DMC/DC/F.14/Comp.2050/2/2020/ 03rd June, 2020 **O R D E R**

**The Delhi Medical Council through its Disciplinary Committee examined** a representation from Dy. Commissioner of Police Central District Delhi, forwarded by the Govt. NCT of Delhi, seeking medical opinion on a complaint of Shri Raman Suri s/o Late Hari Ram Suri r/o D-20, Green Park, First Floor, New Delhi-110016, alleging medical negligence on the part of doctors of Jeewan Mala Hospital, 67/1, New Rohtak Road, Karol Bagh, New Delhi-110005, in the treatment administered to the complaint’s father late Hari Ram Suri, resulting in his death on 22.08.2014.

The Order of the Disciplinary Committee dated 16th March, 2020 is reproduced herein-below :-

**The Disciplinary Committee of the Delhi Medical Council examined** a representation from Dy. Commissioner of Police Central District Delhi, forwarded by the Govt. NCT of Delhi, seeking medical opinion on a complaint of Shri Raman Suri s/o Late Hari Ram Suri r/o D-20, Green Park, First Floor, New Delhi-110016 (referred hereinafter as the complainant), alleging medical negligence on the part of doctors of Jeewan Mala Hospital, 67/1, New Rohtak Road, Karol Bagh, New Delhi-110005 (referred hereinafter as the said Hosptial), in the treatment administered to the complaint’s father late Hari Ram Suri (referred hereinafter as the patient), resulting in his death on 22.08.2014.

The Disciplinary Committee perused the representation from Dy. Commissioner of Police, copy of complaint of Shri Raman Suri, written statement of CEO of Jeewan Mala Hospital, enclosing therewith written statement of Dr. Vineet Sabharwal, Dr. Pankaj Kumar, Dr. Ujjwal Parakh, copy of medical records of Jeewan Mala Hospital and other documents on record.

The following were heard in person :-

1. Shri Raman Suri Complainant
2. Dr. Vineet Sabharwal Consultant Medicine, Jeewan Mala Hospital
3. Dr. Pankaj Kumar Consultant Medicine, Jeewan Mala Hospital
4. Dr. Ujjwal Parakh Chest Specialist, Consultant Medicine, Jeewan Mala Hospital
5. Dr. Naresh Jaiswal CEO, Consultant Medicine, Jeewan Mala

 Hospital

The complainant Shri Raman Suri alleged that he took his father (the patient) to Hospital on 5th July 2014 for a regular check-up of inconsequential phlegm condition. Except this phlegm, his father was in a healthy condition with no outward signs/symptoms of any serious medical issue pertaining to the lungs. His father was examined by Dr. Vineet Sabharwal who prescribed antibiotics for the phlegm condition and advised his father to get an ultrasound of the whole abdomen alongwith an x-ray of the chest done. Dr. Vineet Sabharwal arranged for his father’s chest x-ray and ultrasound of the whole abdomen on 5th Iuly 2014. Dr. Vineet Sabharwal instructed Dr. Vinod Kumar to conduct pleural tapping and took a sample of pleural fluid of his father. Dr. Vineet Sabharwal had to leave the hospital and could not see the x-ray and ultrasound report. Dr. Vineet Sabharwal was rash in his approach in failing to prescribe a follow up medical review of his father on 5th July, 2014 despite the fact that it was he who had instructed that a pleural tapping be conducted on his father without looking at the report, especially because it is essential to monitor the accumulation of pleural fluid for diagnoses and the treatment. The medico-legal report dated 1st July, 2016 prepared by Dr. Pankaj Vats clearly states that Dr. Vineet Sabharwal’s prescription slip was written in a very casual manner and was not prepared according to the prescribed standard norms of clinical examination. His father was advised almost all tests including ECG, x-ray chest, ultrasound of the whole abdomen, PSA, LFT, KFT, lipid profile, TSH, CBS, ESR without considering differential diagnosis. According to the medico-legal report, his father was also prescribed medicine without prescribing a duration for which it had to be taken. Dr. Vineet Sabhrawal only gave symptomatic treatment and did not make any provisional diagnosis. The hospital also failed to hand over the x-ray and ultrasound reports to him inspite of the fact that he and his mother spent hours in the hospital. They were also not informed about the gravity of the disease; neither follow-up instructions were given by Dr. Vinod Kumar on prescription slip given by Dr. Vineet Sabharwal nor did he give one of his own after the pleural tapping. The results of the tests done on 5th July 2014 show that his father had pleural effusion with high ESR, cause of which had to be investigated and treated. The report indicated that the pleural fluid was exudative in nature which ought to have been drained immediately, however, the hospital and the doctors miserably failed to either drain, monitor, investigate or treat the pleural effusion in any manner. Despite such callous and unwarranted conduct resulting in the deteriorating condition of his father, Dr. Vineet Sabharwal called up his mother and advised that his father was perfectly healthy and that the antibiotics would dry up phlegm in the lungs. Dr. Vineet Sabharwal failed to provide the information on the passive collapse of lungs as noted in the ultrasound done on 5th July, 2014, he (Dr. Vineet Sabharwal) failed to provide information on the pleural fluid accumulated in his father, failed to recommend a CECT scan for further investigation of pleural fluid and passive collapse of the lung. The medico-legal report that he received later on 1st July, 2016 clearly shows that a clinical evaluation a follow-up after 5-7 days antibiotic therapy was essential which was not done. The medico-legal report of Dr. Pankaj Vats, highlights that his father should not have been left untreated for one month. A bare perusal of reports clearly indicates that his father needed hospitalisation for investigation of cause of the pleural effusion and further treatment. In between he tried on multiple occasions to collect the reports from Dr. Vineet Sabharwal and the hospital, but despite his repeated efforts and requests they did not provide him with these reports nor did they peruse the reports before administering the further course of treatment. On 3rd August 2014, his father lost his appetite and could not eat all day. On 4th, August 2014, his father complaint of weakness and Dr. T.N. Rao was thereafter called to examine his father for a home visit. He provided the medication for the symptoms. Realizing Dr. Vineet Sabharwal had not handed over the reports after giving his advice, he(the complainant) urgently sent a courier to collect the reports for further treatment/investigation. Dr. Vineet Sabharwal on arrival of his courier of reports of July immediately called to advise CECT Scan for the patient at the hospital. It was a shock to the complainant that on the basis of the tests done in July and no additional information Dr. Vineet Sabharwal advised an urgent CECT. His father was taken to the hospital where his father was admitted immediately without being examined by a registered medical practitioner. His father was admitted in the hospital at 11:35 p.m. on 4th August 2014 whereupon he was purportedly taken for an x-ray of the chest without being examined by any medical practitioner. Only after this alleged x-ray, Dr. Pankaj Kumar examined his father and diagnosed him to be having respiratory distress, this was despite the fact that his father showed no symptoms of any respiratory distress which can be shown by the fact that the physician Dr. T.N. Rao did not report/ note any respiratory distress. Dr. Pankaj Kumar misdiagnosed the pleural fluid in the lungs of his father as “transudate” even though the medical report showed the nature of the fluid as exudative. Dr. Pankaj Kumar did not only fail to determine the nature of the pleural fluid, he (Dr. Pankaj Kumar) also did not drain the pleural fluid despite the report indicating that pleural fluid ought to have been drained. On 7th August 2014 anti-tubercular treatment was started, as combination of 4 drugs and daily doses without considering risk factor of liver hepatotoxicity, age of the patient, weight of the patient, without prescription-of pulmonologist, as highlighted by the medico-legal report prepared by Dr, Pankaj Vats on 1st July, 2016. The negligence of the Hospital can be made evident from the fact that adenosine deaminase values in pleural fluid were within normal limits and still his father was medicated for tuberculosis. The medico-legal report also highlighted that anti-tuberculosis treatment was started before making any differential diagnosis, without ruling out other reasons of mild pleural effusion and most importantly without taking 2-3 mandatory samples of sputum for testing for AFB and culture. Neither was his family advised about their toxicity nor was their permission taken for administering these toxic medicines to his 89 year old father. The medication for tuberculosis was started and continued inspite of no AFB seen in pleural fluid. The medico-legal report pointed out that quantiferon TB gold test was negative which shows that tuberculosis infection was not likely and still his father was treated from 7th August to 9th August, 2014 without even receiving any reports confirming tuberculosis. Anti-tuberculosis treatment was continued inspite of his father being in coma on 13th August 2014. The receipt of liver function test dated 13th August 2014 show the acute onset of heptotoxity symptoms 10 to 13 times and still the treatment for tuberculosis continued till the death of his father. On 13th, August 2014, his father went into cardio respiratory arrest and the cause of the cardio-respiratory arrest was not investigated and treated after resuscitation. No opinion of the cardiologist was taken. Even when his father was on ventilator, there is no evidence of central venous line an arterial line insertion which shows that he was· never on a ventilator in actuality. This only means that his father who had already expired on 13th August 2014 and the doctors of Jeewan Mala Hospital kept his father on ventilator to cover up the cause of his father death. In this manner, they also cheated the complainant and C.G.H.S. by compelling him to pay for the treatment purportedly given to his father on ventilator from 13th August, 2014 to 22nd August, 2014. His father died on 22nd August, 2014 due to fraudulent, negligent and callous conduct of the doctors of the Jeewan Mala Hospital. The Hospital went on to provide the complainant with death summary after several days gap which had no mention of anti-tuberculosis treatment and its toxicity, it had no notes of referral consultant on tuberculosis treatment, the summary had missing pages which shows intentional covering up for some wrong done by the hospital. As per the analysis of the Dr. Pankaj Vats, a medico-legal expert, cause of death of his father was Anti tubercular drugs which resulted in acute liver injury and sequencial terminal event. He has also suggested that the cause of death was asphysia due to aspiration of food/phlegm resulting in cerebra hypoxia and unconsciousness. He had already filed a consumer complaint for negligence earlier, as he did not have the benefit of the report of the medico-legal expert. It is now apparent that the conduct of the doctors of Jeewan Mala Hospital has not only been negligent but also deliberate. They played fraud upon him and also indulged in acts that they knew would result in the death of his father. They did not monitor the liver of his father and recklessly kept administering the toxic anti-TB medication, even when the patient was in a state of coma and totally unconscious, resulting in the death of his father. The toxicity of this medication weakened him enormously where he first lost his ability to communicate verbally, and then became so weak because of this toxicity that on 13.04.14 was not able to cough out aspiration or regurgitation of some food or phlegm, causing asphyxia (choking) leading to his death. Because of the above weakness condition, his father should have been in the ICU when in this quasi-unconscious state, before his asphyxiation and not left in the care of his attendant alone (him), which was a gross negligence on part of the hospital. At the same time, no treatment was prescribed for his father’s pleural effusion for more than one and half months since its detection with fluid inside. The hospital administration also appears to have forged and fabricated the x-ray of his father. The x-ray dated 05.08.14 finds mention only in the death summary and nowhere else. The fluid in the lungs seems same in both x-rays dated 05.08.14 and dated 04.08.14, when the hospital’s own CT scan and ultrasound tests show that it had doubled between July and August. He has also been making efforts to obtain the complete medical records of his father from Jeewan Mala Hospital but his efforts have not succeeded. The hospital is deliberately avoiding their obligation to give him the entire medical records of his father. Even the documents that he has received are not complete. The essential documents that are missing are as follow:-1.Admission Form. 2. Casualty Medical Report. 3. Prescription for x-ray on 4/8/14. 4. Physicians’ prescription for medications, particularly for the critical ATT medication. 5. LFT reports. LFT was to be done daily (page 92/57). Reports are available only for 13th, 14th and 15th Aug 2014. 6. CT Abdomen report. 7. Cytology report for the 2nd diagnostic tap in .August. 8. Brain scan report. He requests that strict action be taken against the doctors of Jeewan Mala Hospital for their act of medical negligence.

He further alleged that no written consent was taken by the doctors of Jeewan Mala Hospital for the procedure of pleural tapping done on 5th July, 2014.

Dr. Vineet Sabharwal, Physician, Jeewan Mala Hospital in his written statement averred that on 05.07.2014, the complainant Shri Raman Suri had approached the Hospital alongwith his 89 years old father later Hari Ram Suri (patient) who was known case of dementia, was brought to the hospital on wheel chair in OPD with complaints of breathlessness with fever and hemoptysis. He at the Hospital had promptly evaluated the medical condition of the patient. After examining the patient, he prescribed the X-ray chest, ultrasound and blood investigation. He further prescribed medicines for five days with the instructions for follow up treatment. The investigations, ultrasound whole abdomen and x-ray PA view were done in the Hospital on urgent basis as the complainant was in hurry to leave the hospital. The radiologist informed him that the patient is having left sided mild pleural effusion. Accordingly, he advised for urgent diagnostic pleural fluid examination which was done on same day evening by Dr. Vinod (Intensivist) under ultrasound guided and sent to lab for testing. The relatives of the patient were explained each and every thing about the procedure required. The attendants were advised to bring the patient for follow up treatment with all the report and in the mean while asked to continue the prescribed medicine for five days. He provided the treatment to the patient in terms of the prevailing medical protocols for exudative pleural effusion (pleural report dated 07.07.2014 shows that protein contents of pleural fluid was 5.49 gm/dl and predominantly lymphocytic (approx. 85% lymphocytes) again suggestive of exudative pleural effusion. It is noteworthy that the pleural fluid was not gross in nature which requires urgent drainage, as shown in ultra sound report dated 05.07.2014 and X-ray report dated 05.07.2014. The patient did not turn up for follow up treatment till 04.08.2014 i.e. nearly one month. On 04.08.2014, the patient’s wife called on him on phone and informed about the condition of the patient to which he responded her to bring the patient immediately to the hospital. The patient was brought to the hospital on 04.08.2014 in an emergency section where Casualty Medical Officer (CMO) Dr. Pradeep examined the patient. Considering the condition of the patient, the patient was immediately advised for the admission of the patient. The doctors at the hospital had taken immediate steps for the well being of the patient; therefore, the X-ray was conducted without any further delay. The doctors had considered the conditions/ symptoms of the patient at the time of administering the treatment and, thus, the X-ray was taken at the hospital in the intervening night of 04.08.2014. Dr. Pankaj Kumar had examined the patient and found that the patient was bed ridden, frail and tachypenic and his respiratory rate was 20 per minute. He had noted that the patient is having Respiratory Distress, as the condition of the patient. The pleural fluid was drained on 05.08.2014 and the same were sent for medical test to investigate the nature of fluid. The patient was treated for exudative nature of fluid which can be seen from the line of treatment followed by them. The pleural fluid was sent for further investigation viz. Cytology for determining the malignancy(cancer), ADA, Culture. On the basis of the reports of these tests and clinical analysis, Empirical ATT was started along with intravenous antibiotic and other supportive treatment. It is noteworthy that the tests conducted showed no evidence of malignancy and any other disease that can be caused by the pleural fluid in the patient; therefore, he had opted for giving the ATT empirically for the betterment of the patient. It is not always possible to make definite diagnosis of tuberculosis esp. when it is outside the lungs. It is submitted that when no other diseases known to cause lymphocytic exudative pleural fluid is evident, in such case, empirical ATT is advisable in a sick patient. He was monitoring the blood oxygen saturation by pulse oximeter regularly and was treating the patient accordingly. ABO test was done on l3.08.2014, as the patient suffered from cardiac pulmonary arrest and was shifted to ICU. The radiologically calculated volume of pleural fluid was mild (as per the ultrasound report dated 06.08.14) and, therefore, not indicated to do therapeutic drainage. It is respectfully submitted that the pleural collection was mild fluid and not PUS; therefore, the patient did not require Intra Coastal Tube Drainage (ICD). It is pertinent to mention here that the patient was advised for feeding with Ryle’s tube on 06.08.2014; however, the complainant kept interfering with the treatment and was compelling the nursing staff for oral feeding of the patient despite being warned of the possible consequences. It is pertinent to note here that the complainant had not given the requisite consent for inserting Ryle’s Tube till 09.08.2014 which can be seen from the documents placed on record. The Patient was looked after by the best doctors of the hospital including Dr. Pankaj Kumar, a qualified chest physician, who was the part of the treating unit in the hospital and has seen the patient regularly during the course of the treatment in the hospital. It is further submitted that Dr. Ujjwal Parikh (a chest specialist from Sir Ganga Ram Hospital) was also called for the second opinion upon the treatment of the patient. Dr. Ujjwal Parikh had perused the case sheet and examined the patient in detail and went through the available investigations report. The said investigation reports revealed- The pleural fluid reports of fluid aspirated on 05/07/14 on OPD Colour----yellow, Appearance - Hazy, pH ----7.0. Coagulum --- absent, protein--- 5.49 gm/dl, albumin---2.00 gm/dl sugar ---105 mg/dl, cell count ---3000 cells/cumm M/E *---*smears show predominantly lymphocytes (approx 85%), few mesothelial cells and occasional polymorph, RBC (++). No Malignant cell seen in the present smear examined. ADA of pleural fluid ---30.24 u/l. Investigations done on 04/08/14 revealed Haemogram dt 05/08/14 -Hemoglobin -11.6 g/dl, TLC- 6300/ uL. DLC- neutrophils -45%, lymphocytes -50%, eosinophils -3%. Monocytes-2%. Platelet count-373000/uL, ESR-33 mm/I hr. Kidney function test (KFT/RFT) dt 05/08/14 -Blood urea- 36.92 mg/dl, Serum creatinine - 0.75 mg/dl, Serum Uric acid - 4.96 mg/dl, Sodium -131 mmol/L, Potassium -5.1 mmol/L, Liver function test (LFT) dt 05/08/14- Total protein- 7.60 gmldl, Albumin - 3.06 gmldl, Globulin - 4.54 gmldl. A:G ratio - 0.7, SGOT-22.69 U/L, SGPT-7.83 U/L, Alkaline phosphatase- 72.08 U/L, GGTP - 19.6 U/L, Bilirubin (Total) - 0.38 mg/dl, Bilirubin (Direct) - 0.13 mg/dl. Bilirubin (Indirect) - 0.25 mg/dl, X-ray chest PA dt 04/08/14. There is scoliosis of dorsal vertebrae noted. Bilateral apical pleural cap (fibrosis) noted. Both lungs are hyper inflated with flattening of domes of diaphragm and prominent bronchovascular markings s/o COPD changes. Left CP angle is blunted. Pleural effusion thickening. Right costophrenic angle is clear. Heart and mediastinum appears normal. Aortic knuckle calcification is noted. Bones under view show reduced bone density (osteopenia). Ultrasound whole abdomen dt 05/08/14-mild left pleural effusion with passive collapse consolidation of left lower lobe. Bilateral renal cortical cysts. Pleural fluid aspirated on 05/08/14 -: Colour - p. yellow, Appearance – hazy, PH -- 7.5, coagulum --- absent, protein - 5.51 gmldl, albumin - 2.00 gmld, sugar - 148 mg/dl, cell count - 2500 cells/ cumm, M/E --- polymorphs -02%, lymphocytes -90%, mesothelial cells -08%, RBC (+0. No malignant cells seen in the present smear examined. ADA of pleural fluid -19.47 u/L. The pleural fluid shown in the report was not the pus. The pleural fluid report was lymphocytic exudative with high cell count with one report of ADA >30 u/l. Lymphocytic exudative pleural effusion can be due to -tuberculosis, - malignancy, -lymphoma or – sarcoidosis. Based upon the above diagnosis and test reports, the patient had been prescribed antibiotics - Augmentin and Glevo, antacids and vitamin and appetizer by the treating unit. Accordingly, Dr. Parikh did not prescribe any changes in the treatment, as there was no conclusive alternate diagnosis. It is further submitted that Dr. Parikh had suggested C'T of abdomen along with CT of chest to rule out other causes especially malignancy considering the age of patient. The attendants of the patient was painstakingly explained by the doctors each and every thing about the ongoing medical treatment. The CT chest has revealed the “mild to moderate low attenuation left pleural effusion with passive collapse consolidation of the left lower lobe. Parenchymal infiltrates involving right lower lobe, mainly superior segment with adjacent ground glass haze. Peripheral branching opacities in left upper lobe, lingular segments and anterior segment of right upper lobe. Mildly enlarged mediastinal lymph nodes - suggestive of infective etiology. COAD changes”. It is noteworthy that the CT abdomen was normal. Therefore, empirically anti tubercular treatment (ATT*)* was given to the patient by them on 07.08.14. The patient was reviewed along with the test reports on 11.08.14 by Dr. Parikh and observed that there was still no conclusive evidence of tuberculosis. However, considering the poor condition of the patient, the pleural fluid being lymphocytic exudative and no clear evidence of alternative diagnosis; Dr. Parikh was of the considered opinion for continuing the empirical ATT because tuberculosis, as cause of pleural effusion is very common in the country and at times said tuberculosis cannot be traced through test reports. It may not be out of place to mention here that the we did not suggest any invasive tests like surgical pleural and lymph node biopsy, bronchoscopy or EBUS-FNA for the patient as 89 years old patient having dementia, was not fit for such invasive tests which were required to be done under general anesthesia. It is further submitted that the said opinion was explained to the attendants. It is further pertinent to mention here that as an alternative to this, the doctors had suggested for PET scan of the patient, a non invasive investigation, to ascertain the condition of the patient; however, the complainant had flatly refused for the said test for reasons best known to him. Since the patient did not have massive pleural effusion or pus in the pleural cavity, draining the pleural fluid by inter coastal chest tube (a painful surgical procedure) was not prescribed. Thus, he had given the best treatment to the patient as per their understanding about the condition of the patient. It is denied that the patient was not investigated and efforts were not made to diagnose. It is respectfully submitted that the test conducted to investigate the medical condition of the patient were as :- 04/08/14 –chest X-ray PA view, 05/08/14 - complete haemogram, urine R/Mrenal function test, LFT, Lipid profile, serum calcium, serum phosphate, TSH, PSA, blood sugar, Mantoux test, ultrasound of whole abdomen, ECHO, ultrasound guided pleural fluid aspiration, CECT thorax, pleural fluid protein and sugar, cytology fluid (TLC, DLC), Cytology fluid (malignant Cells), ADA level, AFB (ZN stain and rapid AFB culture). 07/08/14-CECT abdomen. 08/08/14, Quantiferon TB gold, Myco TMA. It is pertinent to mention here that all the above mentioned tests were conducted at the earliest possible stages considering the conditions of the patient which itself shows the promptness of the doctors with regard to the health of the patient. It is most respectfully submitted that the treatment of possible infections with antibiotics and ATT was initiated quickly. The other causes of pleural effusion including malignancy were looked into but no way could the anticancer drugs be given without confirmed diagnosis of cancer. It will not be out of place to mention that empirical treatment of tuberculosis is an acceptable modality, as confirmed diagnosis of tuberculosis especially outside the lung is often not possible. It is pertinent to mention here that there was no evidence for the presence of cancer cell in the pleural fluid on two occasions when the tests were conducted on 05.08.2014 and 08.08.2014. It is further submitted that the PET scan requires administration of radioactive dye and X-ray radiation exposure to the whole body and, therefore, not the initial choice of investigation especially considering the health of the patient. PET scan was advised when other modalities of the investigations did not yield any conclusive results. It was suggested for the patient as no conclusive diagnosis could be made out with the above non invasive investigations. It is pertinent to mention here that the PET scan was denied by the complainant for reasons best known to him. It is further submitted that the procedures like EBUS, thoracoscopic biopsy of pleura and the lymph nodes require surgery under general anaesthesia for which the patient was not fit. Therefore, the doctors did not advise the patient who was 89 years old, to undergo the above mentioned invasive surgical procedures. On 13.08.2014, at around 9:00 a.m. the patient had sudden cardio respiratory arrest in the room. Blue code was announced immediately and CPR was started along with cardiac massage, patient's heartbeat revived, was intubated and taken to intensive care unit, with full precaution and ventilated. Later on, the patient had recurrent seizures may be due to hypoxic brain damage for which antiepileptic started and managed with injectable phenytoin and other supporting measures. In due course of hospital treatment, the patient’s condition was very poor and had episode of intermittent VT also. The patient continued on mechanical ventilator and inotropic support. Neurologist opinion was also taken in view of seizure and advice was followed. On 22/08/14 at around 11 a.m., the patient had cardiac arrest and could not be revived and CPR effort terminated and patient declared dead at 11.40 a.m. It is most humbly submitted that he had taken every precaution to provide the best treatment to the patient. The said treatment can be seen from the case sheet itself which is placed on record alongwith medical documents, wherein the details of each and every treatment is recorded. It is further recorded in the case sheet itself that the poor prognosis of the patient has been explained to the family member. The doctors have taken the every possible steps to clear the phlegm by doing regular physiotherapy. It may not be out of place to mention here that treatment to an 89 year old patient suffering from dementia has to be given in a cautious manner. He has adopted all due care and caution for the treatment of the patient and as per the available medical guidelines. On above said facts, he is of the opinion that in this case, standard treatment as per standard protocol was followed. Empirical treatment of ATT was started as per National Tuberculosis Control Programme Guidelines. The patient was quite old; precisely 89 years carried a bad prognosis in terms of age. The patient when brought to hospital was in bad shape clinically. Strong possibility of natural death keeping in view of advanced age and bad clinical condition is a high probability. There has been no negligence on part of doctors and hospital. The doctors and hospital provided standard medical treatment and care as per laid down procedure. The patient’s relatives did not give consent many times and not followed the advice given by him, thus, contributed to contributory negligence.

Dr. Ujjwal Parakh Chest Specialist, Jeewan Mala Hospital in his written statement averred that he was called by Dr. Vineet Sabarwal and Dr. Pankaj Kumar, to give second opinion for the patient, Shri Hari Ram Suri, 89 years old gentleman, a bedridden patient of dementia with left sided mild pleural effusion and extreme weakness, who was admitted under them on 04/8/14 in Jeewan Mala Hospital. He first saw the patient on 07/08/14. He went through the case sheet, the history, examined the patient in detail and went through the available investigations. The investigation reports revealed-the pleural fluid reports of fluid aspirated on 05/07/14on OPD basis-Colour---- yellow, Appearance – Hazy, pH ---- 7.0, coagulum --- absent, protein --- 5.49 gm/dl, albumin --- 2.00 gm/dl, sugar --- 105 mg/dl cell count --- 3000 cells/cumm. M/E --- smears show predominantly lymphocytes(approx 85%), few mesothelial cells and occasional polymorph, RBC (++). No Malignant cell seen in the present smear examined. ADA of pleural fluid---30.24 u/l. The investigations done in the present admission after 04/08/14revealed X-ray chest PA dt 04/08/14, there is scoliosis of dorsal vertebrae noted. Bilateral apical pleural cap(fibrosis) noted. Both lungs are hyperinflated with flattening of domes of diaphragm and prominent bronchovascular markings s/o COPD changes. Left CP angle is blunted? pleural effusion ?? thickening. right costophrenic angle is clear. Heart and mediastinum appears normal. Aortic knuckle calcification is noted. Bones under view show reduced bone density (osteopenia). Ultrasound whole abdomen dt 05/08/14 -mild left pleural effusion with passive collapse consolidation of left lower lobe. Bilateral renal cortical cysts. Pleural fluid aspirated on 05/08/14, colour - p. yellow, Appearance – hazy, pH -- 7.5, coagulum --- absent, protein - 5.51 gm/dl, albumin - 2.00 gm/dl, sugar - 148 mg/dl cell count - 2500 cellsl cu mm, M/E---polymorphs -02%, lymphocytes -90%, mesothelial cells -08%, RBC (+0. No malignant cells seen in the present smear examined. ADA of pleural fluid -19.47 u/L. The pleural fluid was not pus as per the report above. The pleural fluid report was lymphocytic exudative with high cell count with one report of ADA >30 u/I. Lymphocytic exudative pleural effusion can be due to -tuberculosis, -malignancy, -lymphoma or –sarcoidosis. The patient had been prescribed antibiotics- Augmentin and Glevo, antacids and vitamin and appetizer. No change in treatment, as prescribed by the treating unit, was suggested, as there was no conclusive alternate diagnosis. Therefore, he suggested CT of abdomen along with CT of chest to rule out other causes especially malignancy considering his age. He was asked to review the patient. He examined the patient for the second time on 11/08/14. The CT chest done was reported to have “mild to moderate low attenuation left pleural effusion with passive collapse consolidation of the left lower lobe. Parenchymal infiltrates involving right lower lobe, mainly superior segment with adjacent ground glass haze. Peripheral branching opacities in left upper lobe, lingular segments and anterior segment of right upper lobe. Mildly enlarged mediastinal lymph nodes - suggestive of infective etiology. COAD changes”. The CT abdomen was essentially normal. The patient had also been empirically started on anti-tubercular treatment (ATT) by the treating unit on 07/08/14. On reviewing the patient and the above reports, there was still no conclusive evidence of tuberculosis. But looking at the poor general condition of the patient, the pleural fluid being lymphocytic exudative and no clear evidence of alternative diagnosis, he was of the opinion of continuing the empirical ATT. He also suggested that PET scan of the patient may be done to simultaneously keep looking for possible alternative diagnosis. The opinion given by him was to the best his knowledge and in good faith. He saw the patient twice, on 07/08/14 and 11/08/14*.* Thereafter, he was never asked to review the patient. On the above said facts, he is of the opinion that in this case, standard treatment as per standard protocol was followed. Empirical treatment of ATT was started as per National Tuberculosis Control Programme Guidelines. The patient was quite old; precisely 89 years carried a bad prognosis in terms of age. The patient when brought to hospital was in bad shape clinically. Strong possibility of natural death keeping in view of advanced age and bad clinical condition is a high probability. There has been no negligence on part of doctors and hospital. The doctors and hospital provided standard medical treatment and care as per laid down procedure.

Dr. Pankaj Kumar, Consultant Medicine, Jeewan Mala Hospital in his written statement averred that he saw the patient Shri Hari Ram Suri on 5th August, 2014 (as per record) who was a known case of dementia and admitted for management of shortness of breath with very poor oral intake. The patient was fragile and bedridden. On reviewing the patient’s medical record and initial examination, he got to know that the patient was admitted for the management of mild pleural effusions. After examining the case, he informed about the patient to his senior Dr. Vineet Sabharwal and advice followed. Entire investigation was focused to look for the cause of pleural effusion, for which, repeat aspiration of pleural fluid done on 5th August, 2014 and 8th August, 2014 but nothing was contributory towards exact cause. So, after taking the second opinion with chest specialist empirical ATT (anti-tuberculosis treatment) was started and further investigation continued. Every suggestion was first discussed with his senior Dr. Vineet Sabharwal and implementation was done with his approval. On 13th August, 2014 at morning, while the patient was in room No.114, a code blue announcement was made, as the patient had vomited, following which, the patient had cardio-respiratory arrest. Their resuscitation team arrived and with due resuscitative effort was able to revive the patient and shifted the patient in ICU and taken on mechanical ventilator and inotropic support. The same event was intimated to Dr. Vineet Sabharwal also. Afterword, all the treatment was continued in ICU. In due course of the treatment, the patient had myoclonic seizure, for which, neurologist opinion was also taken. Putting all effort together with the given treatment, the patient kept on deteriorating and took his last breath on 22nd August, 2014. On above said facts, he is of the opinion that in this case, standard treatment as per standard protocol was followed. Empirical treatment of ATT was started as per National Tuberculosis Control Programme Guidelines. The patient was quite old; precisely 89 years old carried a bad prognosis in terms of age. The patient when brought to the hospital was in bad shape clinically. The strong possibility of natural death keeping in view of advance age and bad clinical condition is a high probability. There has been no negligence on the part of the doctors and hospital. The doctors and hospital provided standard medical treatment and care as per laid down procedure.

CEO of Jeewan Mala Hospital in his written statement averred that they denied any medical negligence in the treatment.

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

1. It is noted that Late Shri Hari Ram Suri (aged 89 years) was examined by Dr. Vineet Sabarwal on 5.7.2014 for shortness of breath/fever and heamoptysis. He was evaluated and started on antibiotics to be given for 5 days. His plueral tap was done as per the protocol, which showed exudative effusion which was predominantly lymphocytic. No follow up was done after 5 days. The patient was readmitted with severe shortness of breath and generalized weakness on 4.8.2014 and found to still have effusion with COPD which was again tapped and found to be exudative with lymphocytic predominant. Anti tubercular treatment (ATT) was started on clinical grounds along with other supportive therapy. On 13th August, 2014 the patient had to be put on ventilatory support and expired on 22.8.2014.
2. The patient was started on Anti Tubercular Treatment (ATT) on 7.8.2014 following clinical suspicion of TB effusion based on the investigations. The LFT test done on 5.8.2014 was normal. Following Anti Tubercular Treatment (ATT), the serum level of transaminases were rising with SGPT at 94U/L and SGOT at 286.5 U/L on 13.8.2014. The ATT was continued with SGOT at 172.65 and SGAT being 169.9 on 14.8.2014 with a normal S. Bilirubin.

However the SGOT was 74.3 and SGPT 75.23U/L on 15.8.2014. Even though the LFT have shown a fall while on ATT on 15.8.2014, no follow up LFTs are available after 15.8.2014, which are expected in a patient on ATT, as part of standard protocol.

In absence of follow up LFTs after the falling level of transaminases, Anti Tubercular Treatment (ATT) induced hepatotoxicity as cause of death cannot be ascertained.

In view of the observations made hereinabove, it is the decision of the Disciplinary Committee recommends that Dr. Vineet Sabharwal is advised to exercise due diligence in strictly adhering to standard protocols, while managing such patient in future.

Complaint stands disposed.

Sd/: Sd/:

(Dr. Subodh Kumar), (Dr. Ashwini Dalmiya)

Chairman, Delhi Medical Association,

Disciplinary Committee Member,

Disciplinary Committee

Sd/: Sd/:

(Dr. Ashwani Khanna) (Dr. Yatish Aggarwal)

Expert Member Expert Member,

Disciplinary Committee Disciplinary Committee

The Order of the Disciplinary Committee dated 16th March, 2020 was confirmed by the Delhi Medical Council in its meeting held on 20th March, 2020.

 By the Order & in the name

 of Delhi Medical Council

 (Dr. Girish Tyagi)

 Secretary

Copy to:-

1. Shri Raman Suri s/o Late Hari Ram Suri r/o D-20, Green Park, First Floor, New Delhi-110016.
2. Dr. Vineet Sabharwal, Through Medical Superintendent, Jeewan Mala Hospital, 67/1, New Rohtak Road, Karol Bagh, New Delhi-110005.
3. Dr. Pankaj Kumar, Through Medical Superintendent, Jeewan Mala Hospital, 67/1, New Rohtak Road, Karol Bagh, New Delhi-110005.
4. Dr. Ujjawal Parakh, Through Medical Superintendent, Jeewan Mala Hospital, 67/1, New Rohtak Road, Karol Bagh, New Delhi-110005.
5. Medical Superintendent, Jeewan Mala Hospital, 67/1, New Rohtak Road, Karol Bagh, New Delhi-110005.
6. Superintendent (P&R), Health & Family Welfare Department, Govt. of NCT of Delhi, 9th Level, A-Wing, Delhi Secretariat, I.P. Estate, New Delhi-110002-w.r.t. letter No.342/MB-18/2017/P&R/H&FW/2427-28 dated 09-03-2017-for information.
7. Dy. Commissioner of Police, Central District, Office of the Dy. Commissioner of Police, Central District, Delhi-110002-w.r.t. letter No.2744/SO/DCP/C(AC-II) dated Delhi the 28.02.2017-**for information**.
8. Station House Officer, Police Station, Desh Bandhu Gupta Road, New Delhi-110005-w.r.t. C C No. 12558/17, DBG Road 200/156 (3) CrPc, Raman Suri Vs. Dr. Vineet Sabharwal & Ors.

 (Dr. Girish Tyagi) Secretary