DMC/DC/F.14/Comp.2857/2/2020/ 21st May, 2020

**O R D E R**

The Delhi Medical Council through its Disciplinary Committee examined a complaint of Smt. Maya Devi, r/o- N-28, Gurudwara Road, Mohan Garden, Uttam Nagar, New Delhi-110059, forwarded by the Police Station, Bindapur, Delhi, alleging medical negligence in the treatment administered to complainant’s husband Shri Vijay Pal Singh at Mahindru Hospital, E-1, Kiran Garden, Main Najafgarh Road, Uttam Nagar, New Delhi-110059, resulting in his death on 05.06.2019 at Akash Hospital, where he subsequently received treatment.

The Order of the Disciplinary Committee dated 24th February, 2020 is reproduced herein-below :-

The Disciplinary Committee of the Delhi Medical Council examined a complaint of Smt. Maya Devi, r/o- N-28, Gurudwara Road, Mohan Garden, Uttam Nagar, New Delhi-110059 (referred hereinafter as the complainant, forwarded by the Police Station, Bindapur, Delhi, alleging medical negligence in the treatment administered to complainant’s husband Shri Vijay Pal Singh (referred hereinafter as the patient) at Mahindru Hospital, E-1, Kiran Garden, Main Najafgarh Road, Uttam Nagar, New Delhi-110059 (referred hereinafter as the said patient, resulting in his death on 05.06.2019 at Akash Hospital, where he subsequently received treatment.

The Disciplinary Committee perused the complaint, written statement of Dr. Sanjay Mahindru Medical Superintendent of Mahindru Hospital enclosing therewith written statement of Dr. Nishant Nagpal (Gastroenterologist), Dr. Nikhil Yadav (Surgeon, Akash Hospital), copy of medical records of Mahindru Hospital rejoinder of Smt. Maya Devi and other documents on record.

The following were heard in person :-

1. Smt. Maya Devi Complainant
2. Shri Anil Kumar Complainant
3. Shri Sunil Kumar Son of the patient
4. Shri Gajender Singh Son of the patient
5. Dr. Nishant Nagpal Consultant, Mahindru Hospital
6. Dr. Vikramjeet Singh Physician, Mahindru Hospital
7. Dr. Sanjay Mahindru Medical Superintendent, Mahindru

 Hospital

The complainant Shri Anil Kumar alleged that his father Shri Vijay Pal was suffering from loose motions for which, he was admitted in Mahindru Hospital on 19th May, 19 for treatment. His father was recovering and on 21st May, 19, the doctors said they would probably discharge his father from the hospital a day after. However, on the same day, they said that they will have to conduct a colonoscopy procedure. The colonoscopy procedure began around 1.00 am on the night of 22nd May, 19. The procedure resulted in a perforation in the region of the sigmoid colon and the colonoscopy was abandoned by the attending doctor. This Negligence was to such an extent that there was injury to the spleenic hilum as well. Then the doctor who performed the colonoscopy called the owners of Mahindru Hospital and discussed his mistake (the perforation caused in the sigmoid colon during colonoscopy and the injury to the spleenic hilum). A short while later, they told them about the perforation during colonoscopy and told them that the surgery was the only option now and that the surgery would need to be performed within the next 5-6 hours only or else there is a risk to life. However after some time they recommended that they shift his father to Aakash Hopsital for the surgery. As the situation was extremely critical, they followed the doctor’s advice and immediately shifted their father to the Aakash Hospital. Even in Aakash Hospital, the doctor advised that it would have to be an immediate surgery or else there was a threat to his father’s life. The doctors in Aakash Hospital initiated the surgery at 5.00 am in the morning of 22nd May, 19 which took approximately 3.5 hours. During surgery, the doctors found that there was an intra-operatively perforation in the sigmoid colon alongwith bleeding laceration on the spleenic hilum. Spleenography was attempted by the doctors at the time of surgery but due to derange PT INR, bleeding could not stop, hence spleenectomy was also done (please refer to the Death Certificate). Post which, his father somehow survived for few days in the hospital but finally on 5th June, 19, his father passed away due to post-op perforation peritonitis with pneumonia with sepsis with multi-organ dysfunction syndrome with refractory septic shock. Please note that no risk of perforation was highlighted to them in Mahindru Hospital, else they would have avoided the colonoscopy and saved their father’s life. His mother is unable to recover from the shock, as is the whole family and they will do everything in their power to ensure that this does not happen to anyone else. He is bringing this to the notice of the Delhi Medical Council with a request to take appropriate action against whosoever is responsible for his father’s premature demise. Also, with a humble request to initiate a stay order on Mahindru Hospital till the time the investigation is over, so that no one else ends up losing their life just because of such doctor's negligence.

The complainant further alleged that there was no risk i.e. demise, perforation etc. highlighted to them because of colonoscopy test. The doctors did not even consider his father’s age and analyzed whether he can survive the test or not. They would have avoided the test and save their father’s life, if they would have highlighted such risks to them. They have received a document as a part of Mahindru Hospital’s response to the Delhi Medical Council which they are calling as consent. This document was not signed by him or anyone from his family members. Someone from the hospital got the thumb impression of his father on the document after the incident of perforation and made forged signatures. Here, he wants to bring few important facts to the Delhi Medical Council’s notice. All the documents in the hospital were signed by him or his brothers, including the hospital admission form. Why the thumb impression was only taken on this document and why not on other documents signed by them, if taking thumb impression was the hospital’s requirement. His father full name was Vijay Pal Singh and it seems, hospital authorities were not aware of this. His father always used to sign using the first name, middle and the last name (Vijay Pal Singh). This can be verified from various sources like his father’s bank account records etc. The document only shows first and the middle name (Vijay Pal). He was not in a position to sign any form. If there was any requirement, that should have been signed by him (the complainant) or somebody from his family, the way, they signed other documents. Dr. Nishant Nagpal who performed the colonoscopy test came to the hospital at 12.30 a.m. in the night and performed the test at 1.00 a.m. They were told that he (Dr. Nishant Nagpal) is too busy and he covers East Delhi Hospital’s like Escorts in day timings and Dr. Nishant Nagpal covers West Delhi hospitals like Mahindru Hospital in night. This proves that Dr. Nishant Nagpal, who performed the test only for money and not at all bothered about people life. Dr. Nishant Nagpal works day and night without taking rest to make money in a profession which may become a reason of somebody’s life and death. He humbly requests the Delhi Medical Council to initiate investigation, why this person came to the hospital at 12.30 a.m. in the night and what was he doing during the day. When Dr. Nishant Nagpal was performing the test, he called the complainant in between and said that his father is not co-operating. He tried but his father complained that he has severe pain when the wire touched a certain part in the stomach. The complainant asked Dr. Nishant Nagpal that if his father is saying that he is having severe pain; hope there is no risk to proceed with the test again. In response, Dr. Nishant Nagpal very confidently said that he has been performing this test since last ten years. Dr. Nishant Nagpal is not even pushing air inside. Dr. Nishant Nagpal would have completed the test if his father would have cooperated. And then Dr. Nishant Nagpal started the test in the complainant presence. After a few moments when the wire again touched a particular part in the intestine, his father again said that it is again panning badly. But this time Dr. Nishant Nagpal did not stop and continued. In very next moment, Dr. Nishant Nagpal started shouting that perforation has happened in the intestine and there is a threat to the complainant’s father life now (inki aant phat gay hair aur inki jaan ko khatra hain). Dr. Nishant Nagpal also showed the complainant the liver in the computer screen. They later on came to know that the doctor was so careless and negligent that he not just perforated the intestine, he also injured the spleen, which the doctors in Aakash had Hospital had to remove at the time of surgery since the spleen was not even repairable.

Dr. Vikramjeet Singh, physician, Mahindru Hospital stated that he patient Shri Vijay Pal Singh, aged about 72 years, old male was admitted under him on 19th May, 2019 at 09:06 am with multiple complaints of pain abdomen - central + lower abdomen, colicky, severe loose stools: multiple, watery, severe weakness and dehydration. During examination, it showed a poorly nourished male with tachycardia (HR 106/min), mild pallor, and mild-moderate dehydration. Per-abdomen examination showed diffuse tenderness of abdomen. Co-morbidity: COPD, post TB bronchiectasis, hypertension, history of alcohol consumption. The past history of the patient : significant past history of the patient in form of recurrent pain abdomen, altered bowel habits (alternating loose / normal stools), progressive anaemia, un-intentional weight loss > 10 kg in last 6 months. The patient was recently admitted to Kalra Hospital for loose stools and pain abdomen where evaluation showed severe anaemia requiring blood transfusions, thrombocytopenia, hypoalbuminemia. Stool routine showing few pus cells. CECT abdomen was also done which was reported grossly normal. The patient had mild symptomatic improvement after transfusions and the treatment at Kalra hospital but again had progressive worsening of loose stools and pain abdomen leading to diarrhea and admission to their hospital. At the time of investigation, it showed that elevated total WBC counts (15,600/cmm), hypocalcemla and hypoalbuminemia (serum albumin 2.6 gm/ dl) and the patient was started on IV fluids, IV antibiotics , pre-probiotics, anti-secretory agents and supportive care, but despite all these therapies, loose stools and pain abdomen persisted. In-view of above background history, elderly male, anaemia requiring blood transfusion, persistent colonic symptoms, hypoalbuminemia , unintentional > 10 kg weight loss and CECT abdomen (outside - during last admission at Kalra Hospital) report being normal-gastroenterology consultation was sought. The patient in addition to above therapy was advised deworming and need for colonoscopy was discussed to rule out colonic causes of diarrhea, anaemia and weight loss. The patient was given IV albumin and need for colonoscopy discussed with available family members (wife) by the treating him. On the next day, in view of no significant improvement in symptoms and only after due approval from family members the colonoscopy was planned. Colonoscopy was done after appropriate consent and colonoscopy could be done there-after only after adequate preparation was done.

Dr. Nishant Nagpal, Gastroenterologist, Mahindru Hospital in his written statement averred that need for colonoscopy upon eelderly male patient was loose Stools- 6 months, weight loss – unintentional > 10 kg, anaemia, requiring blood transfusion and hypoalbuminemia. The recent evaluation: stool R/E : showing pus cells, CECT abdomen (outside hospital) was reported normal. During current admission, the pain abdomen, dehydration and persistent loose stools, despite medical therapy, hence, the colonoscopy was advised to rule out colonic causes of diarrhea. The colonoscopy was planned after discussion with the patient family members and done only after the patient consumes-colon cleansing agent and has passed clear watery stools. Prior to colonoscopy, the consent was taken from the patient. The colonoscopy was done in OT under monitoring with technician / staff nurse, in situ procedure done using llympus GF 150 Series System and Flexible colonoscope with the patient placed in left lateral position. The procedure of colonoscopy was done in OT under continuous vital monitoring. Scope negotiated in rectum after lubrication with 2% Lignocaine Jelly, hemorrhoids noticed and rectal erythema seen. The scope was advanced further in recto-sigmoid. There was a sharp / acute bend at sigmoid colon /descending colon. There was difficulty in negotiating at the same bend and perforation was noticed. The procedure was immediately abandoned and scope was removed. There was no bleeding from perforation site or per-rectum. There was no haemodynamical instability immediate procedure (IIR 70/min, BP 150/100 mm Hg, RR-20/min). Post noticing perforation, the patient was immediately shifted to second OT under monitoring and call to surgeon / anaesthetist given for immediate reparative surgery. Complication was explained in detail to immediate available son and other family members on their arrival. Need for urgent reparative surgery was explained. Option of reparative surgery at Mahindru Hospital / Higher Centre was given. The procedure of reparative surgery, risks and possible need for ventilatory support in post operative period in view of very poor respiratory reserve and possible prolonged stay were explained. After detailed discussion amongst the family members, the final decision of shifting the patient to Aakash hospital Dwarka was taken. Once finalized, the transport to Aakas hospital with life support ambulance was arranged immediately. The hospital doctor accompanied the patient during transport and safely escorted the patient in Aakash hospital emergency without any delay. Prior to transport, during transport and at time of receiving at Aakash Hospital Emergency, the patient was fully conscious, oriented and haemodynamically stable (GCS 15/15). Moreover, the emergency room physician, the treating surgeon at Aakash hospital was also apprised of condition and necessary measures for immediate repairative surgery were already made. It is to be noted that during the entire period from noticing perforation till surgery, the patient was always under observation of doctor, he continued to be haemodynamically stable, conscious, oriented and did riot require any inotropes - rather has persistent blood pressures > 140 /90 mm Hg and no significant tachycardia. Since, there was no evidence to suggest splenic tear, it was not discussed with the patient. Post detailed analysis of the patient records, it is noted that perforation could be managed with simple suture and closure, suggesting a small perforation. Till demise of the patient, there has been no evidence to suggest peritonitis.

He further averred that it is worth to mention that it is totally wrong and denied that splenic tear of the patient occurred during colonoscopy. Perforation was in sigmoid colon which is located in left iliac fossa -left lower abdomen in pelvis. Spleen is located in left hypochondrium -upper left abdomen behind the lower ribs. There is mesentry , vessels, descending colon, fascia - in between sigmoid colon and spleen Splenic injury from sigmoid colon perforation without injuring any intervening organs is less likely. The colonoscopy perforation was at around 12:30 am. The patient remained hernodynarmcally stable till the surgery which was around 4:30 am (four hours -injury to surgery time). The vital records at time of transfer from Mahindru Hospital were HR-67/min, BP-150/100 mm Hg, the patient conscious / co-operative / oriented / mobile. At time of receiving at Aakash Hospital were HR 98 / min, BP: 150/80 mm Hg, GCS 15/15. The patient is mobile without any giddiness / postural symptoms. It is to be noted that any splenic laceration especially in patient with prolonged INR, there will be massive blood loss which will lead to hemodynamic instability. In this case, there is no evidence to suggest hemodynamical instability in the period of 4 hours post perforation till the surgery. There has been no requirement of inotropes (blood pressure increasing medications in this case till surgery/immediate post surgery). Hemoglobin at Mahindru Hospital at admission was 11.8 gm %(In dehydrated state). Hemoglobin at Aakash Hospital at presentation was 10.9 gm % (2-3 house post perforation). On opening of abdomen, the peritoneal contamination with yellow fluid was in pelvis. Perforation noted in sigmoid colon-repaired using silk. Since, there was no evidence to suggest splenic tear, the same was not discussed with the patient’s relatives.

Dr. Sanjay Mahindru in his written statement averred that the patient Mr. Vijay Pal Singh, aged about 72 year, old male was admitted to Mahindru Hospital on 19th May 2019 at 09:06 am with multiple complaints : Pain Abdomen - central + lower abdomen, Colicky, severe Loose Stools: Multiple, watery, Severe Weakness Dehydration. During examination, it showed a poorly nourished male with Tachycardia (HR 106/min), Mild Pallor, and Mild-moderate Dehydration. Per-abdomen examination showed diffuse tenderness of abdomen. Co-morbidity: COPD, Post TB bronchiectasis, hypertension, history of alcohol consumption. Significant past history of the patient in form of recurrent pain abdomen, altered bowel habits (alternating loose/normal stools), progressive anaemia, un-intentional weight loss > 10 kg in last 6 months. He was recently admitted to Kalra Hospital for loose stools and pain abdomen where evaluation showed severe anemia requiring blood transfusions, thrombocytopenia, hypoalbuminemia. Stool routine showing few pus cells. The CECT abdomen was also done which was reported grossly normal. The patient had mild symptomatic improvement after transfusions and treatment at Kalra hospital but again had progressive worsening of loose stools and pain abdomen leading to diarrhea and admission to our Hospital. At the time of investigation, it showed that elevated total WBC counts (l5,600/cmm), hypocalcemia and hypoalbuminemia (Serum Albumin 2.6 gm/dl) and the patient was started on IV Fluids, IV Anti-biotics, pre-probiotics, anti-secretory agents and supportive care, but despite all these therapies loose stools and pain abdomen persisted. In view of above background history, elderly male, anaemia – requiring blood transfusion, persistent colonic symptoms, hypoalbuminemia , unintentional, 10 kg weight loss and CECT abdomen (Outside - during last admission at Kalra Hospital) report being normal - gastroenterology consult sought. The patient in addition to above therapy was advised deworming and Need for Colonoscopy was discussed - to rule out colonic causes of diarrhea, anemia and weight loss. The patient was given IV albumin and need for colonoscopy discussed with available family members (wife) by the treating physician. On the next day in view of no significant improvement in symptoms and only after due approval from family members the colonoscopy was planned. Colonoscopy was done after appropriate consent and Colonoscopy could be done there-after only after adequate preparation was done. Before starting the colonoscopy, an Informed Consent was taken from the patient citing complications like pain / bleeding and perforation. In view of malnourished state and persistent pain abdomen, the patient was taken up for colonoscopy in OT under continuous vital monitoring. Scope negotiated in rectum after lubrication with 2% Lignocaine Jelly, Hemorrhoids noticed and rectal erythema seen. The scope was advanced further in recto-sigmoid. There was a sharp / acute bend at Sigmoid Colon / Descending Colon. There was difficulty in negotiating at the same bend and perforation was noticed. The procedure was immediately abandoned and scope removed. There was no bleeding / haemodynamical instability. (HR 70/min, BP 150/100 mm Hg, RR -20/min). After noticing the perforation; the patient was immediately shifted to second OT under monitoring and call to surgeon / anaesthetist given for immediate reparative surgery. The complications were explained in detail to immediate available attendants i.e. son and other family members of the patient on their arrival. The urgent need of surgery was explained to family of patient and after detailed discussion amongst the family members, the final decision of shifting the patient to Aakash Hospital, Dwarka was taken. The transport to Aakash Hospital with Life support Ambulance was arranged immediately and one doctor from their hospital accompanied the patient during transport and safely escorted the patient in Aakash Hospital emergency without any delay. During transport and at time of reaching at Aakash Hospital, the patient was fully conscious, oriented and haemodynamically stable (GCS 15/15). The emergency room physician, the treating surgeon at Aakash Hospital was also apprised of condition and necessary measures for immediate repairative surgery were already made. During the entire period from noticing perforation till surgery, the patient was always under observation of doctor. He continued to be haemodynamically stable, conscious, oriented and did not require any inotropes- rather has persistent blood pressures >140 /90 mm Hg and no significant tachycardia. Elderly, fragile male with co-morbidities (COPD, Post TB bronchiectasis, Hypertension), History of 6 months anemia - requiring blood transfusion, pain abdomen, loose stool, unintentional weight loss > 10 kg hypoalbuminemia was brought to emergency room from Mahindru Hospital with accompanying Doctor with history of recent colonic perforation noticed during colonoscopy. Hemodynamically stable, vitals Pulse 98 /min, BP 150/80 mm Hg, RBS 115 mg/dl, GCS 15/15. Per-abdomen examination showed distended abdomen with tenderness / guarding. Blood investigations were sent immediately which showed Hb 10.9 gm%, TLC 13370/cmm, Plt. count of 2,33,OOO/cmm. Albumin was 3.0 gm% and INR of 2. Perforation was confirmed on x-ray and the patient was planned for immediate repairative surgery/laprotomy. The abdomen of the patient was opened through midline incision and peritoneal contamination with yellow fluid in pelvis was seen. Perforation noted in sigmoid colon which was repaired using silk 2-0. On further exploration, exploration of gut-splenic laceration 1 cm size at lower pole was seen with fresh bleeding was seen. Local hemostatic measures – local pressure, blood component support was done-splenorraphy was attempted but failed to stop bleeding, as the patient had high INR 2.0. In view of persistent bleed, splenectomy was done. Loop ileostomy was done at 100 cm of IC junction. Complete hemostasis was done. Abdomen was closed by No 1 nylon loop. SC tissue by vicryl and skin by staplers. Entire surgery lasted 2 hours and not 3.5 hours, as alleged by the complainant. (Analysis of notes: On Incision: Peritoneum has yellow clear fluid – No blood. Splenic laceration with fresh blood was seen on further exploration of abdomen-suggesting an acute cause of laceration. In view of splenic laceration-active bleeding especially in case of prolonged INR, which did not respond to local measures and blood/component support mandated splenectomy. Hence, splenectomy was done and hemostasis could be achieved. The patient was fully recovered well and extubated immediately in post operative room. Post-operative hemoglobin was 8.4 gm% (despite blood transfusion). TLC9750/cmm. Post Op Day 1: hemodynamically stable, adequate urine, minimal drain output (25 cc. 80 cc). Orally Liquid Sips allowed on Post procedure day 1. Full Liquid diet on Day 2 and patient shifted to ward. The patient was started on soft diet on 25th May 2019 (Post Op Day 3). Ileostomy functioning(passed stool). One drain removed on 27th May and the patient being planned for discharge. The doctor records at 10 pm on 27th May show that patient was stable, abdomen soft. At 11.32 p.m., the patient developed sudden breathing difficulty with Sp02 87% and development of coarse crepitations and the patient as shifted to ICU. Sinus tachycardia (HR 160/· min), bronchospasm, ECG : poor R wave progression and screening ECHO - Fresh Resting wall motion abnormality in LAD Territory with development of acute cardiac failure (ejection fraction 35-40%). Cardiac markers (Troponin / NtProBNP) were elevated. The patient required mechanical ventilation, inotropes and was started on lowmolecular weight heparin and antiplatelets. The patient’s condition remained critical, there was leucoctosis / Sepsis and ET tube cultures grew Klebsiella. The abdomen remained soft and USG abdomen done to look for any abdominal focus for sepsis-did not show any collection / free fluid. The patient was managed with parenteral antibiotics, albumin, low molecular weight heparin, antiplatelets, hemodialysis, mechanical ventilation and all best possible supportive measures. Hospital course was characterized by further fluctuating periods of improvement / worsening. However in view of old age / poor nutritional state / multiple comorbidities / poor respiratory reserve – recuperating from recent surgery - development of acute cardiac event followed by development of hospital acquired sepsis and multi-organ failure proved detrimental and eventually led to demise of patient on 05 June 2019 at 5.00 a.m. - despite best of Medical and Surgical Care being provided.

He further averred that it is vehemently denied that there has been any negligence during colonoscopy/after colonoscopy - taking care of the patient */*explaining the complications to the patient/meticulously arranging for shifting of patient /accompanied by duty doctor */s*afely escorted till emergency department of higher centre. Moreover, treating surgeon at referral hospital informed regarding the case and necessary arrangements being kept in place for immediate surgery. Complication of Perforation in Colonoscopy is well recognized complication of colonoscopy. Colonic perforation rates quoted in literature in various studies vary from as low as - 0.016% - 0.2 %, to as high as 5% (Reference Studies submitted). Sigmoid colon is the most common site of perforation (62%). Perforations are most commonly seen in Age group of 60-80 years. The patients with comorbidity are more likely to have perforation. He completely sympathize with the family of deceased (the patient) and are deeply disturbed by the turn of events, but he denies any negligence on his part or part of any doctor and hope this explanation will clarify the misunderstandings of family members of the patient Shri Vijay Pal Singh Ji.

He also averred that colonoscopy was indicated to identify cause of chronic prolonged diarrhea in an alcoholic elderly male with progressive anemia associated with marked weight reduction. colonoscopy was performed after informed consent Perforation unfortunately happened, which is a well recognized complication. However, it was diagnosed immediately and nothing was hidden from relatives. Splenic injury was not even considered and hence not discussed. Adequate and prompt care for management of the patient was carried out. The perforation during colonoscopy does occur globally and has been reported in scientific medical journals. The colonoscopy causing splenic tear is not substantiated by any evidence, rather evidences do not support such associations. The gap between colonoscopy abandonement and laparotomy was more than three hours and yet when peritoneum was opened it had yellow fluids (if spleen would have been torn at the time of colonoscopy, blood in peritoneum after 3 hour was expected. Other arguments provided in text). No evidence of negligence is substantiated. All sincere effort with commitment was evident from record.

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

1. It is observed that the Shri Vijay Pal Singh a 72 year’s old male was admitted to Mahindru Hospital on 19th May, 2019 with history of abdominal pain, loose stool severe weakness and dehydration. He had other co-morbidities COPD, post-tuberculosis bronchiectasis and hypertension. There was a similar history of being treated at Kalra Hospital for loose stool and abdominal pain. At admission, he was found to have leucocytosis Hypoalbuminemia and hypocalcemia. CECT abdomen (done outside) at Kalra Hospital was normal. At Mahindru Hospital, the colonoscopy (22-5-19) was carried out by Dr. Nishant Nagpal as a diagnostic procedure and while carrying out the procedure, the patient had colonic perforation and he was shifted to Aakash Hoapital Dwarka on 22nd May, 2019. At Aakash Hospital, the patient was found to have evidence of sepsis and the perforation was confirmed on x-ray and the patient was subjected to laparotomy for repairative surgery. On exploratory, the patient’s perforation was noted in the sigmoid colon and there was evidence of splenic laceration 1cm in size at the lower pole and there was evidence of peritonitis. In view of persistent bleed, splenectomy was carried out alongwith Loop ileostomy. The patient recovered stable post-operatively from 23rd May, 2019 to 26th May, 2019. On 27th May, 2019, the patient developed cardiac failure and chest infection and was shifted to CCU, where he succumbed on 5th June, 2019 at 5am from the medical records.
2. The undertaking of colonoscopy under consent, as a diagnostic procedure, as part of comprehensive line of treatment for ruling out colonic causes of diarrhea, anemia and weight loss, was as per accepted professional practices in such cases. However, the choice of time (in the night) for conducting an elective procedure, is something which perhaps was ill-advised.
3. The patient suffered from colonic perforation, a complication associated with colonoscopy, which was diagnosed, informed to the patient’s attendant and timely referred for surgical intervention at Aakash Hospital. The patient, subsequently suffered from post-op perforation peritonitis with pneumonia with sepsis with multi-organ dysfunction syndrome with refractory septic shock, which led to his demise on 05th June, 2019.

In light of the observations made hereinabove, it is the decision of the Disciplinary Committee that no medical negligence can be attributed on the part of the doctors of Mahindru Hospital, in the treatment administered to the Shri Vijay Pal Singh at Mahindru Hospital.

Complaint stands disposed.

Sd/: Sd/:

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

Chairman, Delhi Medical Association,

Disciplinary Committee Member,

Disciplinary Committee

 Sd/:

(Dr. P. Kar)

Member,

Disciplinary Committee

The Order of the Disciplinary Committee dated 24th February, 2020 was confirmed by the Delhi Medical Council in its meeting held on 28th February, 2020.

 By the Order & in the name

 of Delhi Medical Council

 (Dr. Girish Tyagi)

 Secretary

Copy to:-

1. Smt. Maya Devi, r/o- N-28, Gurudwara Road, Mohan Garden, Uttam Nagar, New Delhi-110059.
2. Shri Anil Kumar, S/o Late Shri Vijay Pal Singh, r/o 28A N Block, Mohan Garden, New Delhi-110059.
3. Dr. Nishant Nagpal, Through Medical Superintendent, Mahindru Hospital, E-1, Kiran Garden, Main Najafgarh Road, Uttam Nagar, New Delhi-110059.
4. Dr. Sanjay Mahindru, Medical Superintendent, Mahindru Hospital, E-1, Kiran Garden, Main Najafgarh Road, Uttam Nagar, New Delhi-110059.
5. SHO Bindapur, New Delhi-110059 (w.r.t. DD No.103A dated 14/07/19- For information.

 (Dr. Girish Tyagi) Secretary