TAMIL NADU MEDICAL COUNCIL

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New No. 914, Old No. 569,
Poonamallee High Road,
Arumbakkam,
Chennai - 600 106.

From

The **REGISTRAR**

By Registered post with Acknowledgement Due

Reference No: TNMC/ T. No. 851 /2019 dated: 24 - 03 - 2022

In the matter of disciplinary case between

1. The Director of Medical and Rural Health Services,
   Chennai - 600 006.

2. Mr.Senthilkumaran,,
   30/3, Kulandaivel Nagar,
   Viswasapuram, Saravanampatti,
   Coimbatore ----- Complainants.

//Versus//

1. Dr. K. Sangeetha, M.D (O & G,
   Registration No. 61653,
   Kumarasamy Hospitals,
   H-137, Periyar Nagar Erode - 638 001.

2. Dr.Thangaraj, M.B.B.S, D.A.,
   Registration No. 90205,
   Kumarasamy Hospitals,
   H-137, Periyar Nagar Erode - 638 001.

----- Respondents.

ORDER

1. The Director of Medical and Rural Health Services, Chennai in his letter Ref. No. 55953/IC/4/ 2021 dated 13.10.2021 has informed that, one Mr.Senthilkumaran of Coimbatore has preferred a Complaint against M/s.Kumarasamy Hospital, Erode District that, due to negligence of the treating Doctors of Kumarasamy Hospital, Erode, one Mrs.krithika (22 Years) admitted for delivery expired (on 19.07.2020.)

2. In this regard, the Joint Director of Health Services, Erode was directed by the Director of Medical and Rural Health Services to conduct an Inquiry and to report and the JDHS, Erode has submitted her Inquiry.Report and concluded that,

"---*Based on the above investigations, it is observed that the lapses pointed out by the State Level Committee (Death Audit Committee) are found correct and documentation of treatment given to the deceased Mrs.Krithika was not done properly.*"

Earlier, the State level Committee which inquired the case found the following lapses.

a) *Case sheet not documented properly*

b) *Supportive documents NST, Partogram not available.*

c) *Cephalopelvic Disproportion (CPO) should have assessed earlier.*

d) *Progress of Labour not monitored.*

e) *LSCS could have been done earlier.*

f) *Post operative monitoring inadequate*

g) *Post-mortem could have been done.*

3. The DM&RHS requested the Council to take appropriate action against those responsible for the death of Mrs.Krithika and to send him an action taken report.

4. Accordingly, Dr.Sangeetha , OGcian and Dr.Thangaraj, Anaesthetist of Kumarasamy Hospital, who treated the deceased were summoned for an inquiry on 21.10.2021, vide this Council Summon Ref no. T.No. 851/2021 dated 15.10.2021. The Complainant was summoned for an inquiry on 27.10.2021 vide Councils Summons dated 16.10.2021.

5. Subsequently, the JDHS, Erode in her letter Ref.No. 7868/I2/2021 dated 16.10.2021 has informed that, another inquiry was conducted by her in this regard and from the statements recorded, it is proved that, if all protocols were followed by Dr.Sangeetha, OGcian of Kumarasamy Hospital, the patients life could have been saved. Further, it is found in the inquiry that, all the investigation reports in Sudha Hospital were created to support Kumarasamy Hospital. As, an appropriate Authority of CEA of Erode District, on Public interest, she has cancelled the CEA certificate issued to Kumarasamy Hospital indefinitely wef from 18.10.2021 and that she is going to file a Civil case before Erode Judicial Magistrate under CEA Act and rules framed there under. The JDHS requested to take a deemed action against Dr.Kumarasamy M.D, Dr.Sangeetha, OGcian and Dr.Thangaraj, Anaesthetist, who gave treatment to Mrs.Krithika and all the Doctors of Sudha Hospital, Erode who created investigation report to support kumarasamy Hospital.

6. Dr.Sangeetha in in her explanations letter dated 18.10.2021 submitted the following main points among others, in her defense:

- Copy of Complaint of Mr.Senthilkumaran is not enclosed.
- Hence, she is giving her reply for a complaint given by Mr.Vishak, H/o the deceased, in this regard, to the Erode District Consumer Protection Secretary Mr.R. Balasubramanian.
- She denied that, there is no negligence on their part in treating Mrs.krithika.
- Their Hospital is fully equipped to handle emergency care with relevant equipment and Medicines.
- The following Team was present during the LSCS of Mrs.Krithika

    i. Dr.Sangeetha, MD(OG),

    ii. Dr. Thangaraj, DA,

    iii. Mrs.Lissi, Staff Nurse

    iv. Dr.N.Rajasekhar, Cardiologist

    v. Dr.Karthikeyan, MS.MCh,

vi. Dr.Mathan kumar, M.S

- The deceased developed sudden cardiac arrest on 18.07.2020 following LSCS. She was resuscitated and Ventilator support was given and cardiac opinion was sought for from Dr. N. Rajasekar.
- At the time of examination by Cardiologist, the BP was 150/90, Pulse rate 156/minute; Respiratory rate was 22 /minute. SPO2 was 95% (on Ventilation). Her echo showed severe LV systolic dysfunction with kinetic mid and distal myocardial segments. Her LV EF was 30%. Her Echo features were suggestive of stress cardiomyopathy.
- The Cardiologist advised to shift her to higher institution for intensive care monitoring. Hence, she was shifted to Sudha Hospitals ICU in an Ambulance, accompanied by Anaesthetist
- Despite all efforts the condition of the patient worsened and she was declared dead on 19.07.2020 at 4.30 AM
- The reason for death of the patient is stress cardiomyopathy

7. During inquiry on 21.10.2021 Dr.Sangeetha and Dr. K.Thangaraj reiterated the points stated in the explanations of Dr. Sangeetha dated 18.10.2021.

8. After the inquiry on 21.10.2021, the Disciplinary Committee opined that,

- the cause of death possibly due to Spinal hypo tension leading to Cardiac arrest or Stress Cardiomyopathy or Pulmonary Embolism,
- 300 ml blood loss will not cause death,
- Post-mortem not done,
- No ECG taken after resuscitation ,
- Pre - operation ECG not clear,
- To call for Cardiologist and Director of Sudha Hospitals with all original records

9. Accordingly Summons were issued to the Managing Director of Sudha Hospitals and Dr. N.Rajasekaran , M.D, DNB for personal inquiry on 28.10.2021.

10. The Complainant during the inquiry on 27.10.2021 says the following:

- As per their complaints submitted to the Mission Director, National Health Mission, Tamil Nadu on 18.08.2020, Maternal Death Audit was conducted at Kumarasamy Hospital, Erode by State level Committee.
- Following the Audit, the Committee has found that the death is due to Anaesthesia mishandling and in adequate post operative care .
- Samples of COVID test for Mrs. Krithika was collected on 19.07.2020 at 5.15 AM. However the body was handed over around 6.30 AM without getting the result of the test and without following the protocols (prevailing at that time) possibly to cover up misdoings of Doctors of Kumarasamy Hospital.
- By Not recommending post-mortem and by Avoidance of Post-mortem, clear medical evidences regarding the cause of death have been destroyed
- Even the new born baby was forced to vacate from the Hospital, within/less than one hour of delivery

He requested to give him time, till 30th November,2021 to submit more evidences.

11. The Patient's Husband Mr. Visak and father Mr. Mohan Kumar who attended the inquiry along with the complainant also reiterated the same complaints.

12. An OGcian Specialist who attended the inquiry as special invitee, opined that,

"-----Dr. Sangeetha explained admission findings and non progress of Labour, decision for Caesarean which proceeded uneventfully. Post Vaginal Bleeding of 300 ml (as mentioned in the case sheet) was as per normal standard and all vitals were normal at the end of the procedure corresponding to average blood loss. Post Op, she left to attend another labour case, when the patient went in for sudden Cardiac arrest."

13. Subsequently, M/s. Kumarasamy Hospitals vide their letter dated 02.11.2021 says that, the Honourable High Court has stayed the orders of closure of their Hospitals by the JDHS, Erode.

14. Another Cardiologist, who was consulted by the Council, opined that,

"---- *My opinion regarding cause of death would be as follows:*

- *Booked primi*
- *Previous cardiac status unknown*
- *Post LSCS*
- *Spinal hypo-tension leading to Cardiac arrest*
- *Acute massive Pulmonary embolism*
- *Acute Heart failure (Shock)*
- *Cardio-pulmonary arrest*

Because of the following reasons:

a) *Acute massive Pulmonary embolism can occur in immediate post operative period following any pelvic surgeries like LSCS,*

b) *Massive Pulmonary embolism may be due to air, amniotic fluid or thrombosis,*

c) *Pregnancy itself is pro-thrombotic state, especially in the immediate post operative period after removal of placenta, when the uterus starts contracting,*

d) *Massive pulmonary embolism can result in sudden stoppage of circulation leading to cardiac arrest,*

e) *The time of Cardiac arrests after LSCS speaks more for Acute Massive Pulmonary embolism rather than Stress Cardiomyopathy,*

f) *Even when we diagnose Massive pulmonary embolism the mortality rate is very high up to 50% even in advanced Centres*

g) *Massive pulmonary embolism can produce sudden pressure over load on right Atrial and right Ventricle which can lead to fatal Arrhythmia,*

h) *Sudden convulsive moments with loss of consciousness in immediate post LSCS patient is due to cardio Shock following Massive pulmonary embolism.*

Overall opinion regarding the management in a given situation is satisfactory."

15. On 03.03.2022, Dr. N. Rajasekar, Cardiologist, Dr. D. Kanthaswami Managing Director of Sudha Hospitals, and the complainant were inquired. They reiterated the same line of arguments/complaints. The complainants were given a opportunity to give further evidence, if any.

16. Subsequently, another specialist Anesthesiologist, who was consulted by Tamil Nadu Medical Council, opined that,

" ___ *Sudden Cardiac arrest, without any premonitory signs is very unlikely in a healthy 22 year old female without any co morbid conditions. Spinal hypo-tension usually responds to intravenous fluids and vasopressors if intervened at the right time.*

Since the surgical time was short I.e 25 minutes and the duration of spinal blockade would be much longer probably hypo-tension would have been unmonitored and the intervention was very late and hence favourable outcome was not achieved. The Cardiologist in his later opinion has ruled out 'pulmonary embolism' as a cause of cardiac arrest, since the RA and RV were not dilated during the initial Electrocardiography.

On *through scrutiny of the available record and based on inquiry , the inquiry officer is of the opinion that, the patient was unmonitored for 15 minutes after surgical procedure(though she was retained inside OT by the Anesthesiologist for monitoring and observation) and the hypo-tension has led to cardiac arrest. By the time it was recognized, it was too late and all resuscitative measures had failed."*

17.The Complainant in his representation dated 12.03.2022 says that, they have asked for further time of 7days to give their further reply and would like to highlight the findings of

State level committee. Further, the Principal Secretary to Government has reported to National Human Rights Commission that, had the protocols have been followed, the patient would have been saved. Hence, arguments of Dr.Sangeetha and Dr.Thangaraj are void and not valid. Moreover, the National Human Rights Commission also observed that there are admitted lapses. Therefore, he requested to take deemed action against Dr.Kumarasamy, Dr.Sangeetha and Dr. Thangaraj for their lapses which resulted in the death of Mrs.Krithika.

18. The case was placed before the Council for consideration during the Special Business Meeting held on 20.03.22. The Council considered the case carefully and independently. It remains for the Council to consider and determine on the evidence, whether the Respondents are guilty of misconduct in professional respect in treating Mrs.Krithika. There is no doubt that, the allegations against Respondents are serious one. Indeed, it is always a serious matter to accuse a registered Medical Practitioner of misconduct in a professional respect. Therefore, the Council need to look at all evidence to consider and determine the case carefully.

19. The Council mainly considered the following points for determination.

a) Whether the lapses pointed out by the State level Committee amounts to gross negligence and directly responsible for the death of the patient?

b) Was the Obstetrician and Gynaecologist negligent in her duties while treating the patient?

c) What could be the cause of the death of the patient?

d) Was the Cardiologist negligent in his duties?

e) Was the Anaesthetist Dr.Thangaraj , negligent in his duties?

f) Whether Sudha hospitals, Erode fabricated the the case Records in favour of Kumarasamy Hospitals?

The observations of the Council on the above points for determination are furnished below:

20. Whether, the lapses pointed out by the State level Committee amounts to gross negligence and directly responsible for the death of the patient?

A) State level Committee which inquired the case found the following lapses.

a) *Case sheet not documented properly*

b) *Supportive documents NST, Partogram not available.*

c) *Cephalopelvic Disproportion (CPO) should have assessed earlier.*

d) *Progress of Labour not monitored.*

e) *LSCS could have been done earlier.*

f) *Post operative monitoring inadequate.*

g) *Post-mortem could have been done*

B) The Disciplinary Committee and the Expert panel are of the opinion that except the lapse (f) i.e. Post operative monitoring is inadequate , other lapses would not would not have caused the death of the patient. As to the allegation that, Post operative monitoring was inadequate, The Disciplinary Committee and the Expert panel is of the opinion that , after the LSCS . the patient might have left unmonitored and probably during that time , unnoticed, Spinal Anaesthesia induced Hypo-tension, might have occurred, leading to Cardiac arrest of the patient and ultimately resulted in the death of the patient.

21. Was the Obstetrician and Gynaecologist negligent in her duties while treating the patient?

The Expert panel opined that, "*Dr.Sangeetha explained admission findings and non progress of Labour, decision for Caesarean which proceeded uneventfully. Post Vaginal Bleeding of 300 ml (as mentioned in the case sheet) was as per normal standard and all vitals were normal at the end of the procedure corresponding to average blood loss. Post Op, she left to attend another labour case, when the patient went in for sudden Cardiac arrest.*" Even though, the Specialist do not find any fault with the Respondent Dr. Sangeetha, the Council is of the view that, Dr.Sangeetha ought not to have left the patient without full recovery from anesthesia and shifting the patient to the post operative ward/room. Had she remained with the

Anaesthetist, she could have helped him to revive the patient, in the emergency situation. The Respondent says that, she left, for seeing another case. But there are eye witness to prove that actually, she went to her house and was seen taking with her husband in front of her house. This is a lapse on the part of Dr.Sangeetha.

22. What could be the cause of the death of the patient?

A. Disciplinary Committee and the expert panel were of the opinion that one of the probable reasons for death could be due to massive acute pulmonary embolism. But the Cardiologist was sure that, it was not Pulmonary embolism as he found during echo-cardiography that, RA and RV were not dilated. The Anesthesiologist Specialist is of the view that, sudden Cardiac arrest, without any premonitory signs is very unlikely in a healthy 22 year old female without any co morbid conditions. Spinal hypo-tension usually responds to intravenous fluids and vasopressors, if, intervened at the right time. Since, the surgical time was short i.e. 25 minutes and the duration of spinal blockade would be much longer probably spinal Anaesthesia induced hypo-tension would have been unmonitored and subsequently, the intervention that was given, that too manual CPR given, was very late, as a defibrillator was not available in the Hospital ,hence favourable outcome was not achieved and the patient could not be revived.

B. The Council is also of the view that, the death may be probably due to unnoticed spinal anaesthesia induced hypo-tension, leading to cardiac arrest of the patient.

23. Was the Cardiologist negligent in his duties?

The Cardiologist consulted by the Tamil Nadu Medical Council says that, *"Overall opinion regarding the management by the Cardiologist in a given situation is satisfactory."*

The Council also comes to the conclusion that there is no negligence on the part of the Cardiologist, Dr.N.Rajasekar.

24. Was the Anaesthetist Dr.Thangaraj , negligent in his duties?

The line of argument of the Respondents is that the patient died due to stress cardiomyopathy. Whereas, the Anesthesiologist Specialist consulted by Tamil Nadu Medical Council, says that, *"Sudden Cardiac arrest, without any premonitory signs is very unlikely in a*

healthy 22 year old female without any co morbid conditions. Spinal hypo-tension usually responds to intravenous fluids and vasopressors if intervened at the right time. Since the surgical time was short i.e 25 minutes and the duration of spinal blockade would be much longer probably hypo-tension would have been unmonitored and the intervention was very late and hence favourable outcome was not achieved. The Cardiologist in his later opinion has ruled out 'pulmonary embolism' as a cause of cardiac arrest, since the RA and RV were not dilated during the initial Echo-cardiography. On *through scrutiny of the available record and based on inquiry , the inquiry officer is of the opinion that, the patient was unmonitored for 15 minutes after surgical procedure(though she was retained inside OT by the Anesthesiologist for monitoring and observation) and the hypo-tension has led to cardiac arrest. By the time it was recognized, it was too late and all resuscitative measures had failed."* The Council endorses with the views of Anesthesiologist Specialist and comes to the conclusion that, the patient was probably unmonitored for 15 minutes after surgical procedure (though she was retained inside OT by the Anesthesiologist for monitoring and observation) and the unnoticed anesthesia induced hypo-tension has led to cardiac arrest and Anesthesiologist Dr.Thangaraj was negligent on his duties and not monitored the patient properly for about 15 minutes and thereby failed in his legitimate duty to attend the patient.

25. Whether Sudha hospitals, Erode fabricated the the case Records of the patient in favour of Kumarasamy Hospitals?

The JDHS Erode alleges that Sudha hospitals, Erode fabricated the the case Records of the patient in favour of Kumarasamy Hospitals. But has failed to elaborate which part of the records was fabricated? And what are the evidences for the allegations of fabrication. The Managing Director of Sudha Hospitals, Dr.Kandasamy denies this allegation. The Council comes to the conclusion that this allegation of fabrication of records is unsubstantiated.

26. The Council applied a well established two stage test to determine, as to whether there is Professional misconduct / negligence in this case. The two steps are:

(a) First, it is to be analyzed as to whether the proven conduct fell short of conduct expected of a reasonably competent health practitioner in that category? This requires an objective analysis of the Practitioner's acts and omissions and such acts and omissions is bringing or likely to bring discredit to the profession, and

(b) Secondly, if so, whether the departure from acceptable standards has been significant to warrant disciplinary sanction for the protection of the public and/or maintaining professional Standards.

Applying the above two step process to determine professional misconduct/negligence, the Council is satisfied that,

(i) Dr. Thangaraj, has derelicted his legitimate duties in caring the patient and left the patient unattended for some time after LSCS and there by missed an early diagnosis of Spinal anesthesia induced hypo-tension which led to hypo-tension and ultimately in the death of the Patient and accordingly he is guilty of having committed civil negligence, in this case

(ii) Dr. Sangeetha, left the patient soon after L.S.C.S, leaving the patient at the care of Anaesthetist, before the recovery of the patient from anesthesia , which is a lapse on her part.

27. The Tamil Nadu Medical Council emphasizes that; public interest considerations are paramount in medical disciplinary proceedings. These include upholding the reputation of and confidence in the medical profession; and the protection of the health, safety and well-being of the public. Other sentencing considerations such as deterrence, retribution and rehabilitation are also being applied by the Tamil Nadu Medical Council.

28. Moreover, the Tamil Nadu Medical Council uses to evaluate the seriousness of the offence with reference to harm and culpability before deciding on the quantum of punishment; "Harm" refers to the type and gravity of the harm or injury that was caused to the patient and society by the commission of the offence. "Culpability" is a measure of the doctor's degree of blameworthiness. Given the evaluation, the harm (untimely death of the healthy young patient) and culpability are high, in this case.

29. Having considered the facts of the case, the submissions of the Respondents, opinions of various Specialists , entirety of evidence and Harm and culpability involved in the case, the Tamil Nadu Medical Council has decided by majority :

(a) That, the name of Dr.Thangaraj be removed from the Medical Register of Tamil Nadu Medical Council for a term of 6 months.

(b) That, Dr.Sangeetha be warned to be more careful in future.

30. Accordingly, it is ordered that, the name of Dr.Thangaraj, (Registration No. 90205) is removed from the Medical Register of Tamil Nadu Medical Council for a term of one year and Dr. Sangeetha (Registration No. 61653) is warned. It is made clear that, Dr. Thangaraj should not practise modern medicine during the period, his name is erased from the Medical Register of Tamil Nadu Medical Council. Dr.Thangaraj is directed to surrender his original Registration Certificate to Tamil Nadu Medical Council, immediately.

31. The Complaint stands disposed.

By the order and in the name of
Tamil Nadu Medical Council,

Registrar

To

1. Dr. K. Sangeetha, M.D (O & G,
Registration No. 61653,
Kumarasamy Hospitals,
H-137, Periyar Nagar Erode - 638 001.

2. Dr.Thangaraj, M.B.B.S, D.A.,
Registration No. 90205,
Kumarasamy Hospitals,
H-137, Periyar Nagar Erode - 638 001.

Copy to:

3. The Director of Medical and Rural Health Services,
Chennai - 600 006.
(With reference to file No. 55953/IC/4/ 2021)

4. Mr. Senthilkumaran,,
30/3, Kulandaivel Nagar,
Viswasapuram, Saravanampatti,
Coimbatore – 641 035.

5. The Managing Director,
Sudha Hospitals,
162/181, Perunthurai Road,
Erode – 638 011.

6. Dr.N.Rajasekar, M.D, DNB.,
Sudha Hospitals,
162/181, Perunthurai Road,
Erode – 638 011.

7. The Mission Director,
359, Anna Salai, 5th Floor, DMS Annex Building,
DMS Complex, Teynampet,
Chennai-600 006.

8. The Joint Director of Health Services,
Erode

9. The Secretary,
The National Medical Commission,
Pocket 14, Sector – 8,
Dwarka, Phase – 1
New Delhi – 110 011 .

10. All the Registrars of State Medical Councils, as per list

11. Registration section of Tamil Nadu Medical Council

- For making necessary entries in the concerned registers

12. Stock file

13. Spare