DMC/DC/F.14/Comp.2494/2/2020/ 01st June, 2020

**O R D E R**

The Delhi Medical Council through its Disciplinary Committee examined a representation no.F.23/Comp./76/NWD/DGHS /HQ /NH/ 2018/536 dated 14.06.2018 from the Directorate General of Health Services, seeking investigation into a complaint of Shri Uttam Chand Meena, Manager (T), 17-D, Vikas Niketan, Pitampura, Delhi-110034, alleging medical negligence on the part of the doctors of Saroj Super Speciality Hospital, Madhuban Chowk, Rohini, Delhi-110085, in the treatment administered to the complainant’s wife Mrs. Gargi Meena at Saroj Super Hospital, resulting in her death on 31.03.2018.

The Order of the Disciplinary Committee dated 09th March, 2020 is reproduced herein-below :-

The Disciplinary Committee of the Delhi Medical Council examined a representation no.F.23/Comp./76/NWD/DGHS /HQ /NH/ 2018/536 dated 14.06.2018 from the Directorate General of Health Services, seeking investigation into a complaint of Shri Uttam Chand Meena, Manager (T), 17-D, Vikas Niketan, Pitampura, Delhi-110034 (referred hereinafter as the complainant), alleging medical negligence on the part of the doctors of Saroj Super Speciality Hospital, Madhuban Chowk, Rohini, Delhi-110085, in the treatment administered to the complainant’s wife Mrs. Gargi Meena (referred hereinafter as the patient) at Saroj Super Hospital(referred hereinafter as the said Hospital), resulting in her death on 31.03.2018.

It is noted that the Delhi Medical Council has also received a representation from the Police Station Prashant Vihar, Delhi, whose subject matter is same as that of complaint of Shri Uttam Chand Meena, hence, the Disciplinary Committee is disposing both of these matters by this common Order.

The Disciplinary Committee perused the complaint, additional complaint of Shri Uttam Chand Meena, representation from Police, written statement of Dr. Kiran Chawla, G.M. Medical Operation, Saroj Super Specialty Hospital enclosing therewith joint written statement of Dr. Nisha Jain, Dr. Greeesh Manwani, Dr. Vivek Gupta, written statement of Dr. Priyanka Gupta, supplementary written statement of Dr. Kiran Chawla, Dy. G.M. Medical Operation, Saroj Super Specialty Hospital enclosing therewith supplementary written statement of Dr. Nisha Jain, Dr. Greeesh Manwani, Dr. Vivek Gupta, written statement of Dr. Dharamvir Sagar made to Diector, Saroj Super Speciality Hospital, Dr. Sanjeev Aggarwal, Dr. Subrat Bhushan Sharma, Dr. Prashant Bothra, Dr. Sushma and Dr. Rajesh Rana, copy of medical records of Saroj Super Specialty Hospital, post-mortem report No.277/2019 dated 03.04.2018, subsequent opinion regarding cause of death in respect of the post-mortem report No.277/2019 dated 01.03.2019, rejoinder of Shri Uttam Chand Meena, additional rejoinder of Shri Uttam Chand Meena and other documents on records.

The following were heard in person :-

1) Shri Uttam Chand Meena Complainant

2) Ms. Geetanjali Meena Daughter of the complainant

3) Shri Pramod Kr. Friend of the complainant

4) Dr. Nisha Jain Sr. Gynae. Consultant, Saroj Super Speciality Hospital

5) Dr. Greesh Manwani Physician, Saroj Super Speciality

 Hospital

6) Dr. Vivek Gupta SR Consultant, Saroj Super Speciality Hospital

7) Dr. Priyanka Gupta Clinical Assistant (formerly), Saroj Super Speciality Hospital

8) Dr. Sushma Senior Resident, Saroj Super Speciality Hospital

9) Dr. Kiran Chawla DGM Med Op, Saroj Super Speciality Hospital

The Disciplinary Committee noted that Dr. Dharamvir Sagar failed to appear before the Disciplinary Committee, inspite of notice.

The complainant Shri Uttam Chand Meena alleged that in the morning of 29.03.2018 at about 9.30 a.m., the patient Smt. Gargi Meena, while under menstrual cycle for last two days (LMP 27.03.2018), felt mild pain of periods in her lower abdomen. He and Smt. Gargi Meena alongwith their children had to visit Ajmer Sharif and Pushkar, they wanted her to be medically fit for the journey and Smt. Gargi Meena alongwith her eldest daughter visited Saroj Hospital in casualty for menstrual pain management. The doctors at casualty examined Smt. Gargi Meena and after giving an injection told her that there is nothing to worry. But by way of abundant precaution, the wife of the complainant decided to consult the doctor in OPD on the same day to take medicine as a precaution for the pain management during aforementioned journey. Smt. Gargi Meena after taking said treatment in causality, went to OPD on the same day within about one hour where she was examined by Dr. Nisha Jain who advised her for an urgent ultrasound of lower abdomen, as according to Dr. Nisha Jain diagnosis there was some serious possibility of fibroid in the uterus of Smt. Gargi Meena. Urgent USG TVS was denied by Saroj Hospital, Dr. Nisha Jain even suggested/insisted to get the ultrasound done from some place other than Saroj Hospital, it means even as per knowledge of Dr. Nisha Jain, Smt. Gargi Meena was fit to go outside , on the other hand she stated that Gargi Meena was bleeding like a tap and fainting in OPD. Why she did so reason is best known to Dr. Nisha Jain. Somehow, a TVS ultrasound of Smt. Gargi Meena was done at Saroj Hospital only after some-time at around 11.04 am, 29.03.2018. It is pertinent to mention that payment of said test was already deposited at Saroj Hospital prior to suggestion of doctor to get USG TVS done from outside Saroj. Therefore, the same was not accepted, moreover, the patient was also fit and fine, as mentioned above. The said visit to the hospital was not planned visit and the patient visited hospital after having breakfast in the morning as usual. After TVS, she proceeded to doctor, and as per doctor advice, they started to get all tests done before admission. After patient’s blood sample, Lab Asstt. advised revisit for 2nd blood sample after taking some food. So, she took some light food. In the meantime, a phone call was received to reach labour ward and there they admitted the patient into labour ward and neither 2nd blood sample was given to lab nor pp blood test report prepared. To exaggerate the problem in the mind of the patient and her attendant, doctors mentioned medical symptoms as many as they can. They wrote Menorrhagia, Metrorrhagia and excessive bleeding which can be written in a single word i.e. Menometrorrhagia. This was our very first of day acknowledging uterine fibroid at Saroj on 29-03-2018 even though doctor jumped to surgery without giving any option of conservative treatment. Besides obtaining signature on blank forms, doctor also took signature on blood transfusion table along with said admission / consent forms. The motive to do so is not clear to them. After seeing the TVS ultrasound report of Smt. Gargi Meena, Dr. Nisha Jain said that urgent operation is to be done and if not done it may be fatal for Smt. Gargi Meena. Believing the doctor, consent under fear of death was given on blank formats without disclosing risks/complications involved in TLH by the doctor and that too with previous three LSCS to make it informed consent. Blank forms were signed under fear of death of the patient as per doctor mouth saying of excessive bleeding; rather the patient was not having any excessive bleeding. It is submitted that during menstruation, uterus is very much vascular and chances of bleeding during these days are extremely high. So ideally procedures are / ought to be done during post-menstruation. Smt. Gargi Meena was admitted for operation as per procedure in the hospital at 2:04 p.m. After preparations for the operation, the operation started at about 5.30 PM and finished at about 8.00 pm i.e. for about 2.30 hrs or so. Orientation of the patient was good as per record of admission. Urine sample was sent on 29.03.18 at 1: 16 pm and the report was not collected by the concerned surgeon before the procedure, surprisingly the report has shown plenty of pus cells(10-12) which is a sign of severe UTI. Thereafter on contacting, Dr. Nisha Jain told that the operation was successful and the patient will be discharged within couple of days. After the operation, the patient was kept in postoperative labour room and thereafter in labour ICU instead of shifting to ward. This change in plan speaks about hidden truth that doctors have some doubt in their surgery for which they wanted to settle before / shifting her. On 30.03.2019 in the morning at about 9.30 AM, the patient was shifted to ICU due to the reason that her pulse rate was 46/min, BP 90/60 and SP02 92%, were down and RBS was very high @358. On 31.03.2018 at 3.00 AM the SP02 came down further and the doctors wanted consent for MV (Mechanical Ventilator) which was received from the relatives of the patient and at 3.20 AM, consent was got signed for mechanical ventilator. The patient was intubated but immediately the patient had cardiac arrest. Resuscitative measures were taken and at 4.12 AM, the patient was declared dead. Cardio pulmonary arrest as per ICU I/C occurred at 3:30 a.m. and death at 4:12 a.m. In these timings, CPR could not be co related with doctor’s treatment for giving CPR as per ACLS standard. The complainant had already made a complaint with police on 100 no. at 3.53 AM that his wife has been killed due to gross medical negligence by Saroj Hospital and its doctors. The post-mortem of the patient took place on 02.04.2018 by a panel of doctors at MAMC who gave their findings and cause for death was pulmonary oedema. However, final opinion was to be given after the report of histopathology and forensic report. The date of events was mentioned wrong and same were corrected later on by the PM department on pursuance of complainant. The police obtained all the records and filed the same with DMC for further findings/ opinion which is pending before the Delhi Medical Council. The complainant has also collected various documents and information which is attached herewith and has filed the present complaint before Delhi Medical Council. The cause of action for filing the present complaint has arisen on 29.03.2018 when Dr. Nisha Jain told that operation (TLH) is to be done urgently otherwise, it may be fatal or even death can happen due to excessive bleeding. The cause of action further arose when the condition of the patient went on deteriorating on 30.03.2018. The cause of action further arose when due to gross medical negligence amounting to murder; the patient was declared dead on 31.03.2018 at 4.12 AM by ICU in-charge, the doctors of Saroj Hospital. In such extreme problem, as defined by the doctor, there was threat to the patient’s life, even though the doctor started operation at 5:30 pm on 29.03.2018, which is not an emergent action of a doctor for a dying patient. If there was an acute emergency of excessive bleeding, the patient must be sent immediately to emergency department for medical management at around 11.00 a.m. on 29.03.2018 by Dr. Nisha Jain.

He further stated that the patient did not suffer from excessive bleeding and there was no acute emergency for conducting the surgery. Further, the OPD card dated 29th March, 2018 wrongly mentions that his wife had history of 3 children all full term normal vaginal delivery, as all his children have been born through L.S.C.S. On the day of admission in the Hospital (29-03-2018), the haemoglobin level of Smt. Gargi Meena was 7.2gm%, blood pressure was 90/70 and blood sugar (fasting) was 105mg%. Under this condition, the treating doctors were required to firstly settle the patient in respect of BP, Hb and other factors, instead of urgently planning for operation. As per the PAC (pre-anesthetic checkup) noted by the concern anaesthesiologist, the Hb of the blood was 7.2gm% at the time of operation and no blood was transfused before operation, as recommended on PAC i.e. 3 unit. For any elective / planned surgery, the Hb of the patient must not be less than 10gm% except in case of emergency surgery, as the present case was not an emergency surgery, the doctors must have monitored the all parameters of vitals and investigations till its normal condition. Unfortunately in this case, these important precautions were ignored/neglected possibly due to reasons best known to them. Further, just before the operation at 4: 20 pm on 29.03.2018, the BP of the patient was 90/60 and pulse rate was 100/min, how it would be possible to attain the normal range of these vital to fit for operation at 5.30 pm. On the same night at 10 pm, the vitals were BP 100/60 and pulse rate was 67/min. and with blood sugar 214 mg%. Both parameters that is pre-operative and post-operative were deranged and how it would be possible to maintain the normal range during intra-operative phase. It suggests that the doctors were very interested to perform the operations to usurp DTL panel money irrespective of saving of the life.

He also stated that Dr. Nisha Jain gave to the complainant’s employer (DTL) an intimation of admission wherein the intended surgery was written as-"TLH with B/L Lap salpingectomy with morcellation with peritoneal lavage with lap sacro-colpopexy under GA with blood transfusion" whereas there was no such report which needed Salpingectomy with morcellation with peritoneal lavage with lap sacro-colpopexy" the same is also confirmed from emergency form for indoor treatment to DTL being panel patient. In request to DTL by the hospital, it is very clearly mentioned that the patient was admitted to treat AUB (Abnormal Uterine Bleeding) and not for sever anemia, excessive bleeding. The urine sample was sent on 29.03.18 at 1: 16 pm and the report was not collected by the concerned surgeon before the procedure, surprisingly the report has shown plenty of pus cells(10-12) which is a sign of sever UTI. And of course, laparoscopy is purely an elective procedure, and, therefore, this UTI should have been treated with proper antibiotics cover and the repeat sample should have been sent before the procedure for the correction of UTI. In his opinion, this could be the cause of septicemia or bacteremia during immediate post-operative period, which possibly caused death of the patient. This is an extremely grave concern which should have been notified by the anaesthetist or gynaecologist only in order to give medical management to correct pus cells before surgery to save his patient’s life. There was massive blood loss intra-operative period, evident in laparoscopic video recording done by the doctor, Saroj Hospital. This caused delayed total time of the surgery due to massive adhesion due to p3 LSCS. Thus, anaesthetists who recommended 3 unit of blood pre-op, was started around 4:20 pm, blood transfused intra-operative and post-operative in a typical manner and time periods. Anesthesia and the doctor remained unnoticed of her previous three LSCS in PAC. The patient was admitted in the hospital at about 2 pm, all investigations done before 5.30 pm and operation started at 5:30 PM and completed at 7:40 pm, so it cannot be understood that at what time the blood was infused to correct the Hb of the patient to 10 Hb for elective surgery as per general rule under GA. As per the medical record, three red cell transfusions were given in the night of 29-3-2018. However, as per the medical record, a whole blood unit was issued by the blood bank which shows discrepancy in the records meaning thereby that some more serious fact has been concealed by Hospital. The name of gas used for pneumoperitoneum, drainage of blood, intraoperative fluids and intraoperative urine output during intra-operative has not been recorded anywhere in hospital record provided to the complainant. Further, OT notes are not having mention of successful pneumoperitoneum through Palmer Test. Since there was non-maintenance of proper operative notes, it is strange how the doctor calculates the amount of fluids to be replaced without following factors intra-operative (i) blood loss (ii) urine output operating time and (iii) volume of fluid already replaced. In the absence of said record, it cannot be understand by anybody that whether the estimated blood loss was less than 500 ml or greater than 500 ml to establish that the surgery was uneventful, as per Dr. Nisha Jain documented everywhere. Inspite of BP 100/60, why injection Lasix-20mg was given. The patient’s: BP-100/60, RR-67 / minutes, RBS-214-this is fasting BS, why it is RBS? If the BP is low ideally pulse rate should be high, explain the reason both being low? Why was the patient sent to OT without stabilizing pulse as well as BP, ignoring the pulse product ratio too? RBS noted by doctor was 214 mgdl and it is shocking figure in fasting when patient was managed by Human Actrapid since 2:35 pm dated 29.03.18 on the other hand inj. Lasix-20mg was started at 10:00 pm when BP-100/60 which lowered BP immediately at 11 pm to BP-100/70, but the doctor did not pay heed to this situation and pt. started sinking due to wrong medical management by the gynaecologist herself; instead of taking immediate physician reference and it is evident from the record that BP and pulse of patient was deteriorating whole night to BP-90/60 at 8 am on 30.3.18. At 10:45 am on 30.03.2018, the ABG (RAPID Point 500) report shows lac-22.51 ↑mg/dL and at 1:41am on 31.03.2018 report shows lac-25.11 ↑mg/dL. No physician/specialist has been called by ICU incharge till 4 pm for management of this high lactate. LAC could not be managed; even the patient was attended by Dr. Manwani. Explain why? The clinical noting of doctors does not reflect the Hb increment before the operation instead of increased Hb level that is given under :-

|  |  |  |
| --- | --- | --- |
| Hb in gm/dl | Time | Date |
| 7.2 | 1.16 p.m. | 29.03.2018 |
| 11.2 | 8.27 a.m. | 30.03.2018 |
| 7.3 | 10.45 a.m. | 30.03.2018 |
| 12.3 | 1.28 p.m. | 30.03.2018 |
| 12.0 | 4.00 p.m.  | 30.03.2018 |
| 13.7 | 1.41 a.m. | 31.03.2018 |
| 13.7 | 3.12 a.m.  | 31.03.2018 |

In this ground, it can be presumed that no blood transfusion was done before operation or intra-operative phase, as per the noting of doctor although 3 units of blood were advised, but in this stage, it can be inferred that no blood transfusion was done (instead of 3 units of blood donated by relatives). In this regard it may be reiterated that if the Hb of the patient reached up-to 13.7%gm on 31-03-2018 (quite normal level) then why the severe anemia would become the contributory factor for cause of death (refer death certificate). Hence, no reliance can be perceived on the documentation in respect of blood transfusion and level of hemoglobin. Since admission till death of the patient, the blood sugar level of patient was increasing progressively and reached up to 358 mg%. However, haphazardly varied the blood sugar level despite of inappropriate dose of insulin (human octapid). Since operation to death of patient, the vital parameters i.e. BP, pulse rate, blood sugar, oxygen saturation etc. were worsening and could not be controlled till her death. The renal function were not assessed properly, as it was going towards renal failure which reflected on 30-03-2018 at 4: 30 PM noting that the IV fluid input was 800 ml and output was 180 ml (the same is overwritten with pen). The acute renal failure also supported by post mortem report which shows that there was "pulmonary oedema" with collection of free fluid in the thoracic cavity (plural cavity) despite of injections lexis for faster urine formation (diuretics). In view of low blood pressure and low pulse rate, the IV fluids that are ringer lactate, dextrose 5% and DNS, were infused in speedy manner which causes increased blood sugar level, overload to heart for pumping (increased blood volume for already malfunctioning heart). This over hydration certainly became the cause of death in later stage due to cardio-pulmonary arrest, as the same is reflected in death summary and post mortem report. In the death summary, it is also noted that severe anemia was one of the contributing factor for cause of death of the patient. In this regard, it is questionable that if the initial Hb level was 7.2 gm% which reached up to 11.2 gm%on 30-03-2018, then how the patient was considered as severe anaemic. If really, the blood transfusion was done(3units of blood as initially prescribed in PAC) and investigation report findings assumed to be true then why patient suffered from anaemia and contributing as a factor for death. In this regard, the story of transfusion of 3 units of blood and increment of Hb(11.2 gm%*)* are only for the documentary enrichment of records. On 30-03-2018, the condition of the patient became very critical at 7:30 am and at 8: 30 am shows parameter of pulse rate 50/min., BP 90/60, and blood-oxygen saturation was 92%*,* blood sugar 358 mg%. The physician reference was called at 7:30 then 8:30 a.m. and again at 11a.m., but the physician reached the patient at 11am. Under that critical situation, the physician must be available immediately instead of laps of 3 hrs., certainly this act, reflect the negligent and careless behaviour of the doctors towards their patients. This proves that due necessary care as per standards of super specialty was not given to the patient. On the same day i.e. 30-03-2018 at 11 am then at 2 pm, the cardiologist reference was also sent for consultation but Dr. S. Aggrwal and team visited at 4 pm. This 5 hrs gap of cardiologist consultation would also be contributory for death of the patient. This lapse again proves that due necessary care as per expected standards of super specialty was not given to the patient and are the factors pushed the patient toward death. This is also a breach in standard of care. On same night i.e.30-03-2018, the general condition of the patient noted was fair, pulse rate 88, BP 140/80, blood oxygen saturation 100% and there after 20 min. at 8: 50 pm, one high risk consent was explained to the attendants of the patients stating that “mujhe bta diva hai ki mere mareej ki halat kharab hair mai mareej ko yanhi rakh kr aage ka ilaj karana chahata hu". In this context, it may be inferred that if condition of the patient was fair with all normal vitals, how condition became worst just after 20 mins. and doctor desired high risk consent from the relatives. Considering the aforementioned facts the doctors were confused and highly cautious to take the consents at all stages of the patients conditions to save themselves rather than safety of the patient’s life. It’s a self-explanatory fact that if the condition of the patient was fare and satisfactory then what could be the necessity of taking high risk consents. Thus, the vitals noted at 8.50 p.m. were manipulated and were an eye wash to the patient’s attendant and a cover-up for gross negligence they performed all over that day in the name of ICU protocol by Dr. D. V. Sagar. Surprisingly, the treating doctors Dr. Nisha Jain and team was always interested to take consents as proportionately as the condition of the patient was deteriorating, her maximum attention was to save herself legally instead of saving the life. For example- on 31-03-2018 at 3 am when the condition of the patient was very critical and irreversible, the treating doctor intended to put her on ventilator support but they could not do so up to 3:30 am in lieu of allegations of doctors stated that “attendants were informed about the shifting of the patients for ventilator support but they refused to give permissions till they come to see the patient first”. What a funny and irresponsible pleading on the part of the doctors since the relatives of the patients had wholly entrusted on the treating doctors (Dr. Nisha Jain and team) since admission to last breath in the hospital. Each and every procedure/ medication/mode of medication were followed by their own decision. Under that life threatening and critical condition of the patient, how is it possible that the husband or daughter of the patient would deny for saving of the life. The treating doctor further stated that in general situations all laws are suspended when a doctor intends to save the life in good faith irrespective of consents or statutory laws when there is threat to life. As per ultrasound report (Trans-vaginal scan) uterus was anteverted, measures 102x64x54 mm enlarged size. Fibroid measuring 33x32mm is seen compressing the end-metrium and displacing it interiorly, suggesting some possibility of sub mucus extension of fibroid. Endometrial thickness is 8.7mm. Cervix is bulky and filled with heterogeneous contents? Clot. Both ovaries are normal in size and Echo pattern. The fibroid was a benign tumor not cancerous as per hystopath report; and too which is not a life threatening outcome. It could have been treated conservatively as well in place of TLH done by Dr. Nisha Jain. In present case, this fibroid was detected in first time in Saroj Hospital which is of average size (10 Week Size) and firstly could be treated conservatively for a certain period and in case of poor response of therapy, then surgical intervention is desirable but treating doctors considered it, as emergency and hastily operated without caring pre-existing illness/condition of the patient. In this case, the uterus was relatively bulky without any pathology in the bilateral fallopian tubes and ovaries. Dr. Nisha Jain firstly plans for total laparoscopic hysterectomy (removal of uterus only) but during operation she removed the bilateral fallopian tubes and right ovary. For this extended surgery, no consent was taken from the relatives of the patient but it is a great surprise and matter of investigation that how this unplanned surgical procedures are written by the doctor in the consent form, which was obtained prior to start of operation by the attendant, the blank consent forms were signed by relatives prior to the start of operation. In this connection, there is doubt when the both fallopian tubes and ovaries were normal in shape, size and echo pattern (refer to ultra sound report) then what was the urgency/emergency to remove these organs apart from uterus. It is very possible that some of the total bill will be enhanced with showing the urgency for the same. This can be evident from the report submitted to DHS/DTL by the doctors and Saroj Hospital. The doctor needs to reply that how procedures were mentioned in consent which was prepared prior to the surgery and how the ovary and fallopian were mentioned when they were explored only during operation by Dr. Nisha Jain. The process of peritoneal lavage, morcellation and bilateral sacro-colpopexy are the integral part of total laparoscopic hysterectomy but in the present case the process and charges are bifurcated from the actual operation done for the benefit of gaining extra amount. Surprisingly it is noted in medical record of the patient that the uterus and cervix along with fallopian tubes were extracted from the abdomen by the method of morcellation (cutting of organs into small pieces and taken out from body using Morcellator Machine). But the histo-pathological report of Saroj Hospital reveals that whole uterus and whole cervix and whole fallopian tubes were examined. This outcome suggestive of that morcellation of said organs were not done other than extracted from vaginal route. The claim of morcellation and charging heavy amount which is highly unfair and fraudulent act on the part of doctor Dr. Nisha Jain and team which is liable for criminal act.

The patient was a known case of hypothyroidism taking tablet eltroxin 50 mg per day for long time. The same illness was informed to treating doctor (Dr. Nisha Jain) and same was noted on medical records and written by herself. As per medical records of patients, no investigation or treatment is given in this regard since her admission till death. This lapse could also be proved to be contributory factor for death of the unexpectedly. The hormones released from thyroid gland maintains the normal metabolism of the body and under that stressful condition, the metabolism must be remain in normal condition for coordination of other physiology of organs or systems. In this situation the metabolism of other system like heart, pancreas, kidney and lungs would certainly derange and lead to malfunction of these organs and resulting into death. Further, in this regard it may also be presumed that after operation, the pancreas did not release sufficient amount of hormone that is insulin to cope up the glucose level (as same was increased up to 358 mg 0/0) after operation and keto-acidosis cannot be ruled out resulting into malfunction of kidney and heart.

As per ultra sound report done on 30-03-2018, there were multiple gall stones but post mortem report does not show any gall stone. In this regard, it can be inferred that the ultra sound report and other investigation done were not reliable and possibility of manipulation of such investigation procedure cannot be ruled out in the interest of misguiding of the patient attendants to show the urgency of treatment/surgery and same facts are reflected in case of Hb reporting.

Dr. Nisha Jain stated to Dr. Kiran Chawla (deputy GM Saroj Super speciality Hospital), in reference to complaint made by the complainant on dated 02-04-2018 that when the patient/ deceased was brought before her, the patient was having complaint of giddiness and bleeding like tap from cervix and vagina. In this context, it can be stated that the patient had normal menstrual period for last two days and was required one sanitary pad per day. The patient was brought in the Saroj Hospital for usual gynecological consultation (not in emergency) and the observation of gynecologist Dr. Nisha Jain was simulated to be a case of emergency for the interest of operation and monetary benefits rather than the safety of the patient. It is well settled presumption that if patient had really excessive or heavily bleeding from vagina like quoted term “bleeding like tap” then how it would be possible to leave the patient for last two days since the commencement of menstruation. This example is very irrational and inconsistent, as the patient could not be alive for more than few minutes if really it was a case of excessive bleeding alike the draining of water from the tap. This example is itself suggestive to show that an emergency and panic situation was created by the doctors, so that the helpless attendants could give the consent for undesired treatment/operation with ignoring the general condition of the patient. The reference to letter/explanation to CMO, Delhi Transco Limited, in last para and last line Dr. Nisha Jain stated that “since there was haemoperitonium, peritoneal lavage was done” this fact indicate that during operative procedure (Intra operative phase) there was massive bleeding into the peritoneal cavity by the cutting of some abdominal blood vessels which resulted haemoperitonium, it is very much possible that uterine artery of either side could be dissected unexpectedly due to lack of knowledge or experience of applied procedure that is laproscopic hysterectomy. The post mortem report shows that the uterine arteries were dissected and ligated but there is no evidence at what stage same procedure was done whether it was done after cutting and excessive bleeding or was done before the operation of the patient the ultra-sonograpghy of abdomen was done and no any free fluid was found into the peritoneal cavity/abdomen cavity. The outcome of massive blood into peritoneal cavity conclusively suggest that the collection of blood into peritoneal cavity only was the result of cutting of blood vessels by rash/negligent act on the part of surgeon and this fact also support by post mortem report. The PM report shows that there was effusion of blood was present beneath the surgical incision area into peritoneal cavity (on the omentum). This is blunder on the part of surgeon.

In conclusion, it is very clear that adequate amount of blood was drain out into peritoneal cavity which resulted very low blood pressure and cardiac problem (bradycardia) followed by cardiac arrest which are mentioned on medical records pertaining to 30-03-2018 and 31-03-2018. The aforementioned facts are sufficient to suggest that Dr. Nisha Jain and team were very reckless, grossly negligent and rash in treating the patient which caused her ultimately death. It is also clear from the entire medical record that no-proper care and proper treatment was given for hypothyroidism during her hospital stay. The post-mortem report states that there are findings suggestive of pulmonary edema. Opinion regarding the cause of death will be given after the receipt of histopathology and chemical analysis report. The doctors wrongly conveyed to the complainant that the patient needed urgent surgery while, in fact, urgent surgery should not have been done in a patient who was in her in 3rd day of menstrual period and had severe anaemia. The fact that she had severe anaemia is documented in the post mortem report. The diagnosis as per death summary, as given in the follows: “P3L3 with DUB with post-operative case of Total Laparoscopic Hysterectomy with shock with severe anaemia with DM with cardio-pulmonary arrest”. The doctors ought to have postponed the surgery till such time, as her haemoglobin level could have been increased to an acceptable level. There was no need to subject the patient to urgent surgery when there was severe anaemia. The present operation was an elective operation and should not be done on emergency basis. The doctors had all the time to do thorough investigations before taking the patient to the operation theatre. A thorough pre-operative check-up of the patient and her heart to accesses actual physical condition for proper stabilization was not done as per standard. Whatever investigations were done was in haphazard manner and without knowing and considering Nill By Mouth (NBM/NPO) status of patient. The doctors obtained consent for urgent surgery under misinformation and coercion. It was not an informed consent. A blank consent form was got signed from the complainant by the doctors showing the fear of death of patient ultimately on pretext of bleeding. This is clear from a look at the consent form where several relevant columns / items are left blank. The consent form can be seen from the medical record. It is obvious that the hand written words “LH with B/L salpingectomy with morcellation with peritoneal lavage with lap sacrocolpopexy under GA" were inserted after the complainant had signed the consent form, which amounts to tampering of a document and also confirms that there was no informed consent. Because there is no way that the operating surgeon could have known beforehand what she would find inside the abdomen upon laparoscopy and what additional surgeries would be needed in a patient to be operated for hysterectomy especially when the report do not say any word regarding them. Besides TVS report, ovary and fallopian tube were also looking normal and is evident from surgery recording CD. In a letter dated 5-4-2018 written by Dr. Nisha Jain to DTL, she states as “not only uterus but both Fallopian tubes needed removal as they were not looking normal. Right ovary had to be removed as it was looking unhealthy and bulky. There were adhesions and small cysts and, to proceed for surgery, extensive adhesiolysis was done as adhesions were present all over the peritoneum due to previous three caesareans in vertical scar. Separation of bladder is necessary to remove uterus which was badly adherent due to repeated surgeries. Since the uterus size was big and cervix was ballooned up, it needed morcellation for removal of uterus. The whole vagina was dilated, so the vault had to be suspended with utero-sacral ligaments tightly to avoid prolapse of vault in future and, since there was hemoperitoneum, peritoneal lavage was done”. It is clear that the decisions to perform the following procedures were taken at the spur of the moment on the operation table itself when the operation was midway:

a) Removal of both Fallopian tubes

b) Removal of Right ovary

c) Morcellation

d) Sacrocolpopexy

e) Peritoneal lavage for hemoperitoneum.

Thus, it is clear that the consent was not a real informed consent and the form itself was tampered with. The doctors formed a factually wrong impression that the patient had three normal vaginal deliveries in the past. The OPD notes dated 29-3-2018 show the following noting “O/H-P3L3, all FTNVD (Full Term Normal Vaginal Delivery). The fact is that all the three earlier deliveries were by caesarean section (LSCS). The doctors completely ignored the fact that the patient was on regular treatment for hypothyroidism and was taking a daily dose of Eltroxin. They did not prescribe/administer Eltroxin to the patient at any time during her hospital stay which was a fatal mistake. The doctors did not assess or treat the patient's diabetes mellitus correctly. She was a known case of diabetes not on medication, as recorded on the OPD record. Her preoperative fasting blood sugar level was only 105 mg% as per page 121 of the medical record. Moreover, her HbA1c level showed good control as per page 122 of the medical record. In spite of this, the doctors wrongly and incorrectly wrote in the death summary jointly signed by Dr. Nisha Jain and Dr. Priyanka Gupta that “patient was known case of DM (Type II on irregular treatment and uncontrolled DM)”. This was a knowingly false and non-factual noting made by the doctors. It is stated that whatever diabetic complication occurred was due to the stress of surgery in a hypothyroid patient. Such stress can very well be expected to lead to aggravation of diabetes. The patient's diabetes got aggravated to the extent that on 30-3-2018, her blood sugar level was found to be very high (358 mg.%) as per notes on page 13 of the record. Moreover, even ketone bodies were present in urine as per notes on page 24 of the record. This clearly shows that her diabetic status was not managed properly even though her fasting blood sugar level and her HbA1c level showed good control. The patient must have had an endocrine consultation before surgery but this was not done. No diabetic risk was informed and no diabetic consent was obtained. The doctors were careless as regards management of anaemia. This is clear from the following discrepancy. On page 63 of the medical record, the doctors have certified under their signature that three RBC packs were given to the patient. On the other hand, the blood bank has clearly written on page 96 that one of the three units was whole blood and not pack cell. The doctors were highly careless and negligent as regards management of anaemia, as is clear from the record of haemoglobin. Such record is entirely confusing and unreliable. This is clear from the following notings in the medical case sheet:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date | Time | Hb | Page No. in the hospital record | Comments |
| 29.03.2018 | 1-16 p.m. | 7.2 | 123 | This is pre-operative sample |
| 30-03-2018 | 8-27 a.m.  | 11.2 | 117 | This is the sample after giving one whole blood and two pack cells. |
| 30-03-2018 | 10-45 a.m. | 7.7 | 109 | This is the sample after 3 blood transfusions.  |
| 30-03-2018 | 1-28 p.m. | 12.3 | 109 | This is the sample after 3 blood transfusions.  |
| 31-03-2018 | 1-41 p.m. | 13.7 | 110 | This is the sample after 3 blood transfusions.  |

It is not possible that Hb level on 30-3-2018 was 11.2 at 8-27 a.m., 7.7 at 10-45 a.m. and 12.3 at 1-28 p.m. There is obviously something wrong somewhere which needs to be explained by the doctors concerned. The doctors were careless and negligent as regards assessment of the patient’s cardiac status. As per the ECG report given to the complainant after the ECG was done after admission on 29-3-2018, the CONCLUSION was “Cardiac electric axis normal. ST depression. Possible mild inferior myocardial ischaemia. III V-2 abnormal T wave”. This cardiac diagnosis does not find mention anywhere in the hospital case sheet. The same was taken back by the hospital at the time of billing on 31.03.2018. The doctors have manipulated and messed up / falsified the medical record to such an extent that even the type of surgery performed upon the patient is in doubt. As per the operation notes “Uterus removed by morcellation”. However, the histopathology report dated 2-4-2018 signed by Dr.Kavita Bhardwaj, Sr. Cons. Pathologist, Saroj Hospital, reads “Received specimen in a single container. Uterus already cut open with separated part of cervix and separated fibroid. Uterus measures approximately 9.0 cm in length, 5.0x4.0 cm. at the fundus Right and left fallopian tubes measure 5.0 cm. in length each”. It is clear that in the present case, no uterine morcellation was done because, in the process of morcellation, the uterus is minced up, or morcellated, into smaller pieces. It is not possible that, as stated in the histopathology report and reaffirm in the post-mortem report, the complete uterus measuring 9x5x4 cm could be taken out through the laparoscopic tube with a lumen of about 12-13 mm. The concerned doctors need to explain the above.

The doctor’s decision to perform laparoscopic hysterectomy was not the proper one for the reason that they knew that the patient had had three caesarean sections in the past and, therefore, there were high chances of extensive adhesions all over the abdomen. In fact, this is what was found during the operation as per the operation notes.

The doctors did not entertain the possibility of pulmonary edema while treating the patient. The words “pulmonary edema” occur nowhere in the hospital records even though the post-mortem report clearly states that there are findings suggestive of pulmonary edema”. This shows negligence on the part of the treating doctors. It is pertinent to mention here that doctor mentioned cardio pulmonary arrest but failed to understand the causes of lungs failure when heart was working fine as per bed side ECHO. This is again a grave lapse in necessary care and medical management of the patient even when the patient was sinking and next step was none other than death.

The hospital case sheet (page 132) which is the ultrasound report of abdomen dated 30-3-2018 reads-“Gall Bladder-Well distended and reveals multiple small intraluminal calculi”. This report has been signed by Dr. Prashant Bothra, Consultant Radiologist, Saroj Hospital. On the other hand, the post mortem report “Gall bladder was empty. No gall stones were present”. Both these findings are mutually contradictory and one of them must be wrong. There is no reason to doubt the veracity of the post-mortem report. Hence, one is left with the conclusion that there was something wrong with the ultrasound test or its report. An x-ray erect was performed after operation which shows patchy opacities in left mid zone which is an indication that there was infection in the abdomen, reason of which is unexplained.

It transpires from the entire record that during TLH some major arteries and urethra were cut by Dr. Nisha Jain which caused loss of blood, infection which was also the reason of repeated greenish vomiting post-operative in labour ICU as well as in ICU. The said infection could not be handled; rather they deliberately and intentionally kept on misleading and misguiding the complainant and his family members about the condition of Smt. Gargi Meena.

In her letter dated 5-4-2018 written to DTL, the operating surgeon Dr. Nisha Jain has stated that “since there was hemoperitoneum, peritoneal lavage was done”. There is no explanation anywhere in the medical record to explain the cause of hemoperitoneum. There is no mention about the approximate quantity of blood that was present in the peritoneal cavity. The presence of blood in the peritoneal cavity is a vital finding, especially in a patient who was admittedly severely anemic, and it might as well have contributed to death. The following question are unanswered which need to be answered:

a) What was the cause of hemoperitoneum?

b) Did hemoperitoneum occur because the surgeon, by mistake, cut up a blood vessel/artery?

c) What was the amount of blood found in the peritoneum?

d) What is against the possibility that such unexpected and unwarranted blood loss contributed to the death of a patient who, admittedly, had severe anaemia?

It is mentioned in the medical record on page 79 that HIV test was Not Done. On the other hand, the report of serological test for HIV is given on page 129. This test without proper consent and is an illegal act in haste of performing surgery. This act is against law, committed by doctors/staff and hospital. Action required in this regard?

The doctors need to explain why there are a large number of cuttings / alterations / overwriting etc. at innumerable places in the medical record. Some examples are at pages 2, 22, 71, 98. (These are merely examples. Many more such can be seen throughout the record). This gives rise to a definite and serious suspicion that there was tampering of records. As a matter of fact, Hon'ble Metropolitan Magistrate Ms. Kadambari Awasthi, Rohini Courts, Delhi has clearly stated in her order dated 2-8-2018 as follows- “Prima facie, it reflects that there are tampering in the medical records of document”. From page 3 of the record, it is clear that the physical appearance of the patient was normal and that she was well nourished and that she had no pallor. This does not corroborate with the notes on Annexed page 64 that she had severe anaemia. Page 42 of the hospital record is the pre-operative check list. It shows that FBS should be done for diabetic patients pre-operatively on the day of surgery. This was not done. The remark against “FBS for diabetic patients” is NO. This is a serious lapse in medical management of this patient. It is obvious that what needed to be done was not done. The blood sugar level on 30-3-2018 morning is shown as 190 mg. On page 84 while it is shown as 352 mg. On page 86. This is rather impossible and casts doubt upon the genuineness of the records, it’s a tempering.

The medical record is devoid of clinical findings pertaining to cardiac arrest and which resuscitation steps were taken by attending or resident doctors”. It was a “serious lapse” on the part of the doctors to not assess the woman’s cardiac condition before the operation. The respondent (doctors) ought to have mentioned the duration of cardiac arrest, especially when the condition could not be revived neurologically. All this indicates that the complainant’s wife went into subsequent conditions because of gross-negligence and mismanagement. The respondents/doctors had all the time to do thorough investigations before taking the patient to the operation theatre. They should have taken another ECG after her admission in the hospital and on assessing her cardiac status proceeded with the operation.

A pedestal fan was kept in ICU towards the face of Smt. Gargi Meena on the pretext that the air from the same will control the palpitation of the patient. Explain why was so all the time in Air Conditioned ICU? Why the bed was propped up when vitals were not stable, BP-90/60 mgdl, pulse-50/min? Why the doctor increased the risk of brain Hypoxia, explanation of which must be sought Dr. Nisha Jain, Dr. Priyanka Gupta and Dr. Dharamveer sagar needs to be provided. At 3:30 Action taken when pulse was dropped to 46? What action was taken by the doctor at this point? Check CNS (central nervous system). This is the situation to put on ventilator. PR was 44 but no action by the doctor. Drain 10 CC normal blood I/O not mentioned in spite of low BP, no active intravenous done for low BP as well as for heart rate. Because it was grave negligence on part of doctors that what was the cause of consistent fall of BP and pulse rate and why cardiologist was not called at this time? On one hand the doctors say that Smt. Gargi Meena was a patient of diabetic mellitus then what tests were done to diagnose that preoperatively and remedy / treatment were done for the same. The concerned treating doctors need to explain the following acts/ treatment on their part. BP was increased-ionotropic treatment. The name of the medication given to improve low BP is dopamin, dobutamine, Noradrenaline. TSH- report to be collected hypo- the patient taken as full stomach NBM/NPO-state not mention anywhere in your HRC, you have said that patient had increased blood sugar due to which she could have weakness in her nerves(neuropathy?), do you mean to say that it has nothing to do with the surgery, as far as I know diabetic neuropathy (autonomic neuropathy) has got quite bad effects on surgery. Why x-ray abdomen erect was recommended by Dr. Nisha Jain post-surgery, give logic, what you are suspecting that is intestinal perforation or obstruction? Till that prolonged hypertension+ bradycardia leading to cardiac arrest as per records. Note: cardiologist attended patient of 7 a.m after repeating reference cardiologist visited at 3:30 p.m.(pg-18) inspite of her BP and PR was low since 7:00 a.m. will the patient not suffer from brain hypoxia (IABP) why IABP was not started since 7 a.m. for such a young patient in spite of intentionally losing her. (a) No intervention to increase the PR (b) Recommended by the cardiologist, explain why? BP- 70/40, PR-56 what interventions were done? RBS charting was not done for every 4 hour as not maintained, however, RBS has been mentioned randomly as and when. Note: cardiologist attended patient of 7 a.m after repeating reference cardiologist visited at 3:30 p.m. (pg-18) in spiteof her BP and PR was low since 7:00 a.m. will the patient not suffer from brain hypoxia(IABP) why IABP was not tarted since 7 a.m. for such a young patient in spiteof intentionally losing her. Why input not mentioned by the doctor against output 1000 / 400- normal. At 8:30 p.m. patients vitals are WNL (within normal limits). The patient is conscious and oriented and you are saying no treatment is required from Gynaecological side but on other hand you are taking HRC at 8:50 p.m. without any seriousness on record? Explanation is required from Dr. Priyanka Gupta that what was the patient’s condition compelling her for HRC?

In life threatening condition all laws become ineffective in order to save life. The same situations occurred before number of times but patient not put on ventilator Why? The action of Dr. Sagar need explanation. 1) Nbm status. 2) Consent remark. 3) No reference for hypothyroidism and diabetic mellitus. 4) PAC chart not filled. 5) ASA status not mentioned. Why? 6) Relevant history, pre-existing disease and concerned medication were not asked (doctor not took consent) and not written on PAC sheet. Name and signature of anaesthesia absent patient was transfer from recovery room to the ward which is must as per protocol but doctor surgeon was in fear of some mishappening which was not disclosed to the attendants. The patient post operatively kept in labor ICU to settle the complications either of surgery or anaesthesia. The doctor’s explanation is required in detail. Record pertains to surgery of Dr. Nisha Jain particularly TLH to cross check whether it was routinely done by the doctor or the patient was kept post-operatively in labor ICU in selected case having complications. The sheet was not filled by anaesthetist, what was the hurry? This was too when senior anaesthetist and junior anaesthetist were engaged which is against protocol, explanation of doctor required. Anaesthesiologist did not discuss, did not meet and also did not discuss about the type of anaesthesia and the related complications with the attendants from whom they obtained signature on blank consent from anaesthesia also did not mention about the diseases she was suffering from and their prior optimization before surgery anaesthesia also did not take any reference from endocrinologist for hypothyroidism and diabetic mellitus as per hospital records. Before operation, no endocrinologist specialist was consulted for the management of diabetes and thyroid. The patient's reason for admission for excessive bleeding reason of 2 days but in vital signs BP is 110/70 pulse is 68 per minute, two are extremely contradictory and hence, contradiction in doctor’s statement is supporting his statement that she was not bleeding in excess. She was having excessive bleeding since 2 days then why she was seen in OPD and why not referred to emergency for casualty for optimization in view of excessive bleeding. Excessive bleeding per vagina, does every patient who comes with excessive bleeding is planned for TLH? She was bleeding like a running tap (as doctor mentioned in her reply/report to DHS), but the patient was able to walk and climb. Why blood was not transfused preoperatively inspite of knowing her preoperative HB was 7.2 and TLH being a purely elective surgery for which Hb must be 10. Go beyond TVS scope size of the fibroid was too small i.e.10 weeks and not recommended for surgery (Annexed at 253, Dutta book and 230 shows). Define criteria of severe anaemia as mentioned by the doctors. The course during hospital stay: Postoperatively BP was 90/60 and she had complaint of chest pain and bilious vomiting and it was continued in labour ICU in the supervision of resident doctor on the other hand on the same page it is written that her postoperative period was uneventful and she was discharge in satisfactory then why she was shifted to ICU. Cardio pulmonary arrest as per ICU 1/C occurred at 3:30 a.m. and death at 4:12 a.m. In these timings, CPR could not be co related with doctor’s treatment for giving CPR as per ACLS standard. Explanation of doctor is required, why he has put wrong statement in this regard? Certified copy of ACLS certificate of Dr. Sagar (ICU in charge) may be provided for justification of his claim about giving ACLS to the deceased/patient. The patient was intubated at 3:30am 31.03.2018, which is contradictory to ICU Incharge Dr. Sagar’s written statement that “ CPR continued for one and half hour” at page-30. CPR duration could not be correlated. All the more and endtractial tube and ventilation charges are not shown in the final bill, does it means patient was not resuscitated?

Before disposal of complaint by an order of the DMC, it is requested that DMC may kindly obtain view of MCI regarding Gazette notification of primary medical institute mentioned in diploma of Dr. Nisha Jain. As per the best of his knowledge, medical institute mentioned in diploma of Dr. Nisha Jain is not been listed in any schedule of MCI. Hence, registration of Dr. Nisha Jain in IMR by MCI is illegal and based on this fact the practice and educational qualification gained by her over the period is illegal and unauthorized. Dr. Nisha Jain has not submitted any CME to the Delhi Medical Council and do not possess any MCI approved/recognized qualification in laparoscopic surgery (MIS), no addition of qualification after MD (Obes. & Gynae.) in DMC record. How such doctor can perform laproscopy which is illegal without having proper qualification, explain? The doctors have violated the Regulation 1.5 of the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002, which states that “*Every physician should, as far as possible, prescribe drugs with generic names”.* Nowhere in the whole medical record have medicines been prescribed with generic names and capital letter. The Delhi Medical Council continued to grant registration in Delhi against the Delhi Medical Council Rules, 2003, Section-3, which is as given under: *"Grant of Registration. - Any person who possesses any of the qualifications in the First, Second or third Schedule to the Indian Medical Council Act,* 1956 *(102 of* 1956) *shall, subject to any conditions laid down by or under that Act, and is in service in connection with, or wishes to practise in, modern scientific system of medicine in Delhi"* The name of institute from where doctor got her primary qualification is not listed in any schedule of MCI. Hence, the action and explanation is required by the Delhi Medical Council before finalization of his complaint. It is therefore, most respectfully prayed that the Hon’ble Delhi Medical Council may kindly summon the doctors named above and may investigate the various instances of negligence/unethical acts listed in the complaint and may take action against them as per law.

Dr. Nisha Jain, Sr. Gynae. Consultant, Saroj Super Speciality Hospital stated that the patient late Gargi Meena was wheeled in Saroj Super Speciality Hospital’s OPD at 10.30 a.m. with with history of bleeding for two days and pain abdomen one day, with panic relatives, to see the patient on priority. The patient was very apprehensive, the patient was examined immediately and her cervix was ballooned up, full of clots and blood. The patient was advised urgent USG which was done at 11.04 a.m. which showed enlarged uterus with fibroid. Fibroid was compressing the endometrium and displacing it anteriorly, suggested possibility of submucuous extension of fibroid. ET was 8.7 mm, cervix was bulky and filed with heterogenous contents ? clots. Hence, the patient was advised certain investigations and hospitalization. The patient’s relatives were not ready to admit the patient. Seeing the patient’s condition (fainted in OPD), the patient was shifted to labour ICU where appropriate treatment was started including I.V. crystalloids infusion. Inspite of that, the attendants were not getting file made, which was ultimately made after three hours by them and then they could arrange and transfuse blood. She called the patient relatives and told them the latest condition of the patient, diagnosis and its treatment with plus and minus points. Relatives took their own time and after discussing among themselves and with their family members, they gave consent, to go ahead with surgery which was done once she got clearance after getting PAC done. Operation was done uneventfully. Anaesthetist shifted the patient to the post-operative room and then to labour ICU after stabilization of the patient and briefing the details of the patient and latest condition to the relatives. After operation, she and Dr. Priyanka Gupta called the relatives and explained about uneventful surgery and the relatives talked to the patient. Throughout night, the patient was monitored and was stable. Next morning, the patient was having breathlessness/suffocation/ghabrahat/vomiting, for which, senior physician was called who after examining the patient, advised to shift the patient in medical ICU. The patient was shifted to ICU after informing the relatives and explaining latest condition of the patient(informed consent). In ICU, the patient was managed by senior consultant physician Dr. Greesh Manwani. At 9.00 a.m. Dr. Greesh Manwani had examined the patient’s pulse which was feeble 46 bpm., BP 90/60 mm of HG, respiratory distress was present with cold extremities and with excessive sweating. The patient was provisionally diagnosed to be suffering with shock cardiac event and appread to be critically sick. Crticial condition of the patient was explained and with the patient’s attendants consent shifted to ICU. The patient was immediately shifted to ICU. On reaching ICU, her BP was 70/50 mm of Hg, pulse 46pm, BS 190mg%. Relevant investigations including x-ray chest, ECG, Echo, ABG, LFT, KFT advised and cardiac consultation from Dr. Sannjeev Aggarwal’s team (Dr. Deepak Tiwari) was taken and they ruled out any cardiac event. Appropriate treatment was started including inotropic and BIPAP support with higher antibiotics and insulin. The patient ultrasound whole abdomen in ICU showed no abnormality and in the drain which was put in POD had minimal fluid which is normal post-operative. So, all this confirms there was no problem/complication related to the surgical procedure. The patient had some medical problem which was also explained to them. One of the consultant of the unit was almost there in ICU throughout the day to coordinate. The patient was continuously monitored and managed, and the condition of the patient was informed time to tome to the attendant throughout the day. As per case sheet, at around 2.30 a.m., the patient started sinking, her blood-pressure started falling despite inotopric support and respiratory distress increased. The patient was intubated after ICU in-charge got consent from Sujata (attendant of the patient) and the patient was put on ventilator but the patient developed bradycardia and low blood-pressure. CPR according to ACLS guidelines was started and continued for at least one hour. After one hour, ECG showed straight line, pupils were dilated and fixed and the patient was declared dead at 4.12 a.m. as on 31st March, 2018. They, medical person treat their patient with great devotion/dedication and experience and to the best of her knowledge. The outcome is not always as per her or other’s liking. Negative outcome always leads to complaints and litigation in today’s scenario. Hence, one will complain, he/she will try to complaint on all aspect saying that there was no indication of admission of/operation/wrote costly medicines/doctors, sisters were not coming to the patient, were misguiding, never telling the facts, staff were saying something, medicines were spurious, investigations were not done, manipulation in the treatment record and ventilator was used for money purpose etc. etcs. But fact remains the truth. If possible, please see post-mortem report and if there is any fault in operation, she is ready to accept her mistake. In the above facts and circumstances, the complaint under reply is liable to be dismissed immediately, as the same is an abuse of the process of law.

Dr. Nisha Jain in her supplementary written statement averred that the patient was wheeled in wheel chair by her daughter in OPD with OPD card made at 10.17 a.m. and as per their apprehension was examined immediately and no diagnosis was made or suggested to the attendant daughter as alleged. Her opinion was? fibroid uterus ? incomplete abortion in view of very soft and ballooned up cervix with lots of clots and bleeding in vagina, and due to obesity, uterine size could not be assessed. It was only after USG report that the diagnosis was clear and she fainted in OPD and the patient’s BP was recorded 90/60 in the OPD card, therefore, the patient was wheeled to the labour room by OPD aya to give emergency treatment. In the meantime they(the patient and daughter) were explained about the USG finding and possible treatment options. It is submitted that the daughter asked them to give other references for USG and they gave it, (to avoid the impression that all investigations are compulsorily done in hospital only). At a time they have at last 5-6 patients inside the OPD, the attendant came to ask about any other place outside the OPD, where USG can be done. She wrote it and then when looked up, recognized the attendant and told her to get it done at hospital only and requested the sonologist telephonically as the patient was bleeding profusely and striked out the information of outside hospital sonologist (OPD Prescription). The complainant is trying to cause prejudice by scandalizing simple facts in the patient care. Being in government service and enjoying free treatment and other facilities at the cost of the tax payers, the complainant is making unwarranted allegations of targets, it is a hospital where the doctors are working 24 hours to save human life and reduce sufferings, not a marketing company, as alleged. It is submitted that all the tests were advised at the same sitting while taking history and examining the patient alongwith USG, before the patient fainted in the OPD with BP recording 90/60 in the OPD card. Those were the routine tests done in any patient with such a condition and history. But after getting the USG report and seeing the deteriorating clinical condition of the patient and discussion with daughter and the patient about the condition and their willingness to get admitted and operated ASAP, the patient did not require to be tested for PPBS as after admission blood sugar charting as per her basic sugar report would be planned. As per their knowledge nothing was given to the patient to eat but if complainant says so kindly provide with evidence of the food item and purchase bill. She would like to know what exactly she took and why they did not disclose this to the treating doctor or resident doctor or to the anaesthetist. This falls in concealment of facts by the patient and the attendant. The complainant has no legal right to question the clinical judgment of the doctors and their recording of history, as told by the patient. And the attendants are not to dictate the same. Para 7 is admission of the patient neglect and lack of family care of an ailing woman. Without prejudice, this fact of them not knowing that she was suffering from fibroid uterus, in itself shows their negligence in taking care of the patient, who was suffering from meno-metrorhagia for three years and they did not get any medical advice or the treatment for this. So, the patient landed up with her in such a critical situation that no medical treatment would have been effective. The medical documentation is done by the hospital protocol. The admission file has only general consent forms. There are no blood transfusion consent forms and no procedure specific surgery consent forms in the admission file. If the patient requires blood transfusion, the consent is taken after admission and explaining the need for transfusion and other details related to possible complications of blood transfusion. She in the hospital has printed procedure specific consent forms for almost all regular/routine surgeries. They are not the part of the admission file and are signed by the patient and or the relatives after proper counseling, explaining the procedure, any possible complication and requirement of any additional procedure according to intra-operative findings. Therefore, the allegations made are completely false and baseless. The complainant and his daughter have made contradictory statements that are false, frivolous, and fictitious for the purpose of harassment. Nowhere, she has written that the patient would die or any high risk consent before surgery, as these are routine surgery for these conditions. In this case since the patient was bleeding, with large clots the earlier they operated and stop bleeding the better for the patient to avoid complication, related to acute blood loss and multiple blood transfusion etc. The photograph they have inserted of the patient before surgery and them being highly educated, can it be considered that the patient may die. It is all afterthoughts, as she could not find any negligence on her part: And to gain false sympathy of the esteemed members of the Delhi Medical Council. The consent form signed by them is only informed procedure specific consent form and complete detailing of the patient, the patient’s daughter and the husband was done before obtaining their signature by Dr. Priyanka Gupta, and Dr. Priyanka Gupta counter signed the same after obtaining the consent. They are literate people and were not tense as they have shown patient’s photograph who were happy and complete in their senses and could understand every detail explained and their queries were answered to their satisfaction. The consent was signed after about 4.00 pm by them after understanding the surgery and possible complications explained in detail to the patient, her daughter and her husband and clearing all their doubts. She has been operating patients laparoscopically with multiple previous surgeries and have, an expertise to operate and deal with intra operative complication and, therefore, for all difficult surgeries the patient are referred to her for expertise in Laparoscopy and Hysteroscopy and, therefore, she has been invited to conferences and CMEs to share her experience and knowledge. The references given by the complainant is the article of “Good clinical practice recommendation for Iron Deficiency anaemia in pregnancy in India”. It is not related to gynae. patients. It is pertinent to mention that despite the above qualifications and experience, she did not start the procedure without the elementary PAC clearance done by the anaesthetist(s) and they have not cited any risk to defer the surgery. The literature annexed by the complainant is not standard literature accepted in post graduation course. This is a literature for under graduate to give him just basic knowledge of subject. She has been operating the patients with bleeding when it is not controlled by the medicine in view to save multiple blood transfusion reactions. Only few leading gyne. Laparoscopic surgeons are trained /capable of laparoscopic suturing. In such cases, she does not use energy sources for uterine vessels. She suture the uterine vessels laparoscopically and then dessicate and cut to take care of blood filled / may be dilated uterine vessels. She trains herself with the best available techniques for the benefit of her patient, so that she can provide them with best possible treatment and care. The hospital and its doctors did nothing in haste leaving plenty of time with the patient to take the decision after discussion and information with all the family members and the attendants. After admission also they had plenty of time to get other opinion or to refuse for surgery/to refuse treatment etc. The patient and her husband signed the consent after 4.00 pm, exact time they may know themselves. Therefore, highly educated, knowledgeable the complainant/ should not deny this. As they have the video recordings of everything as mentioned in last hearing verbally. The urine reports were asked telephonically. The presence of puss cells in urine without any sign or symptoms of UTI with TLC with normal range, afebrile patient does not indicate UTI. The culture report was received later on which shows the urine to be sterile. Just presence of puss cells does not mean that the patient have urinary infection. The complainant has no legal right to question the clinical judgment of the doctors and protocols. It is a routine practice to keep the patient in post-op ICU after surgery under the observation and management of post op nursing staff and anaesthetist. As per the condition and the requirement of the patient, the patient is further shifted to required facility from post-op ICU as per advice of anaesthetist. The patient was shifted to Labour Room ICU as per the advice of anaesthetist, as blood transfusion has to be given. There was no doubt in success of the surgery, kindly go through the recording. The complainant has no legal right to question the clinical judgment of the doctors and protocols. The post mortem report provided by the complainant clearly shows no surgical fault / complication responsible as cause of death in the matter. It is specifically denied that she is not qualified to be enrolled under the Indian Medical Register or with the Delhi Medical Council, as alleged. It is specifically denied that her qualification is not included in the MCI Schedules, as alleged. In the Third Schedule “M.D. (Physician) (Moscow Medical Stomatological Institute) Moscow, U.S.S.R. She on qualifying and upon returning to India had submitted her certificate issued by the said Institute along with her degree to the Medical Council of India and after detailed scrutiny, her name was entered into the Indian Medical Register. Complaint no.DMC/DC/F.4/comp.2799/2/2019/282807 dated 06/06/2019 filed by the complainant agitates on this issue and detailed reply has already been filed by her with annexures to the Delhi Medical Council. Para A with all the allegations made and contentions raised therein is wrong and specifically denied. Averments are eye wash to swab his callous and uncaring attitude towards his wife, when it is a matter of record that, the patient was wheeled in wheel chair, daughter shouting emergency, please see immediately and he not even accompanying her and describing it a minor problem shows his uncaring attitude and perhaps, the main cause of 3 years of suffering position. The complainant has no legal right to question the clinical judgment of the doctors and their recording of history, as told by the patient. And the attendants are not to dictate the same. The complainant has no legal right to question the clinical judgment of the doctors and their assigning consultants for treatment. And the attendants are not to dictate the same. The patient has not shown any casualty record. This OPD case comes to the OPD in wheel chair, faints and needs support. Kindly referred to the annexed pages of OPD prescription. At times when they force the patient to get the investigation done from the hospital only the blame on her or doing so citing some annexure between her and hospital, therefore, whenever a patient or attendant asked them any alternative options she has to give. Routinely in their OPD at a time there are 4-5 patients, as it is a General Gynae. OPD. In this case, the daughter came and asked for alternative for getting USG done, she suggested the name and wrote it but when she looked up and saw her to be bleeding patient’s daughter, she crossed it and insisted her to get it done at the hospital only and to help them she called the USG department and requested them to do urgent USG for her. The patient was examined. USG done when the patient came back from USG room, she fainted though her BP was recorded to be 90/60 mmhg in OPD card. Loosing no time in documentation and any other thing she immediately shifted the patient to labour ICU to manage the condition of shock. It in itself shows the point of excessive bleeding : that over the period of bleeding for about an hour in the hospital after making OPD card till, the patient came back from the USG room, her condition worsened. Chronic anaemia (meno-metrorrhagia for 3 years) followed by excessive bleeding led to decompensation and fainting attack with low BP (shock). The prime importance at that time was to shift the patient to intensive care gynae facility to manage the shock, where the patent was taken care of accordingly. The complainant has no legal right to question the clinical judgment of the doctors and treatment protocols. Initially there are nursing assessment notes of the patient’s condition at the time of admission only which was made after 2 pm, after resuscitation done. They are to see the vitals and related history to any medical treatment the patient is on, so to continue previous medicines. They are not part of treatment decision. The treatment decision was taken by after the clinical examination details as per OPD prescription: p/a- obese, p/s*-* vaginal full of clots, bleeding p/vCx very soft, full of clots, uterine size could not be made out due to obesity history given by the patient herself 3 years of meno-metrorrhagin leading to anaemia (HB 7.2mg%) on admission with excessive bleeding p/v leading to decompensation(reference T.Lend’s text book of Gynaecology) with continuing bleeding despite giving injection Tranexa I/V, was the reason to advise surgery. In view that the present bleeding episode may not reflect in HB report because it takes time for lab. Reading to show actual blood loss (12-24 hours). For reference statement of the OPD staff nurse filed by her may be read. The complainant has no legal right to question the clinical judgment of the doctors and their recording of history as told by the patient. And the attendants are not to dictate the same. All lab reports (pre-operative) were absolutely within normal limit. So no super specialist required or referred. In theOPD prescription, history was written by Dr. Priyanka as per patient’s description before examination. After admission, history of previous 3 LSCS was corrected by the resident doctor in initial assessment notes after examining the patient (by Dr. Sushma). However, for her, the history of previous surgeries only may change the first entry port location and nothing else, which is decided according to the scar line, abdominal wall consistency and possibility of location of presence of adhesions on OT table. By the time admission file was made the patient was given crystalloids and her BP came to 110/70mmhg as per record, 1 unit of blood was already on flow when the patient was taken for surgeryand immediately post-op another unit of blood and started. All needed precautions were taken. it was important to stop bleeding along with blood transfusion, as there is no sense in giving blood when patient is bleeding profusely without taking care of measures to stop the bleeding. As the requirement of blood and blood products would increase bleeding to complication like DIC transfusion related syndrome etc. Bleeding like tap is routine mention, in Obst. & Gynae. is used, when there is profuse / excessive / continuous bleeding. Blood pressure was 90/ 60 mmhg, as mentioned in the OPD card, after resuscitation it was 110/70 as per record and in the OT at the time of recovery 140/ 90mmgh as per post op observation then every 15 min. The BP range was absolutely within normal limit as well as HR and SP02. The urine culture report of 10-12 pus cells with no fever, normal TLC, DLC with no urinary complaint, points out to the patient not suffering from UTI which is also evident from the urine culture report which shows it to be sterile. Therefore, it cannot cause septicaemia and related complication. Detailing of anaesthesia record shows intra operative fluid and drugs given and I/O charting. She has been using the practice of direct entry for last 30 years and was trained by Padamshree Dr Usha Sharma during their post graduation in 1987-1990 and she does not use vere’s needle insertion technique. The complainant is trying to cause prejudice by scandalising simple facts in patient care. Per operative the urine was haemorrhagic, so to assess if there is any injury of the bladder, injection lasix was given. RBS is expected to be high in a DM patient post operatively and she has to make sure that the patient does not go into hypoglycaemia as well. Anaesthetist is the best specialist to stabilise the patient. She has best of anaesthetist, post-operative management is usually done under the guidance of anaesthetist and physician is called if they advise. Routinely, they follow this protocol. Kindly go though post operative record (page- 37/132). The BP and HR were within normal limit BP range between 109/80 to 128/86 and pulse rate between 59-68 BPM. Intra-operative record (page 36/132) BP - 140/90 on recovery, SP02 - 1000/0 in recovery period BP gets high normally. After operation on 29.3.18 till morning 8.30 am on 30.3.18 vitals were stable as per nursing record. It is wrong to suggest that the medication / mode of medication was supervised by the treating gynaecologist. Since the condition, the patient developed was not at all the gynaecological condition but it was cardiac/medical event requiring treatment from these specialities and same was explained to the attendants (page 22, 24 / 134). As per international studies most of the ovarian cancer has origin from to fallopian tube endothelium and, therefore, it is now a routine to remove the fallopian tubes to avoid future problem for the patient and all the more they were not healthy, ovary was not looking healthy with multiple solid/liquid cysts so they had to be removed and any other procedure required to be done during surgery consent was already there. After surgery, the attendant were shown the specimen and explained in detail the surgery done and its requirement and they had sign the specimen register maintained by her. The patient was not hastily operated. The USG was seen at 11.05 am dated 29.3.2018 and all the treatment options were discussed with the patient and the attendants all the pre-operative investigations were done, which were within normal limits. PAC (Pre anaesthesia check-up by team of anaesthetist) was done which was also as per records within normal limits. Blood was arranged. One blood transfusion was started pre operatively. Injection Tranexa I /V, Crystalloids I / V broad spectrum antibiotics given I/V alongwith injections Ranitidine, Perinorm given. Therefore, all necessary routine pre operative protocols were followed. Even after giving injection tranexa I / V and other supportive treatments, the bleeding did not decrease or stop. Therefore, the patient and the complainant signed the consent forms for surgery. She was shifted to OT after 5.00 pm : they had more than six hours to take any decision regarding continuation of treatment as per her advised or take any other opinion or take the patient to any other hospital. Kindly refer to HPE report (Grossing) of this patient. Both the tubes show haematosalpinx with acute salpingitis, paratuban cysts present. This same blood in pelvis from vagina and cervical canal came into the abdominal cavity when vaginal vault was opened and was not looking healthy, therefore, suction and peritoneal lavage done. CX- chronic cervicities with Squamous metaplasia with Keratinisation with viral changes. Endometrial cavity irregular, filled with blood clot. Right Ovary solid Cystic with -Corpus albicans, Follicular Cyst, Benign Simple cyst Haemorrhagic Corpus Leutum Cyst. Uterus Distorted, cut open, separated Cervix, separated fibroid. In view of gush of unhealthy blood in peritoneum after opening the vaginal vault and tubes and ovaries not looking healthy, the decision was taken to morcellate the specimen from below (vaginally), so the specimen was retrieved by vaginal morcellation to reduce the risk of infection. The route of morcellation is decided at the time of surgery. She was a known case of hypothyroid and had taken medicine on day of admission. Next day due to her condition tablet eltroxin could not be given. Her pre-op reports were within normal limits. eltroxin/thyroxin has very long half life. The word “tap”in medical sciences is used not as meaning of plumber tap, but to mention continues flow of blood and should not be confused with plumber’s tap like she has other words spinal tap, peritoneal tap, pleural tap on the same lines - continues flow of liquid state of matter is mentioned in medical science as tap. Haemoperitoneum and clots were present when she opened the vaginal vault and as per histopathology report - B/Lfallopian tubes were filled with blood- it shows that the whole genital tract was full of blood and impregnated with it. Kindly watch the video B/L uterirne vessels were ligated laproscopically and then desiccated and then cut (please watch the video). In case a uterine vessels gets cut or injured, any medical person can understand what to expect. After these vessels are injured they will be no where to find to ligate, only internal iliac artery ligation can save the patient. Post mortem report - effusion of blood is normal finding of the area separated from adhesions. In the OPD history is written as per the patient’s statement before examining the patient (Dr. Priyanka). On examination, the patient was found to be bleeding profusely with clots. Urgently we sent her for ultrasound. Later on in Resident doctor’s notes patient gave same history but on examination the patient was having a surgical scar on abdomen. On further inquiry she disclosed the history of previous three LSCS. The patient tried to hide her medical history but after examination we very well knew about the history of previous three LSCS. As stated by the attendant her blood sugar and glycaemic control were good pre -operatively and since she had given history of irregular treatment the same was written in death summary. Diabetic patients under surgical stress may show increase level of blood sugars and they are managed accordingly. And her hypothyroid was completely controlled. Since the patients diabetes and hypothyroid condition was well controlled according to pre - operative reports. No separate consent required. The patient was transfused with 1 unit of whole blood and 2 units of packed cells. She gets all pre-operative investigations done and these are assessed by the anaesthetist during their PAC and their advice is followed as mandatory. No patient can be .shifted for surgery without PAC clearance. Already explained that the specimen was retrieved by morecellating through vaginal route. Therefore, large chunks were separated and handed over to the pathologist. They knew everything and has experience and expertise in dealing with such patients and she of-course expected adhesions, therefore, consent was already taken for this. This was the reason for primary port at PALMER’s point. Laparoscopy is best for patients who are obese, diabetic as to avoid post operative complications and wound infection, flaring up of DM as there is no open wound, abdomen to air to contract infection as well as no stretching of abdominal wall and no bowel handling, less wound infection better ambulance and recovery. She has been doing these surgeries for 19 years and has vast experience and by God’s grace for last 15 years never had to convert a laproscopic surgery to open due to any mishap, all our patients survived and almost all of them were discharged on day three of surgery except this unfortunate patient where she developed some medical condition beyond our control, knowledge, acumen, scope of work, therefore concerned specialist were called and managed accordingly. There was no indication of any high risk in pre-operation check up otherwise anaesthetist could have guided her about it. Post -operative due to the patient's condition X-ray chest and X-ray abdomen were done. “Patchy opacities in left mid zone” are the finding of chest x-ray and not abdominal x-ray. There was no intra-operative complication or bleeding. Preoperative chest x-ray done and seen by anaesthetist was absolutely within normal limits. There was no reason to expect pulmonary oedema as per pre-operative work out. As per anaesthesia record and anaesthetist team there were no events from respiratory of cardiac side, therefore, operative also there was no suspecting factors in favour of development of pulmonary oedema in post operative period. After successful completion of surgery, the anaesthetist did reversal of anaesthesia and everything was absolutely within normal limits and vitals were normal. In view of haematuria (which usually happens due to separation of bladder adhesions and clears off on its own after giving fluid and injection lasix), she requested the anaesthetist to give I/V injection Lasix to see if there is persistent haematuria or the urine is clear to take needed action. But after injection LASIX, the urine was clear so she was more than satisfied with the surgery performed. In case of cutting of major arteries, the patient may not even survive on OT table itself. About Uretheral injury, Please specify how it can be cut in Laparoscopic surgery, as it is not approachable through abdominal route, even if someone wishes to cut it laparoscopically, it is impossible. Post- operative greenish vomiting (bilious vomiting) has no connection with the surgical procedure, but just a post-operative event which is managed by keeping the patient NIL orally, emetics, I/V fluids, antibiotics and other supportive treatment which was given. Post- operative vomiting can occur due to parylitic ILEUS. To rule out USG abdomen and x-ray abdomen erect done which were within normal post-operative limits. So there was no infection in abdomen as such. As explained earlier also that when the vaginal vault was opened by monopalar hook plenty of unhealthy looking blood and clots from vagina came into the peritoneal cavity (collected blood due to prolonged persistent heavy bleeding) and, therefore, suction along with pelvic cavity lavage was undertaken to clean the area of blood and blood clots and avoidance of any post operative infection. There was minimal to around nil blood lost by surgical procedure. The evidence of Hb raised from 7.2mg% (on admission) to around 11.2-mg%>at 8.27 am on 30.3.2018 and 12.3 mg% at 1.28 pm. on 30.3.2018. Post operatively after only 3 units of blood transfusion (1 whole blood, 2 packed cells) in itself is sufficient to explain it. She requests again to please go through the recording of surgery which was for the teaching purpose. On following Sunday, there was a conference at Asian Hospital Gurugram organised by Haryana OBGY society and she was requested by the organisers to show unedited video and the time allotted was 1/2hour , therefore, in between the recording, it was paused for unnecessary events like – taking out fog, cleaning of camera, suction of blood which came out after opening the vault etc, as she had to restrict the recording as per stipulated time. She also did recording for the next patient on the same day who was posted for routine surgery for the same purpose to enable her to choose one of the best videos for the purpose of teaching in conference. The source of bleeding was taken care of for the patient’s well being therefore it was the necessity to operate the patient and stop bleeding as early as possible to avoid further worsening of her condition. If a pitchers’s tap(ghada- in hindi)is open how can you fill it (anaemia blood due to blood loss). So first one has to stop the tap and then fill it; only then it would be full (correction of anaemia). It is a standard hospital protocol to get the patient’s HIV status before taking up the patient for surgery, as if it is positive, necessary precautions can be taken for operating surgeon / staff and other follow up patients in the O.T. The consent form is signed by the patient and the report says that HIV status is negative, which is a compliance done by the hospital. Had the patient refused to give consent for the sample the surgery would have been definitely cancelled or postponed? The samples were taken before the admission file was made by the patient’s attendants. The HIV testing was done on OPD basis through lab which has the HIV consent signed. Because her vitals condition was not explainable, she had called the cardiologist to see it here is any cardiac event, explained the attendants the situation in writing (by Dr. Manwani and Dr. Priyanka) indicating danger to life at 11 am on 30.03.2018. The situation was beyond the scope of work, capability, training, specialization of the gynaecologist; therefore, the treatment done was as per physician, cardiologist, and ICU incharge and intensivist doctor. Routinely whenever there is late hours surgery and or patient requires blood transfusion and monitoring, she keeps the patients in labour room for better care and this was explained to the attendants verbally (daughter and sister) as per page 38/132 Replies filed by O.T. and nursing staff and anaesthetist may be referred to. The patient’s condition was absolutely within normal limits as per post-Op standards. (Respiratory arrow can breathe and cough, O2 saturation was more than 92% on room air, breathing. The patient was in shock in OPD and, therefore, shifted to labour room for resuscitation. The file was made after 2 pm by the attendants. At that time I/Vcrystalloids transfusion was done to the patient and, therefore, vitals were within normal limits after resuscitative measures. She was sent to labour ICU. It is the place where OBGY emergencies are dealt with. Surgical / medical option of treatment is planned on the basis of many factors:- Complaint, - History, Vitals, physical condition, Examination findings - USG / lab reports. Desire of the patient and attendants and their decision already replied and explained. Dutta’s title is not a standard post graduation text book. Rest is already explained. The size of fibroid is important in quiescent cases; in this case it was not the size but the clinical presentation of the patient condition was the deciding factors which were explained in detail to the patients and attendants. Postoperative period was uneventful and the patient was discharged in satisfactory condition - it is no where written in the patient’s case sheet. The same is mentioned in provisional discharge slip as per hospital policy.

Dr. Vivek Gupta, SR Consultant, Saroj Super Speciality Hospital stated that he was anaesthetist who administered the anaesthesia to the patient late Gargi Meena after she had been cleared for the same after PAC, in the surgery done on 29th March, 2018. The surgery was uneventful. After the surgery, the patient was shifted to post-operative room and then to labour ICU after stabilization.

Dr. Vivek Gupta in his supplementary written statement averred that the patient was bleeding; the Hb was 7.2 gm% as recorded by their lab. In PAC 3 units of blood were asked to be arranged. One unit of blood was started pre-op. The blood pressure of 90/70 mm Hg was at the time of admission. In labour room, the patient was given one unit of R/L and one unit of DNS (page 55 showing blood-pressure at the time of admission) (page 32 showing R/L and DNS). As the patient was bleeding, she was taken for operation as an emergency surgery with low Hb but will blood on flow and two more units of blood arranged. The blood pressure of 90/60 was not just before the operation it was so at the time of admission. Because the blood pressure was low patient was administered 1 R/L, 1DNS with neutralizing insulin. At 2.00 p.m. in labour room, the blood pressure was 110/70 (page-55). The blood was started at 4.20 p.m. (page-6) with blood pressure came up-to 110/70, pulse 98 (page-35). In PAC, it is clearly noted about previous 3 LSCS by the anaesthetist. It was also declared on ‘please tell about yourself’ by the patient(page-46). The surgery time was around 1.5 hours. One unit of blood was on flow, second unit of blood was started at the end of surgery. One NS was also given in between. There was no sign of hypotension. The patient was hemodynamically stable during the surgery. The urine output was around 75 ml. At 10.00 p.m. in labour room, urine output was 200cc which included intra-operative urine also (page-8). The patient was well controlled hypothyroid taking 50 mg Eltroxin daily. TSH of 2.65 confirms that (page -156). HbA1C was 6.8, FBS-105mg %. The patient was well controlled, was not on any oral hypoglycaemic. So, no intervention was done. He the doctor was neither careless nor negligent. Proper pre-operative assessment of the patient was done. The patient was well examined pre-operative pulse, BP were within normal limits. Pre-operative ECG was done and was within normal limits (page-160-165). The patient also did not give any history of any cardiac problem and it is documented in “please tell them about yourself form” (page-45). There were also no physical sign of any cardiac problem on auscultation and as well as on examination. A thorough investigation was done. Pre-operatively ECG and other blood investigations done were within normal limits. A through PAC was done. Proper history was taken proper examination was done. As every investigation was normal and the patient also denied any cardiac illness, so no further cardiac evaluations was required to be done. The patient was in hospital for more than six hours and was nil by mouth as confirmed by the anaesthetist in PAC record. The consent was taken and signed by the patient and herself and her husband (page-46). Hypothyroid status was documented in anaesthesia consent form (p-46) and was counter signed by the anaesthetis. The relevant information was filed in PAC chart. Reports which were awaited were collected before operation. Their PAC chart is a continuation of anaesthesia consent form and self declaration form and all relevant information was there in tell about yourself form. Pre existing disease, relevant history and medication was documented an anaesthesia consent form (please tell about yourself) (page-45-66) signed by the patient herself and the husband and counter signed by anaesthetist their PAC chart is a continuation anaesthesia consent form and self declaration from and all information was there is tell about yourself form. In post-op, the patient was kept for one hour and five minutes and was signed by the anaesthetist before shifting to labour room (p-37, 38). At the time of shifting aldrete score was 10. The quality sheet is meant for hospital records. Not filling it does not effect the patient’s treatment and outcome. The anaesthetist did meet the patient and the attendant and discussed about anaesthesia and its complication. It was read and filled by the attendant of the patient. It was signed by the husband and the patient herself (P-46, 47). The patient was well controlled they are TSH-2.65 (P-156). Fasting blood-sugar-105 mg %, Hb1C-6.8 (p-146. 148), so endocrinologist reference was not required. A through PAC was done. All routine investigation was done (P-146, 147, 148, 149). Pre-operative, ECG was done and was within normal limits. NPO status patient thoroughly assessed. The patient had light breakfast in the morning and the patient was in OPD at 10.17 a.m. Since, then the patient was fasting. Just before USG at 11.00 a.m., the patient had some clear fluids. At the time of operation patient was fasting for 5 hours.

Dr. Dharam Veer Sagar in his written statement made to Director, Saroj Super Speciality Hospital averred that he was on duty in ICU. On evening of 30th March, 2018, when he received the patient, the patient was on Bed No.13 in ICU, has blood-pressure was 70/40 mmHg, and HR-4. Already cardiac reference was sent in the Morning hrs. and 2 D echo was done, 2D echo revealed normal charmber and LVEF-60%(approx.) Nu RWOMA, the patient was seen by cardiologist and advised followed. The patient was already in noradrenaline injection, injection Dopamine. Infusion was started her heart rate 100-110/min and blood pressure came up-to 110/70 to 130/80 mmHg. The patient had adequate urinary output. In the evening, the patient had complained of nausea and vomiting. Immediately, the patient was shifting to bed No.15, in front of the Nursing Station and injection Emset given. In between the patient was regularly seen by the senior resident, gynaecology and the consultant Dr. Priyanka Gupta, every minute detail was sent to Dr. Nisha Jain telephonically and had advised followed, up-to about 2.00 p.m. on 31st March, 2018. The patient was stable, suddenly PHS, SPO2 leveled started falling up-to 70-80 % and the patient complained of restlessness, Dr. Nisha Jain and Dr. G. Manwani were informed about the condition of the patient and the anaesthetist was called. ABG and other blood investigations were sent. In view of respiratory failure, the patient’s husband was informed about the need for intubation and ventilation, but he denied telephonically and said that he will come and see the patient and then will give consent for ventilator. In the meantime, the patient was put on BIPAP support, but the patient was not maintaining SPO2 level. After above half and hour, the complainant gave consent for intubation and ventilation. The patient was intubated at about 3.00 a.m. on 31st March, 2018 (approximately) and put on ventilator, but soon after, this patient started having bradycardia, and in few minutes, the patient had cardiac arrest, at that time, the doctor of ICU and gynae. senior resident were present and the CPR was started as per the ACLS guidelines and continued for already one hour. ECG taken showed straight line and pupils were found to be dilated and fixed and the patient declared dead at 4.12 a.m. on 31st March, 2018.

Dr. Greesh Manwani, Physician, Saroj Super Speciality Hospital stated that at 9.00 a.m. he examined the patient, her pulse was feeble 46 bpm, blood-presure 90/60 mm of Hg, respiratory distress was present with cold extremities and with excessive sweating. The patient was provisionally diagnosed to suffer with shock cardiac event and appeared to be critically sick. Critical condition of the patient was explained to Dr. Nisha Jain and with the patient’s attendants consent shifted to ICU. On reaching ICU, her blood-pressure was 70/50 mm of Hg, pulse 46 pm, BS 19 mg%, Relevant investigations including x-ray chest, ECG, echo, ABG, LFT, KFT were advised and cardiac consultation from Dr. Sanjeev Aggarwal’s team (Dr. Deepak Tiwari) was taken and they were ruled out any cardiac event. Appropriate treatment was started including inotropic and BIPAP support with higher antibiotics and insulin. The patient was continuously monitored and managed, and the condition of the patient was informed time to time to time to the attendant throughout the day. At around 2.30 a.m., the patient started sinking, her blood-pressure despite of inotropic support and respiratory distress increased. The patient was intubated after ICU in-charge got consent from Sujata (attendant of the patient) and the patient was put on ventilator, but the patient developed bradycardia and low blood-pressure. CPR according to ACLS guidelines was started and continued for at least one hour. After one hour, ECG showed straight line, pupils were dilated and fixed and the patient was declared dead at 4.12 a.m. as on 31st May, 2018.

Dr. Greesh Manwani in his supplementary written statement averred that he was called by Dr. Rachna Rawat on the instructions of Dr. Nisha Jian to give his opinion on patient Gargi Meena in labour room, her pulse was 46 pm, BP 90/60mmHg, lungs B/L clear with cold extremities, excessive sweating and restlessness. The patient was provisionally diagnosed to suffer with ? shock ? cardiac event and appeared to be critically sick. He raised the alarm about the critical condition of the patient and informed the critical condition of the patient to Dr. Nisha Jain telephonically and the patient attendant with consent to shift in ICU. The patient was immediately shifted to ICU. On reaching ICU, her BP was 70/50 mm of Hg, pulse 46 pm, BS 190 mg%. The relevant investigation including x-ray chest, ECG, Echo, ABG, LFT, KFT, CPK, CPK-MB, urine and the blood culture advised and cardiac consultation from Dr. Sanjeev Aggarwal’s team was sought to manage any cardiac event. Appropriate treatment was started including inotropic and BIPAP support with higher antibiotics and insulin. When the patient was seen by him, the patient’s condition was critical, her vitals was abnormal (pulse 46 pm, BP 90/60 mmHg at that given time) whatsoever was required, he has done in the capacity of physician. The patient was continuously being monitored and managed by the team of ICU doctor and staff, the condition of the patient was informed time to time to the attendant throughout the day. At 4.00 p.m., he reviewed the patient and all the investigation reports and advised repeat TLC, DLC, ESR, report and escalated the higher antibiotic for the management of the patient. At 3.30 a.m. of 31.03.2018, Dr. Dharamvir Sagar (Resident Doctor ICU) telephonically informed about the cardiopulmonary arrest of the patient and he asked Dr. Dharamvir Sagar to resuscitate the patient as per ACLS protocol and do the needful. But the patient could not be revived despite of their best efforts and declared dead at 4.12 a.m. on 31st March, 2018. At 10.45 a.m. on 30th March, 2018, the ABG (raid point 500) report shows lac-22.5% which is very high (normal range is 0.5 to 1.5) the most common cause of raised lactate is shock (cardiogenic/septicaemia) but sepsis can produce lactic acidosis in the hypotension or other clinical features of shock. This is due to the fact that oxygen supply is not commensurate with the increase demand of oxygen by tissue in sepsis. The treatment of high lactate is directed towards the cause. Such a high of lactate indicate that when he saw the patient for first time, she had already suffered with prolonged tissue hypoxia due to hypo perfusion of tissue and irreversible shock (cardigenic/septicaemia). The treatment of shock started by him immediately at 9.00 am according to standard protocol without waiting for the investigations reports. When, he examined the patient at 9.00 a.m., the blood sugar was 190 mg%. He has started injection H Actrapid S/C four hourly accordingly to sliding scale. This was remained high due to surgical stress and shock. Once he has started insulin, the blood sugar remained within normal rage (except one reading of 229 mg %) for a post operative patient chart of blood sugar was as : 9.00 a.m.-190 mg%, 1.00 p.m.-184 mg%, 5.00 p.m.-229 mg%, 9.00 p.m.-211 mg% and 1.00 a.m. -118 mg%. The blood sugar charting was done every four hourly and according to blood sugar insulin human actrapid S/C was given. The pulse and the BP were tried to be maintained with help of Inotropes (initially with noradrenalin and later on with dopamine infusion). Intake output chart was maintained post-operatively, intake was 2100ml, output was 170 ml and KFT was normal range. Potassium was low, for which, syrup Potklar started. He was called by Dr. Rachna Rawat (Gynae. post in LR) at 8.40 a.m. on 30th March, 2018 telephonically for the patient and he reached there within 15-20 minutes and examined the patient immediately at 9.00 a.m. and statement of Dr. Rachna Rawat(Gynae. Posted in LR). He has not received any call prior to 8.40 a.m. Regarding pulmonary edema when he examined the patient, there was no clinical evidence of pulmonary edema nor any investigation (ABG, ECHO, X-ray chest) shows pulmonary edema. Pulmonary edema might have developed in the night of 30.03.2018 only. Pre-operatively, TSH level of the patient was within normal range and she was controlled on tablet Eltroxin 50 mcg p/d daily in the morning empty stomach. At 9.00 a.m. when he saw the patient she had already given breakfast on the instruction of gynaecologist and she was not empty stomach to give tablet Eltroxin (which is to be given on empty stomach). This is the reason he has not advised tablet eltroxin for the same day. Moreover half life of Eltroxin is 07 days. At 9.00 a.m. 30.03.2018, her pulse was 46 per minute, BP 90/60 mm of Hg this was due to shock. He has started management of shock to correct the pulse and the blood pressure.

Dr. Priyanka Gupta, Clinical Assistant (formerly), Saroj Super Speciality Hospital in her written statement averred that complete treatment advised, the treatment done and further follow up undertaken, monitored and supervised by her senior consultant, Dr. Nisha Jain. She was only junior doctor (clinical assistant) assisting her senior consultant all throughout the treatment of the patient Smt. Gargi Meena, 42 years female. This was also her duty to follow each and every instructions and advice given by her senior consultant, Dr. Nisha Jain. Initially when the patient presented in OPD, the patient had complained of heavy bleeding per vagina (PV) during menses (i.e. menorhagia) since last three years. Whereas upon asking her direct question to rule other negative history, the patient later also told about frequent episodes of bleeding per vagina in between menses i.e. metrorhagia since last three years. As now, the patient was having heavy bleeding per vagina since last two days with pain abdomen since last one day and, hence, all symptoms has been written in sequential order as separate wording. The patient’s history was duly recorded and was explained to the patient’s party. In OPD, the history was written as per the patient’s own statement before examining the patient. As per records maintained by hospital or she can recall, on her (the patient) vaginal examination, as done by Dr. Nisha Jain, she (the patient) was found to be bleeding profusely, as advised by her (Dr. Priyanka Gupta) senior consultant, Dr. Nisha Jain. Further, interaction with the patient and her relatives was done with senior, Dr. Nisha Jain. Later on, in resident doctor’s note in LR (labour room), the patient again gave same history of 3 FTNVD. But during examination by the resident doctor in LR, a scar was seen on the patient’s abdomen and asked about surgery of that scar, then the patient revealed history of previous 3 LSCS and, hence, resident doctor corrected her previous written history. On 30th March, 2018 at 8.30 a.m., the patient was seen by the resident doctor on duty and informed to senior consultant. Cutting is done as whatever was written was repeated of above line so to correct this doubling it was cut. It is such written advices are absolutely legible by a bare-eye reading. The vitals and input/output were regularly mentioned in ICU chart. There could be multiple causes of low blood-pressure, one of them could be diabetic neuropathic effect on heart as the patient was k/c/o DM, not on any treatment (as per OPD record) and, hence, high risk consent was taken and specialist as physician and cardiologist had been called. When the patient was in ICU, the vitals were maintained on life saving drugs (i.e. Dopamine, Noradrenaline-as Ionotropic support), under guidance of physician, cardiologist and ICU in-charge. On 30th March, 2018 at 8.30 p.m. when she (Dr. Priyanka Gupta) saw the patient, her ionotropic requirement was reduced (as per hospital record maintained in ICU charge page No.111-112). The patient’s clinical status and the vitals were duly informed in detail to senior consultant Dr. Nisha Jain telephonically. As per senior consultant advice and also as per her experience, each and every aspect of the patient’s condition and prognosis explained to the patient’s relatives in detail. As the patient was still on iontropic support, detail high risk consent was taken from the relative of the patient. Consent taking and explaining the patient’s condition with prognosis is part of the patient management. The patient had expired on 31st March, 2018 despite best treatment afforded having had followed as per medical protocol. She had resigned due to personal reasons.

Dr. Sushma, Senior Resident, Saroj Super Speciality Hospital in her written statement averred that when she took the history from the patient, the patient told that she (the patient) had three normal deliveries but on examination, she (Dr. Sushma) noticed a scar on abdomen. When she again asked the patient about the scar, the patient said that she (the patient) had three caesarean delivery(3LSCS), so she corrected in the case sheet. Page 22/132:- correction made in pulse rate according to the reading on the monitor during her stay in ICU. When she reached, it was 120 bpm when she was leaving ICU, it was 140 bpm. Output-visual estimate was of 200 ml in the bag but when it was measured by measuring flask, it was 180 ml, so, she corrected it.

Dr. Sanjeev Aggarwal, Sr. Consultant Cardiologist, Saroj Super Speciality Hospital in his written statement averred that the referral was received by Dr. Deepak Tiwari (Sr. consultant cardiology in team of Dr. Sanjeev Aggarwal) at approx. 2.30 p.m. on 30th March, 2018, when the whole cardiac team was busy in cath lab within 15 minutes, as soon as he was free from cath lab, Dr. Deepak Tiwari accompanied by Dr. Manish Gupta went to see the patient. After detailed examination, he could not elucidate any cardiac cause of her illness though, she was having relative bradycardia. Dr. Tiwari then ordered for an urgent bed sided Echo. The Echo machine came from the Echo room and he himself performed the Echo. Echo could not also find any cardiac cause responsible for the illness. The same was noted in the file by Dr. Manish Gupta at 3.30 p.m. Unable to explain any cause of her illness, Dr. Tiwari remained on bed side with the patient for another 30 minutes. Dr. Tiwari increased the dose of IV fluids and vasopressors to increase her BP. The patient responded positively to this treatment. After staying there for more than an hour and not able to get any cardiac cause of her illness, then the clinical notes were put in the file again by Dr. Tewari at 4.00 p.m. Hence, there was no delay in seeing the patient after the referral was received at 2.30 p.m. As per principles of cardiology, there is no indication of IABP in this patient. Since, there is no question of any cardiac cause to be responsible for her illness; the question put by the complainant that the delay by the cardiology is responsible for her illness is contradictory.

Dr. Subrat Bhushan Sharma, Saroj Super Speciality Hospital in his written statement averred that there is no time limit for CPR, the patient had bradycardia followed by cardiac arrest at 3.30 a.m. on 31st March, 2018 and CPR was continued till 4.12 a.m. and no ROSC. So, the patient was declared dead after straight line in ECG and B/L and dilated pupil. Explained to the relatives and informed to consultants incharge and security.

Dr. Prashant Bothra, Consultant Cardiology, Saroj Super Speciality Hospital in his written statement averred that he was on duty radiologist on day of the unfortunate turn of events which culminated with the demise of the patient. He was asked to conduct a bedside ultrasound of the patient on 30th March, 2018 in the ICU, to rule out any intra-abdominal bleeding and evaluate for cause of shock. No evidence of intra-peritoneal collection of any active bleeding was seen. Note, however, was made of multiple small echogenic foci within the gall bladder lumen which was interpreted as “multiple small intraluminal calculi”. It is noteworthy here that there are many pit falls in the interpretation of gall bladder lumen, particularly in the given setting. i.e. ICU and immobile the patient on IV fluid (evidence based article submitted). With this clinical scenario, the patients are usually followed up after discharge to evaluate for cholelithiasis and cholecystitis. Possibility of misinterpretation of sludge for calculus is likely. However, with due respect the possibility of missing small gall bladder stones at autopsy cannot be entirely ruled out.

Dr. Rajesh Rana, CMO, Saroj Super Speciality Hospital in his written statement averred that as per casualty record of 29.03.2019, they do not have any record in their casualty register and no casualty card is available of the patient Smt. Gargi Meena on 29th March, 2018 except at 14.00.00.

The complainant Shri Uttam Chand Meena in his rejoinder averred that that it is denied that the patient fainted in OPD or that she was wheeled to the labour room by OPD Aaya or that in the mean time they (the patient and daughter) were explained about the USG finding and possible treatment options. It is denied that all the tests were advised at the same sitting while taking a history and examining the patient alongwith USG, before the patient fainted in the OPD with blood-pressure recording 90/60 in the OPD card or that those were the routine tests done in any patient with such a condition and history or that after getting the USG report and seeing the deteriorating clinical condition of the patient and discussion with daughter and the patient about the condition and their willingness to get admitted and operated ASAP, the patient did not require to be tested for PPBS as after admission blood-sugar charting as per her basic sugar report would be planned or that as per their knowledge nothing was given to the patient. It is denied that the complainant did not disclose to the treating doctor or the resident doctor or to the anaesthetist that what the patient had eaten or that this falls is concealment of facts by the patient and the attendant. It is evident from the IPD file that no sugar charting was done by Dr. Nisha Jain, as claimed in her reply. No record of charting is either filed by her or is available on record. First RBS was recorded post-surgery at 10.00 p.m. on 29th March, 2018 which was 214 mg% (IPD) file page-8. Further, no charting was done after 10.00 p.m. and thereafter, in morning at 7.30 a.m. as 358 (IPD file page-10). It is surprising that blood sugar increased from 214 to 358 even after the patient was given IVF 5 unit DNS with 6 unit human actrapid insulin in each vac (IPD file page-8). Hence, the doctor’s statement in her reply is baseless and wrong, hence, denied. Further, it is beyond normal understanding that why DNS was given when human actrapid was given to control blood sugar by the treating doctor (Dr. Nisha Jain). It is submitted that Dr. Nisha Jain is trying to evade responsibility from such important lapse on aground of petty eatery item bill. The patient had breakfast around 9.40 a.m. with Saunf Rusk, Churma and a Rasgulla on promotion of Sagun from 8th to 9th and Xth calls maths paper of Mahima, the unlucky children of the deceased Gargi Meena. It was the duty of the treating doctor to ensure all such important parameter as per standard protocols in such surgeries.

He further stated that Dr. Nisha Jain is not possessing any qualification in laparoscopic surgery. Dr. Nisha Jain and Dr. Priyanka Gupta have not been trained from any recognized medical institute in laparoscopic surgery (MIS), as per guidelines of MCI. Hence, Dr. Nisha Jain decision was far beyond the scope of her competency and Dr. Nisha Jain and Dr. Priyanka Gupta have been working as a quack in the field of laparoscopic surgery (MIS) alongwith her assistant Dr. Priynaka Gupta.

It is submitted that injection Tranexa is allegedly to be given for stopping bleeding which is in an apparent lie. It is submitted that injection Tranexa has not been mentioned in doctor’s notes but they are claimed to be administered at 3.30 p.m. (in nursing notes at page No.32 & 42 of 132 pages IPD/OPD file submitted by the complainant) and the patient was taken for the surgery at 5.05 p.m. on 29th March, 2019. It means the patient was on conservative treatment for one and half hour only and sufficient time and dosage were not given for proper action in body. However, there is no observation of any doctor in the OPD card “Treatment” other than patient history prior to that patient was clinically profusely bleeding and was having any sort of dizziness or medication prior to admission at 2.00 p.m. The medicines were only started at 3.30 p.m. for the surgery only. All are fact available on medical record of hospital. It is denied that the urine reports were asked telephonically or that the presence of puss cells in urine without any sign or symptoms of UTI with TLC with normal range, afebrile patient does not indicate UTI or that the culture report was received later on which shown the urine to be sterile or that just presence or puss cells does not mean that the patient have urinary infection or that the complainant has no legal right to question the clinical judgment of the doctors and protocols. It is pertinent to mention that it is questionable that why the doctor did not wait for the urine culture report as per standard protocol. It does not lie in the mouth of doctors and the hospital that the complainant has no legal right to question the clinical judgment of the doctors and protocols especially when they have acted to cause the death of the patient. It is denied that all the lab report (pre-operative) were absolutely within normal limit. It is submitted that as per the said reports, the Hb of the patient was not within normal limits. It is denied that no super specialist was required or to be referred. It is admitted that in the OPD prescription history was written by Dr. Priyanka but it is denied that the same was as per the patient’s description before examination. It is denied that after admission, history of previous 3 LSCS was corrected by the resident doctor in initial assessment notes after examining the patient (by Dr. Sushma). There is no support document in favour of statement that, however, for history previous surgeries only may change the first entry port location and nothing else, which is decided according to the scare line, abdominal wall consistency and possibility of location of presence of adhesions on OT table. It is denied for want of knowledge that by the time admission file was made she was given crystalloids and here BP came to 110/70 mmHg as per record, 1 unit of blood was already on flow when the patient was taken for surgery and immediately post-op another unit of blood and started or that all needed precaution were taken. It is totally false on part of the doctor that it was important stop bleeding alongwith blood transfusion, as there is no sense in giving blood when the patient is bleeding profusely without taking care of measures to stop the bleeding. It is totally irrelevant in this case that as the requirement of blood and blood products would increase bleeding to complication like DIC, transfusion related syndrome etc. It is submitted that it is known fact that the patients who undergo abdominal surgery develop adhesions; these are almost inevitable part of the body’s healing process. The problem occurred in surgery was adhesions due to 3-LSCS and this fact remained unnoticed till start of surgery. All the correction made in the record are just to hide their mistake and cutting and over writings are not acceptable when life of innocent people are on stake. This act of cutting and over writing in record is against the acceptable standard of medical record as per ethics. It is a medical fact that the rate of conversion to laparotomy during laparoscopic hysterectomy is dependent on the prior CS or concomitant adhesiolysis, which increase this risk of laparoscopic surgery. In the present case, no information has been added in pre-OT notes that doctor have to perform extensive adhesiolysis on the patient, which speaks about the truth that the doctors were not aware of the patients past history of previous 3LSCS. It is the duty of the surgeon to inform this to the patient as it is a specific and independent surgical procedure performed as per the wish of doctor without considering risk to the life of the patient. This internal damage by the surgical instrument were also remain untouched as no laparoscopic expert from Gynae. & Obst. was included in the post-mortem team. Without having knowledge of performing laparoscopic procedure intensive adhesiolysis was done as per the doctors. It is clear that due to addition of the surgical procedure, total surgery period increased which also prolonged bleeding period, forced doctor to transfuse blood after the surgery, the doctor not submitted any clarification for transfusion of blood during and after surgery. The anaesthetist submits in his reply that he noted 3 LSCS and the patient had also declared, which is the patient’s self-declaration instead of the doctors’ notes prescription/PAC. In all the four pages prepared by the anaesthetist even the entries are not filed completely which is mandatory as per rule. The anaesthetist work is very sensitive and cannot refer to notes of other to save himself, as anaesthetist has not performed his role as per Hippocratic oath otherwise in such unstable condition (pre-OP: Hb 7.2no 10, BP-90/60) albumin++, pus cell 10-12 urine-RM on 29/03/2018) surgery must be postponed in the best interest medical protocol and life of the patient. The anesthetist has not assessed the patient’s condition himself rather it seems that he is more relying on the surgeon’s documentation and it is evident from the IPD page -35, 36, 37 and 38 how well these formats were filled. It is submitted that the anaesthetist is also equally responsible to push the patient toward this unplanned, unwanted surgery. It is very suprising that the anaesthetist did not even meet attendants of the patient and to inform them about the pros and cons of anaesthesia which was duty of the anaesthetist. Even the forms required to be filled by the anaesthetist do not bear his signatures. It is denied that pre-operative, the urine was haemorrhagic, so to assess if there is any injury of the bladder, injection Lasix was given. It is surprising that nowhere in the entire medical record of the patient, it is mentioned that urine was hemorrhagic. It is denied that RBS is expected to be high in a DM patient post-operatively and they have to make sure that the patient does not go into hypoglycemia as well. The anaesthetist is the best specialist to stabilize the patient but in this case, the anaesthetist failed to perform his duty. It is denied that hospital have best of anaesthetist or that post-operative management is usually done under the guidance of anaesthetist and physician is called if they advise or that routinely they follow this protocol. Kindly go through post-operative record-(page-37/132). Even, if the blood-pressure and HR were within normal limit, the BP range between 109/80 to 128/86 and pulse rate between 59-68 BPM, it is unimaginable that how without any medication, the anaesthetist could normalize the blood-pressure and HR. It is submitted that the doctors themselves noted at many places the LMP 27/03/2019 which means that on 29/03/2018, the patient was under her menstrual period. It is a well known factor that urine sample taken in menstrual period get mixed with menstruating blood which may lead to wrong conclusion of ‘hemorrhagic urine’. Even if the urine was hemorrhagic, the patient was not checked thoroughly prior to the surgery for “any injury in the urinary bladder/tract before the surgery”. There is no evidence on record that how the anaesthetist raised the BP-90/60 to 110/70 (IPD file P-6/132 & 35/132) without medical management of the patient, as nothing is available on records in PAC papers. It is correct that the medical/mode of medication was supervised by the treating gynaecologist. It is denied that since the condition, the patient developed was not at all the gynecological condition but it was cardiac/medical event requiring treatment from these specialties and same was explained to the attendants (page 22, 241/134). It is not applicable to this case that per international studies most of the ovarian cancer have origin from fallopian tube endothelium or that, therefore, it is now a routine to remove the fallopian tubes to avoid future problem for the patient and all the more they were not healthy, ovary was not looking healthy with multiple solid/liquid cysts, so they had to be removed and any other procedure required to be done during the surgery consent was already there or that after surgery, the attendant were shown the specimen and explained in detail the surgery done and its requirement and they had sign the specimen register maintained by the doctor. It is not understood why the patient was only put under the care of specialties (page 22, 24/134) at 4.30 p.m., 8.30 p.m. on 30th March, 2018 when the patient’s condition was totally hopeless since after the surgery on 29th March, 2018, reason is best known to Dr. Nisha Jain who had not seen the patient after completion of TLH performed in evening on 29th March, 2018. It is denied that in view of gush unhealthy blood in peritoneum after opening the vaginal vault and tubes and ovaries not looking health, the decision was taken to morcellate the specimen from below (vaginally), so the specimen was retrieved by vaginal morecellation to reduce the risk of infection or that the route of morcellation is decided at the time of the surgery or that the complainant.

 He further stated that Dr. Nisha Jain says that the patient was bleeding like tap and on the other hand she also says that blood was trapped inside the vaginal cavity. It is submitted that as per records there was no mention of blood in TVS report. There was huge blood loss during the operation as can be seen in the video of laparoscopy itself. The doctor is confused where the blood was prior to operation in the vaginal cavity during the operation. It is false that three units of blood were given post-operative. In fact one unit whole blood was given post-operative. In fact one unit pack cells were given post-op as per own record of the doctors and the hospital. It is highly surprisingly that the video recording was of half an hour. It is false that the video was unedited as Dr. Nisha Jain herself stated that the recording was paused for unnecessary events like taking out fog, cleaning of camera, suction of blood which came out after opening the vault. How could Dr. Nisha Jain know that by pausing the recording for such and such purposes the exact time duration of the operation shall be half and hour1 especially when the extra procedure like adhesiolysis were done which take time, which cannot be calculated. Dr. Nisha Jain herself admitted that in place of taking care of filling the lack of blood and stopping the loss of blood conservatively, she tried only to stop the blood loss knowing fully well that that the patient is anaemic. It will not be out of place mention here that in the CCTV footage provided to the complainant at about 1.25 a.m. dated 31.03.2018, Dr. Dharamveer Sagar had done intubation on the patient due to some serious advancement but the same has not been recorded in any document or informed by the doctors and hospital just to hide their failure and manipulate the records. As per CCTV footage and mobile data, Dr. Dharamveer Sagar informed them for ventilator consent at 03.06 Hrs and consent was given to Dr. Dharamveer Sagar at 03.14.25 Hrs, hence, claim of the doctor/hospital is wrong and baseless for delayed ventilator consent by the attendants. In life threatening condition of the patient, rule of consent is not applicable.

The complainant Shri Uttam Chand Meena in his additional rejoinder averred that he filed application under RTI Act dated 12.12.2019 wherein specific queries were made before the Medical Council of India regarding the certificates issued by FOGSI (Federation of Obstetric and Gynaecological Societies of India) regarding authorization/approval/legality to grant certification in special surgery like gynaecological laparoscopy etc. wherein the Medical Council of India (MCI) in its reply dated 02.01.2020 has specifically mentioned that FOGSI certified training centre for gynaecologist in laparoscopic and hysteroscopc surgery is not recognized for running any medical courses under the IMC Act, 1956. It is pertinent to mention here that Dr. Nisha Jain, Dr. Priyanka Gupta, in this case do not possess any legally valid/statutory qualification which is mandatory to perform any type of such gynaecological laparoscopic surgery. They have not filed any documentary proof to show that they possess any such qualification such as certificate in Minimal Invasive Surgery (MIS) from recognized body such as National Board of Examination rather they have filed certificate from FOGSI which is not recognized as per the above reply by the Medical Council of India. This shows that Dr. Nisha Jain and Dr. Priyanka Gupta have deliberately and intentionally and knowing well that they are not qualified but performed gynaecological surgery upon his wife Smt. Gargi Meena which attracts strict penal action against them as well as other responsible doctors. The photocoy of aforesaid documents like his application and its reply by the Medical Council of India have been submitted for kind perusal. In the light of aforesaid, it is necessary that the aforesaid facts may kindly be read with his complaint and the same be adjudicated accordingly. In the light of above stated facts, it is, therefore, most respectfully prayed that the further necessary documents like his application under RTI Ct and its reply by the Medical Council of India may kindly be taken on record. It is further requested that the matter may kindly be finalized as possible, in the interest of justice.

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

1. It is noted that as per the history recorded in the document titled ‘Initial Assessment and Plan Diagnosis Case/OPD Card of the said Hospital on 29th March, 2018 at 10.17 a.m., it is mentioned that the patient had complaint of Menorhagia, Metrrohagia for period of three years, with complaint of excessive bleeding per vagina since two days and pain lower abdomen since one day. She was a known case of Thyroid (50 mg Eltroxin) and Diabetic not on medication, her LMP was 27th March, 2018. Further, she had given history of P3L3-All FTNVD (however, subsequently the same was correctly recorded in the records, as FT LSCS LCB-13 years back, B/L-TL done 13 years back. On examination, P/a-soft, P/s-Cx soft, P/V-Balloned up, full of clots. Urgent TVS (Trans-vaginal) ultrasound was advised. The TVS scan (Lab No.1498533) dated 29th March, 2019; timed 11:04:00 (11.04 a.m.) revealed “ulterus-anteverted, measuring 102x64x54mm, enlarged in size. A fibroid measuring 33x32 mm is seen compressing the endometrium and displacing it anteriorly suggesting possibility of submucous extension of fibroid. Endometrial thickness is 8.7 mm. Cervix is bulky and filled, with heterogeneous contents ? clots”. This picture could have been due to 2nd day of menstrual cycle.

Apparently, when the patient reported to Dr. Nisha Jain with the TVS report, her blood pressure was recorded as 90/60 mmHg. Further, the blood investigations with ECG, chest x-ray, urine test were advised on urgent basis and emergency hysterectomy was planned (indication not clear). PAP smear and endometrial sampling was neither available nor advised. The patient was admitted in the said Hospital at 2.04 p.m. on 29th March, 2018.

The patient, thereafter, underwent PAC check-up, where her Hb was noted as 7.2, pulse 98/mt. B.P-110/70 mmHg, ECG-WNL, chest B/L clear, three units blood was asked to be arranged. The patient was taken up for the surgery under blanket consent duly signed by the patient and her attendant. The blood pressure in the immediate pre-anaesthesia re-evaluation was noted to be 140/90 and similarily, at the time of recovery was also 140/90, as per Intra-operative monitoring chart. It is noted that the surgical procedure was started at 5.30 p.m. and finished at 7.40 p.m., as per the Intra-operative Nursing Record (there is no mention of surgery time in either the O.T. notes or Anesthesia notes). Patient underwent surgery-TLH with right salpingo-oophorectomy with left salpingectomy with sacrocolpopexy with extensive adhesiolysis with morcellation during menstruation (day 2 of period). The surgery though complex was reported to be uneventful although hematuria was present per-operative and at the end of surgery. There is no mention of intra-operative blood loss.

In the immediate post-op, the patient’s blood-pressure at 8.10 p.m. was 109/80, HR-67, SPO2 100%, injection Dexa, injection Voveran, and one unit of blood was started. By 9.15 p.m., the blood-pressure was 112/68, HR-68, SPO2-99%

As per records, at the time of shifting the patient to labour room, the patient’s Aldret Score was 10. In the night, the patient remained stable. However, around 9.00 a.m., the patient was found to have low blood pressure (90/60) and pulse (50/min), blood sugar was 358 mg/dl, SPO2 was 92 % and she was, therefore, shifted to ICU on advice of physician Dr. Greeesh Manwani. In the ICU, her general condition was sick, P/R-44/min, blood pressure 70/40 mmHg. The relevant investigations alongwith cardiac consultation was taken. The patient was put on inotropic and BIPAP support with higher antibiotics and insulin. The chain of events leading to sudden deterioration of patient is not clear from records. The patient’s condition continued to remain poor and at 3.30 a.m. on 31st March, 2018, she became unconscious, blood pressure-not recordable, P/R-not recordable. She was intubated. CPR was initiated, but inspite of efforts could not be revived and declared dead at 4.12 a.m. on 31st March, 2018.

The cause of death as per the subsequent opinion in relation to post-mortem report No.22/2018 dated 1st March, 2019 was ‘Death in this case occurred due to pulmonary edema consequent upon acute myocarditis in an operated case of hysterectomy.

1. In view of the above, the following issues relevant for determination for this complaint were taken-up for consideration.

(1) Whether the surgical procedure of Total Laparoscopic hysterectomy + left salpingectomy + Peritoneal Lavage + Bilateral Sacrocolpopexy + Right Salphingoopherectomy + Morecellation large size, performed on 29th March, 2018, on the patient Smt. Gargi Meena, by Dr. Nisha Jain (primay surgeron), was warranted and whether the same was done as per accepted professional practices in such cases.

 After reviewing the records of history, examination, investigations, surgery, it seems that urgency of going for emergency hysterectomy; especially in view of multiple co-morbidities and the fact that patient was in menstrual period, is unjustified. We are of the opinion that initial medical management should have beento bring up hemoglobin level**,** control heavy menstrual bleeding, correct/optimise the co-morbidities; rather than resorting to emergency hysterectomy; especially in a patient who also had previous -3 pelvic surgeries which madeher a high risk from surgical point of view also.

 Even otherwise the accepted surgical procedure for such an indication (AUB-L) would be total hysterectomy and B/L salpingectomy. So it is unclear why right sided oophorectomy and sacrocolpopexy were done in addition, as these were not warranted. Looking at the gross histopathology report it appears that morcellation was also not done.

 One would also definitely anticipate surgical difficulties in a patient with history of previous three pelvic surgeries (Previous 3 LSCS) and is expected to include these specifically in the informed written consent.

 Patient could also have been suffering from U.T.I (urine M/E-10-12 pus cells) and ideally any genital tract surgery should be done after U.T.I has been treated, as it can flare the urinary sepsis; the same was not taken note of in the present case.

 Dr. Nisha Jain failed to exercise reasonable, degree of skill, care and knowledge, which was expected of a prudent doctor in the management of this case.

There is no mention of hypothyroidism and diabetes in the PAC sheet but the records elsewhere do mention about presence of these conditions and that patient had been an eltroxin for hypothyroism. No treatment for diabetes has been mentioned.

 PAC sheet mentions Hb of 7.2gm, so blood was transfused probably because of low Hb and 3 units were asked to be arranged.No other significant finding has been mentioned in the PAC sheet except pulse rate of 98 per minute and BP of 110/70 mm.

 No adverse event has been shown in the anaesthesia chart signifying uneventful intra-operative course. The blood loss during surgery also has not been mentioned.

 Recovery score post operatively recorded by the nurse was 10/10. Quality sheet for OT proves that Anaesthetist’s part has not been filled which could have explained any intra operative modification of anaesthesia plan, any unplanned ventilation after anaesthesia, any adverse anaesthetic event or any anaesthesia related mortality.

 Dr. Vivek Gupta, Anesthetist failed to exercise due diligence in record keeping, which is an integral part of patient management.

2) Was the patient managed adequately as per standard protocols in the post-operative period?

The chain of events leading to sudden deterioration of patient in post-operative period is not very clear from records, as notings are inadequate.

Patient’s blood pressure started falling in the late evening of 30.03.2018; no reason was mentioned in the records.

Blood sugar reading of 358 mg on 30.03.2018 at 9:00am may be explained by infusions of dextrose saline and improper management of diabetes without any rationale, as there is no mention of hourly blood sugar charting and treatment there off. Insulin has been administered probably without any rationale.

On 31.03.2018, need for ventilation has been recorded but without any record of indications or investigations including ABG. Therefore, no clear cut conclusions for rapid deterioration of patient in the post-operative period can be drawn due to lack of recording of any adverse events (if), during surgery and in the post operative period.

Dr. Greesh Manwani, Physician was also not diligent in the management of this patient.

 The probability of patient dying of pulmonary edema, as was opined in the post mortem report, can occur in patients of severe anemia undergoing major surgical procedure.

1. Was Dr. Nisha Jain qualified to conduct the surgical procedure which was done in this case?

It is noted that Dr. Nisha Jain is registered with Delhi Medical Council under registration no. 12996 with the qualification of ‘General Physician’ from Moscow Medical Institute, Moscow, U.S.S.R, 1984 and M.D. (Obst & Gynae) from Meerut University, 1990. Dr. Nisha Jain, being holder of Post Graduate qualification in M.D. (Obst & Gynae) was qualified to conduct the surgical procedure in the present case.

In light of the observations made herein-above, the Disciplinary Committee recommends that name of Dr. Nisha Jain (Delhi Medical Council Registration No.12996) be removed from the State Medical Register of the Delhi Medical Council for period of 30 days with a direction that she should undergo ten hours C.M.E. on the subject ‘decision making and ethical practices in Gynecology’ and to submit a compliance report to this effect to the Delhi Medical Council. The Disciplinary Committee further recommends that a warning be issued to Dr. Vivek Gupta (Delhi Medical Council Registration No.12973) and Dr. Greesh Manwani (Delhi Medical Council Registration No.3433) . All three named doctors are directed to ensure better record keeping for future as part of good medical practice.

Matter stands disposed.

Sd/: Sd/:

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

Chairman, Delhi Medical Association,

Disciplinary Committee Member, Disciplinary Committee

Sd/: Sd/:

(Dr. Kiran Guleria) (Dr. A.K. Sethi)

Expert Member, Expert Member

Disciplinary Committee Disciplinary Committee

The Order of the Disciplinary Committee dated 09th March, 2020 was confirmed by the Delhi Medical Council in its meeting held on 20th March, 2020.

The Council also confirmed the punishment of warning awarded to Dr. Vivek Gupta (Delhi Medical Council Registration No.12973) and Dr. Greesh Manwani (Delhi Medical Council Registration No.3433) by the Disciplinary Committee.

The Council further confirmed the punishment of removal of name of Dr. Nisha Jain (Delhi Medical Council Registration No.12996) for a period of 30 days awarded by the Disciplinary Committee with a direction that she should undergo ten hours C.M.E. on the subject ‘decision making and ethical practices in Gynecology’ and to submit a compliance report to this effect to the Delhi Medical Council within a period of three months.

The Council further observed that the Order directing the removal of name from the State Medical Register of Delhi Medical Council shall come into effect after 30 days from the date of the Order.

This observation is to be incorporated in the final Order to be issued. The Order of the Disciplinary Committee stands modified to this extent and the modified Order is confirmed.

 By the Order & in the name

 of Delhi Medical Council

 (Dr. Girish Tyagi)

 Secretary

Copy to:-

1. Shri Uttam Chand Meena, Manager (T), 17-D, Vikas Niketan, Pitampura, Delhi-110034.
2. Dr. Nisha Jain, Through Medical Superintendent, Saroj Super Speciality Hospital, Madhuban Chowk, Rohini, Delhi-110085.
3. Dr. Greesh Manwani, Through Medical Superintendent, Saroj Super Speciality Hospital, Madhuban Chowk, Rohini, Delhi-110085.
4. Dr. Vivek Gupta, Through Medical Superintendent, Saroj Super Speciality Hospital, Madhuban Chowk, Rohini, Delhi-110085.
5. Dr. Dharamvir Sagar, House No.172, Block 2, Paschim Vihar, New Delhi-110063.
6. Dr. Priyanka Gupta, House No.133-134, Pocket C-7, Sector-7, Rohini, New Delhi-110085.
7. Dr. Sushma, Sr. Resident, Obst. & Gynae. Department, Through Medical Superintendent, Saroj Super Speciality Hospital, Madhuban Chowk, Rohini, Delhi-110085.
8. Medical Superintendent, Saroj Super Speciality Hospital, Madhuban Chowk, Rohini, Delhi-110085.
9. Medical Superintendent, Nursing Homes, Directorate General of Health Services, Govt. of NCT of Delhi, F-17, Karkardooma, Delhi-110032-w.r.t. letter No.F.23/ Comp./76/NWD/DGHS/HQ2018/536 dated 14.06.18-for information.
10. S.H.O. Police Station Prashant Vihar, Delhi-110085-w.r.t. FIR No : 0414 date 30/08/2018, P.S. : Prashant Vihar,-for information.
11. Secretary, Medical Council of India, Pocket-14, Phase-1, Sector-8, Dwarka, New Delhi-110077 (Dr. Nisha Jain is also registered with the Medical Council of India under registration No.5233 dated 18.01.1986-for information & necessary action.
12. Registrar, Uttar Pradesh Medical Council, 5, Sarvapally Mall Avenue Road, Lucknow-226001, Uttar Pradesh (Dr. Vivek Gupta and Dr. Greesh Manwani are also registered with Uttar Pradesh Medical Council under registration No-25084 dated 23.2.1981 and No. 29000 dated 29/04.1985)-for information & necessary action.
13. Secretary, Medical Council of India, Pocket-14, Phase-1, Sector-8, Dwarka, New Delhi-110077-for information & necessary action

 (Dr. Girish Tyagi) Secretary