was negative. BAL gene xpert-negative. BAL aerobic culture showed MDR Acinetobacter baumannii sensitive to colistin only which was already going. Elores was started and Meropenem was stopped. The patient continued to be breathlessness and drowsy, so continued on mechanical ventilation only. The patient started having fever. Repeat procalcitonin was 1.830. The patient’s creatinine was also rising. The nephrologist opinion was taken. USG KUB done was suggestive of changes of CKD. The patient started becoming hypotensive, inotropic support was started, urine output was decreasing and become anuric. Two cycles of SLED were done. The patient’s ionotropic requirement was continuously increasing. On 23rd March, 2019 in morning, she developed asystole. The patient was revived after CPR, but continued to be critical. Again, she developed cardiac asystole and could not be revived after the CPR according to ACLS protocol and expired on 23rd March, 2019 at 09.56 p.m.

1. It is observed that the clinical condition with which, the patient presented to the Indian Spinal Injuries Centre on 28th February, 2019, warranted ICU treatment. It is noted that the patient responded to the treatment; hence, was shifted to ward on 04th March, 2019. However, the patient’s condition again deteriorated and; hence, the patient was shifted back to the ICU on 05th March, 2019. Subsequently, on 11th March, 2019, as there was improvement in the patient’s condition again, the patient was shifted to ward and on 13th March, 2019, she was considered fit to be discharged.

It is observed that that the decision to treat the patient in the ICU or to discharge her, falls squarely in the purview of the clinical judgement of the treatment doctor.

1. The explanation given by Dr. Raj Kumar in response to the various queries, raised by the complainant, are found to be reasonable and satisfactory.
2. It is observed that the patient was examined, investigated and treated as per accepted professional practices in such cases. She died due to her underlying condition, which carried a guarded prognosis, inspite of adequate treatment.

In light of the observations made hereinabove, it is the decision of the Disciplinary Committee that no medical negligence can be attributed part of Dr. Rajkumar of Indian Spinal Injuries Centre, in the treatment of complainant’s mother Smt. Pramila Srivastava.

Complaint stands disposed.

Sd/: Sd/: Sd/:

(Dr. Maneesh Singhal) (Dr. Satish Tyagi) (Dr. Ashwani Khanna) Chairman, Delhi Medical Association Expert Member,

Disciplinary Committee Member Disciplinary Committee

Disciplinary Committee

The Order of the Disciplinary Committee dated 31st October, 2023 was confirmed by the Delhi Medical Council in its meeting held on 06th November, 2023.

By the Order & in the name of

Delhi Medical Council

(Dr. Girish Tyagi)

Secretary

Copy to :-

1. Shri Piyush Chandra, r/o 11 Floor B-56, Vasant Kunj Enclave, New Delhi-110070.
2. Dr. Raj Kumar, Through Medical Superintendent, Indian Spinal Injuries Centre, Sec-C, Vasant Kunj, New Delhi-110070.
3. Medical Superintendent, Indian Spinal Injuries Centre, Sec-C, Vasant Kunj, New Delhi-110070.

(Dr. Girish Tyagi)

Secretary