DMC/DC/F.14/Comp.3576/2/2024/ 19th March, 2024

**O R D E R**

The Delhi Medical Council through its Disciplinary Committee examined a complaint of Dr. Preeti Ahuja, r/o- 5-E, Chander Nagar, Near Radha Krishan Mandir, Saharanpur-247001, Uttar Pradesh, India, alleging medical negligence on the part of Dr. Neeraj Awasthy of Max Super Specialty Hospital, Press Enclave, Saket, New Delhi-110017, in the treatment administered to the complainant’s son Master Sahil Ahuja.

The Order of the Disciplinary Committee dated 13th February, 2024 is reproduced herein-below:-

The Disciplinary Committee of the Delhi Medical Council examined a complaint of Dr. Preeti Ahuja, r/o- 5-E, Chander Nagar, Near Radha Krishan Mandir, Saharanpur-247001, Uttar Pradesh, India (referred hereinafter as the complainant), alleging medical negligence on the part of Dr. Neeraj Awasthy of Max Super Specialty Hospital, Press Enclave, Saket, New Delhi-110017(referred hereinafter as the said hospital), in the treatment administered to the complainant’s son Master Sahil Ahuja(referred hereinafter as the patient).

It is noted that the Delhi Medical Council has also received a representation from Police Station Saket, Delhi, whose subject matter is same as that the complaint of Dr. Preeti Ahuja, hence, the Disciplinary Committee is disposing both of these matters by this common Order.

The Disciplinary Committee perused the representation from police, complaint of Dr. Preeti Ahuja, joint written statement of Dr. Neeraj Awasthy, Dr. Pranav Shankar Medical Superintendent of Max Super Specialty Hospital, written statement of Dr. K. S. Dagar of Max Super Specialty Hospital, written submission of Dr. Neeraj Awasthy, written submission of the complainant and copy of medical records of Max Super Specialty Hospital other documents on record.

The following were heard in person:-

1. Dr. Preeti Ahuja Complainant
2. Dr. Neeraj Awasthy CTVS, Max Super Specialty Hospital
3. Dr. Pranav Shankar Medical Superintendent, Max Super Specialty Hospital
4. Dr. K. S. Dagar CTVS Surgeon, Max Super Specialty Hospital

It is noted that as per the police representation it is averred that the complainant Dr. Preeti Ahuja had filed a complaint at police station Saket as well as before Hon’ble Ld. ACMM, South District, Saket court vide which it is alleged that on 20th March, 2022, her son Master Sahil Ahuja was admitted in the Max Hospital, Saket Delhi for heart surgery in the supervision of Dr. Neeraj Awasthy and a heart surgery was done by the said doctor and it was unsuccessful. There was carelessness of Dr. Neeraj Awasthy in this surgery. During the course of inquiry, a notice U/s-91 Cr.P.C. was sent to Max Hospital, Saket to provide medical records of complainant’s son. On 22nd June, 2023, medical records were received. During course of inquiry, medical records of the complainant were collected from Max Hospital. It is, therefore, requested that an opinion may please given whether any negligent act was occurred in the surgery of the patient on the part of Max Hospital, Saket, Delhi.

The complainant Dr. Preeti Ahuja in her complaint averred that she wants to make her submissions regarding the medical treatment of her child Sahil Ahuja age five months, weight 5.6 kg, received at Max Super specialty Hospital, Saket under Dr. Neeraj Awasthy, a Pediatric Cardiologist. She came from South Africa and had been communicating with Dr. Neeraj Awasthy from South Africa, who mentioned that she can bring her baby to India for a VSD device closure or the surgical repair. After reaching India, he examined the baby on several occasions. But still, he could not diagnose the large ASD alongwith large-mid-muscular VSD of 10 mm. He said that her baby is an ideal candidate for VSD device closure. Little did, she knows afterwards that he was experimenting on her baby to enhance his portfolio. Dr. Neeraj Awasthy never explained to her the risk factors but now he is claiming that device closure was high risk yet when she asked him for open-heart surgery, Dr. Neeraj Awsathy only explained her that if there are not adequate rims then, they will do open-heart surgery. Unfortunately, he did VSD device closure for five months old baby on 21st March, 2022 which she came to know after the procedure that it was not appropriate for a five months old child with a large mid muscular VSD. Dr. Neeraj Awsathy burst one of the chambers of his heart while doing catheter procedure due to gross, grave and reckless criminal negligence and put him under cardiac arrest. Her baby had renal failure, stroke and lost his voice due to the hypoxia. Her baby’s left hand is completely twisted and has weakness in his left side of his body. The trauma had caused seizures and many other complications including hypotonia, even his muscles of the mouth also gone very weak. Due to which, it is very hard for him to drink the milk or swallow the solid food. His brain’s parietal region is also damaged which controls the memory, gross motor skills like walking and holding and sensitivity (touch), which makes it very hard to get therapies because the baby does not like their touch. While doing the catheter procedure, Dr. Neeraj Awsathy took access of her baby’s neck and the both femoral arteries which badly bruised her baby’s private parts. After this incident, Dr. Neeraj Awasthy mentioned under CCTV camera and audio recording room at Max, that her baby was not meant for device closure. Now, it’s bad for his career. So, her point is if he knew it, why did he do it? He had 18 years of experience and they trusted him. But Dr. Neeraj Awasthy is the most dishonest doctor she came across. He even went as far as to edit the documents which were already signed with every single symptom what her child had after the incident (fraud). On the documents, it was also stating that the doctor chose the best option, which is suitable for the baby. But only to find out afterwards, that open heart-surgery was the safest option for her baby due to his age and weight. Now, the doctors recommended occupational therapy and physiotherapy daily basis for her baby. Apart from this, regular checkup to the pediatrician, cardiologist, neurologist, psychologist and dietician which is quite expensive in South Africa. This has incurred unnecessary expenses on her side which has destroyed her child’s life as well. With all the information provided above, it is clearly evident that it is medical negligence and unethical by providing the VSD device closure to her five months old baby with 5 kgs weight for a large mid muscular VSD knowing that the age and weight restriction on the device was not met by her child and more so bursting the chamber of his heart and putting him under cardiac arrest. She strongly feels in all fairness, Dr. Neeraj Awasthy license should be cancelled to prevent this happening in the future and they must compensate for the damage they have incurred to her child and for his treatment for his life, going forward.

Dr. Neeraj Awasthy, Max Super Specialty Hospital in his written statement averred that the father of the patient (Master Sahil Ahuja) started communicating with him from South Africa regarding the patient since November, 2021. At that time, the patient was two months old. A report of an echo test performed in South Africa, was sent to him over WhatsApp and it was mentioned that the patient was suffering from a restrictive PFO/ASD and large mid muscular VSD with tiny adjacent VSD and borderline left sided structures including mitral valve, borderline aortic valve (Z score 2), borderline arch. It is pertinent to mention that the patient’s father repeatedly insisted that the hole in the patient’s heart i.e. the VSD, be closed without the surgery. Since, the patient was not examined by him (Dr. Neeraj Awasthy) and discussion was happening over WhatsApp, it was clearly communicated by him to the patient’s father that the patient should gain weight before any intervention can be considered. It is submitted that on 14th December, 2021, the patient’s father messaged the following to him (Dr. Neeraj Awasthy). The relevant excerpts of the message are reproduced herein for ease.

*“Hi Dr. hope you well. Please see latest reports of Sahil (the patient). Can you please advise if you can close all holes with device closure without open heart surgery? He now weights 5.2 kgs. I have started high calorie diet thanks”.* To this message he (Dr. Neeraj Awasthy replied stating that “*by this report with multiple defects it seems they are heading for a surgical closure of defect. For closure with a device, there should be adequate rims to support the device. As Dr. Raymond has planned, it would be a good idea to review after 5 to 6 weeks and take a call. It seems surgical by this report. Although, even if a chance by device need to review the echo. Seems higher chance of surgical”.*

It is submitted that on 26th December, 2021, the patient’s father shared an article regarding the procedure and enquired whether it can be done on the patient as well. The publication shared was of a patient who had multiple defects and was closed with a device. The relevant excerpts of the message are reproduced herein for ease :

*“Hi Dr. Hope you are well. I came across this article would it be possible for him (Dr. Neeraj Awasthy) to try this procedure on their baby when he reaches 4.5 months old. Currently he is 3 months old and 5.5 kg.*

It is submitted that the publication being referred was a case where a four-month old baby, weighing 4.6 kilograms who underwent VSD closure with 4x4 Amplatzer R Ductal Occluder II device and ASD with 9 mm-sized Amplatzer Septal Occluder. He (Dr. Neeraj Awasthy) then, provided the following response to the patient’s father :

*“As communicated earlier if rims are suitable can be tried”.*

Thereafter, the patient’s father insisted that he needs to come to India on 26th January, 2022 and would like to bring the patient for a consultation. The patient’s father was advised to consult the local physician there, to wait and see if the patient was doing fine on decongestive therapy before taking up the travel. It is submitted that the patient and his father visited the OPD of the hospital in January, 2022. An echo evaluation was done for the patient which showed a large VSD with borderline LV, mitral valve and borderline arch with no gradient. Furthermore, the patient’s case was discussed with the surgical team and thereafter, with the patient’s family. In view of the associated lesions, it was considered that the surgical option may involve more risk and since there were adequate rims for the VSD, device closure of the defect may be offered. However, since the intervention to place the device for closure of the defect was a high-risk surgery, it was decided that the procedure should be planned once the surgical beds were available as a standby. The patient was borderline tachypnoeic with optimized therapy. The parents of the patient insisted that they wish to visit their hometown in Saharanpur and it was mutually decided that the procedure would be planned once the family returns. This would have also allowed the patient to gain some weight before any procedure could be considered. It is submitted that on 07th March, 2022, the patient required admission in paediatric ICU of the hospital because of chest infection. The patient’s father had insisted that they (doctors) tried and closed the defect in one sitting. After consulting the surgical team, he (Dr. Neeraj Awasthy) informed the patient’s family that since the defect closure with a device is a high-risk case and needs surgical backup, it is advisable and prudent to wait. It is submitted that the surgical closure needed to be done on bypass and for that he(Dr. Neeraj Awasthy) wanted to wait for few weeks before considering the same in view of recent chest infection, as the chest infection increased the risk of the surgical procedure. The patient’s chest infection was significant, the patient needed hospitalization within the paediatric ICU of the hospital. Inspite of optimum therapy, the patient was suffering from persistent congestive heart failure and this indicated an urgent need to close the VSD. The only available option to close such defects were either insertion of device in a catheterization lab or open-heart surgery. Considering the patient was suffering from several associated anomalies such as borderline mitral valve, borderline arch anomaly which may need catheterization evaluation, the surgical team, cardiology team and the family discussed the case. Pursuant to this, it is concluded that both procedures weather VSD closure or open-heart surgery were high risk for the patient. When the parents of the patient specifically asked the question about the risk, they were informed by the surgeon himself that there was a risk in surgery as well the VSD device procedure and they need to choose between the two. In view of the significantly increased flow, the recent history of chest infection, it was considered that closure of the defect with VSD device may be a better option. Be that as it may, given the inherent risk involved in the said procedure, a surgical team was on standby. All standard guidelines for closure of VSD with a device was discussed and the treatment of an isolated case of the lesion. However, the patient was not only suffering from VSD but had associated lesions of mitral valve and aortic valve with a recent chest infection. This made the patient high risk for closure. The risk factors were explained to the family repeatedly and they were informed about the complications regarding the entire procedure. The complainant was informed regarding the need to electively take the multiple venous accesses including the neck access, the femoral arterial and venous accesses considering the complexity of the procedure including the risk of neurological injury, local site injury, tamponade need for immediate surgery and mortality. It is right to mention that appropriate consents including high risk consent were sought and signed by the parents of the patient for the procedure. It is submitted that with all due consents, the patient was taken electively for VSD device closure on 21st March, 2022. It is submitted that typically, the VSD device closures done at the hospital are electively done in sedation without general anaesthesia; however, this procedure was electively done under general anaesthesia, considering, it was a high-risk procedure. It is submitted that in the catheterization laboratory, all haemodynamic data were evaluated and angiogram done in appropriate view. Considering the VSD with adequate margins, VSD device was planned as per the protocol. Furthermore, an arteriovenous loop was created and appropriate size venous sheath for the device was being parked from the neck access across the VSD. However, the patient had sudden bradycardia while the attempt was being made to cross the tricuspid valve and immediate echo was done which suggested effusion. The patient was immediately considered for pericardial tapping which was introduced, and the surgical team was alerted. In view of hypotension, CPR was simultaneously commenced. Considering the tamponade, the sternum was opened on the catheterization table and rent in the RA was repaired. It is pertinent to mention that the tamponade is a known complication for any such procedure and accordingly the medical team was well prepared to handle the same. Given the patient’s condition, the VSD closure was not carried out the same day. Thereafter, the parents of the patient were informed about the above events and were counselled about the need to observe the patient for twenty-four hours, as he would be haemodynamically stable thereafter. The patient was shifted to paediatric ICU and was closely observed for hemodynamic and neurological insult. The patient was observed to be haemodynamically stable, spontaneous eye movements and limb movements. The parents of the patient were counselled again for the need of the surgery and the possible risk and benefit, they were also explained the inability to preoperatively assess neurological status alongwith the possibility of guarded neurological outcome. With the consent of the complainant, the patient was electively taken for VSD closure the next day and underwent emergent dacron patch VDS closure plus direct closure of additional muscular VSD+PDA ligation on 22nd March, 2022, successfully. During the surgery, the findings of the echo were confirmed and it was observed that the patient had PFO and no large ASD was found, as was claimed by the family. It was during the surgery itself that the PFO was intentionally dilated to an ASD because of the patient’s heart condition. It is submitted that post surgery, the patient’s haemodynamics were stable and post-operative echo was consistent with anatomic repair. However, the patient was noted to have abnormal movements on post-operative day (POD) one. The patient was started on anti-epileptic therapy for the same. Neurological opinion was sought but the MRI was deferred, as it would have led to haemodynamic instability. Once the patient was stabilized, a CT scan of the head was done and neurological advice was incorporated. There was no adverse neurological event since the surgery. The patient underwent renal failure, which is common during a bypass and the same was cured with dialysis. The parents of the patient were extensively counselled by the neurologist regarding the patient’s present status and future prognosis. Thereafter, a few days later, the patient was discharged.

It is submitted that from the other facts, it is evident that he (Dr. Neeraj Awasthy) always acted in the best interest of the patient. The patient was suffering from several complicated pre-conditions which made the case high risk and all risks were explained to the family of the patient. Based on the communication with the patient’s father set out above, it is clear that the patient’s father was very keen and persistent that the patient undergoes VSD closure with a device and not surgery. When he (Dr. Neeraj Awasthy) insisted that the patient needs to be optimized for therapy and allow for the weight gain if possible. The patient’s father shared a publication to support his argument that children with lesser weight have undergone these procedures. During the initial discussions, it is clear from the above excerpts that he (Dr. Neeraj Awasthy) was certain the patient needed to gain some weight to undergo any intervention at all and that the decision to close the hole be it surgery or the device would only be made after evaluation. There is sufficient medical literature to evidence that the VSD can be closed without surgery with a device in babies of such weight and age. Furthermore, the VSD can be attempted for device closure as per the standard treatment guidelines issued by the Indian Academy of Paediatrics. It is pertinent to mention that the patient was not only suffering from VSD but had associated lesions of mitral valve and aortic valve with a recent chest infection and that made the patient high risk for closure. The complainant and father of the patient were being regularly briefed at every step of the way, through daily meetings of the family of the patient with him (Dr. Neeraj Awasthy) and team. The relatives of the family were also briefed on a regular basis, almost twice a day. Furthermore, it is right to mention that all the queries and concerns of the patient’s family were being addressed on WhatsApp by Dr. Neeraj Awasthy. It is pertinent to mention that the parents of the patient were not only being informed about the progress of the patient’s procedure, but were also apprised about the risks of the procedure. The patient’s family was informed about the risk of closure of device and the need for the surgery that may arise. Furthermore, they were also informed about the accesses that would be used including neck access and femoral access for the procedure. At time when VSD closure with device was elected as the procedure, the patient was already suffering from congestive heart failure and both surgery as well as device closure were high-risk. Therefore, he (Dr. Neeraj Awasthy) would never have said that the patient was the ideal candidate for VSD closure. However, that was the less risky option for the patient at the time and was undertaken pursuant to discussions with other specialists and the family of the patient. The renal failure, transient hypoxia, are common and well-known risk of bypass and was accordingly, addressed by the medical team. With respect to the abnormal movements on POD (post-operative day) one, the same were addressed by the neurologist when the patient was well enough to run tests. During early discussions with the patient’s parents, it was discovered that there was a history of developmental delay and delayed neck holding was elicited. The family had asked him (Dr. Neeraj Awasthy) whether the surgery would improve the condition and it was informed that there may not be any significant correlation between the two. The CT scan that was done for the neurological assessment, was suggestive of chronic cerebral atrophy, likely to cause chronic illness for the patient, which is completely unrelated to the present issue at hand for VSD closure. He had involved the neurologist right from the start as per general protocol and in view of the persistent concerns of the family, additional neurological consults were sought from other doctors and all were satisfied with the neurological status of the child. There was transient decreased movement of the left upper limb which has shown significant improvement over the course of time.

It is pertinent to mention that the patient was electively ventilated with open sternum, which is done in several postoperative cases, the patient’s family took photographs without permission and that have been circulating such pictures on multiple social media platforms. It is right to mention that on certain public platforms, his (Dr. Neeraj Awasthy) personal photograph was replaced with the photographs of the patient. The family of the patient have displayed their hostility to tarnish his (Dr. Neeraj Awasthy) image by displaying post-operative photographs and writing negative and derogatory comments on multiple social media platforms, which has negatively impacted his reputation, and his emotional and his mental status. Inspite of the fact, he (Dr. Neeraj Awasthy) acted in best interest of the patient but the family has been persistently threatening him. In the present case of the patient, who had failure to thrive and had persistent congestive heart failure and was a high-risk patient, proper consent for device closure of the defect was acquired from the parents of the patients and it was understood that he may still need surgery. However, there were other complications when the procedure was undertaken which could not be predicted which is why this was a high-risk procedure. The defect was closed without any significant neurological deficit attributable to the device or the surgery, yet the family is trying to utilize the opportunity to negotiate compensation and allege negligence for personal and financial gains.

It is right to mention that post-operatively, the patient has been active and playful with well moving limbs and interactive in the last interaction in OPD with the patient. He (Dr. Neeraj Awasthy) and the team of the specialist doctors of the hospital extensively investigated, evaluated the patient repeatedly and the entire treatment was instituted promptly as per internationally accepted standard of care and as per protocol. The patient suffered a known complication during the VSD procedure, which was appropriately managed by the doctors of the hospital. The doctors were very diligent and active in treatment of the patient as per best medical practices and the outcome cannot be even remotely blamed on him (Dr. Neeraj Awasthy). The information provided by the complainant in her complaint, is incomplete and misleading and important facts have been suppressed by the complainant.

In response to the allegation of suggesting the complainant to come to India for a VSD device closure, he (Dr. Neeraj Awasthy) further stated that the complications of the procedure with the patent was communicated thoroughly with the family. The patient’s family has well researched the lesion and have been sharing the case reports of the similar kids who have undergone the same treatment and were constantly insisting on that the same procedure be offered for their child or the patient instead of the surgery. He never insisted the complainant or their family to visit India, on the contrary the patient’s father insisted that he (father of the patient) needs to come to India on 26th January, 2022 and would like to bring the patient for a consultation. The patient’s father was advised to consult the local physician there to wait and see, if the patient was doing fine on decongestive therapy before taking up the travel. During conversation over WhatsApp and over the phone, it was clearly communicated that the final decision will be taken after examining the patient and keeping in mind the co-morbid conditions of the patient as well as the age of the patient.

In regard to the allegation that Dr. Neeraj Aweasthy could not diagnose the large ASD along with large-midmuscular VSD of 10 mm (Misdiagnosis), it is vehemently denied that he (Dr. Neeraj Awasthy) could not diagnose the large ASD and is based on mere conjecture and surmises. After the examination of the echo, during the surgery, it was found that the patient only had a PFO and not ASD, and in order for the heart function to improve, the surgeon acting in the best interest of the patient, had intentionally dilated the PFO. It is denied that there was any misdiagnosis on his part. In the present case, the patient had failure to thrive and had persistent congestive heart failure and was not fit to be taken for elective surgery, proper consent for device closure of the defect was acquired from the patient’s family and it was understood that he may still need the surgery. It is submitted that since there were other complications when the procedure was undertaken as a precaution a high-risk consent was also acquired from the patient’s family. It is pertinent to mention that the defect was closed without any significant neurological deficit attributable to the device or the surgery. The diagnosis of the patient on the surgical table was the same as the pre-operative diagnosis and; hence, there was no misdiagnosis by him. The complainant is misinterpreting the medical terminology to show things in a wrong manner.

In regard to the allegation of communicating to the family that the patient was an ideal case for VSD device closure, it is vehemently denied that he said that the patient was an ideal candidate for VSD device closure. The complainant and the father of the patient were being regularly briefed at every step of the way, through daily meetings of the family of the patient with him and team. The relatives of the family were also briefed on a regular basis, almost twice a day. Furthermore, it is right to mention that all the queries and concerns of the patient’s family were being addressed on WhatsApp by him. It is submitted that the parents of the patient were informed about the risk of closure of device and the need for the surgery that may arise. They were informed about the accesses that would be used including neck access and femoral access for the procedure. That at time, VSD closure with device was elected as the procedure, as the patient was already suffering from congestive heart failure and both the surgery as well as device closure were high risk procedures. It is submitted that VSD closure was the less risky option for the patient at the time and was undertaken pursuant to discussions with other specialists and the family of the patient.

In regard to the allegation that Dr. Neeraj Awasthy burst one of the chambers of his heart while doing catheter procedure due to gross, grave and reckless criminal negligence and put him under cardiac arrest, he (Dr. Neeraj Awasthy) submitted that the indication to close the VSD in child being in congestive heart failure risk through surgery as well as device closure is a high-risk procedure. The optimal therapy with document chest infection required the admission of the patient in pediatric ICU. It is submitted that the available option to close the defect includes device closure (in catheterization lab) or surgery. It is right to mention that considering the associated anomalies in the children such as borderline mitral valve, borderline arch anomaly which may need catheterization evaluation, the VSD device closure was considered less risky option for the patient at the time and was undertaken pursuant to discussions with other specialists and the family of the patient. It was further discussed and concluded that due to the risk involved, the procedure could be tackled in catheterization lab (with surgical backup) in the best interest of the patient. In the catheterization lab all the haemodynamic data was evaluated and angiogram was done in appropriate view. It is submitted that considering the VSD with adequate margins, VSD device was planned as per the protocol. Arteriovenous loop was created and appropriate size venous sheath for the device was being parked from the neck assess across the VSD. The patient had sudden bradycardia while the attempt was being made to cross the tricuspid valve and immediate echo which suggested effusion. The patient was immediately considered for pericardial tapping which was introduced and surgical team was alerted. In view of hypotension, CPR was simultaneously commenced. Considering the tamponade, sternum was opened on the catheterization table and rent in the RA repaired. It should be noted that tamponade is a known complication of any such procedure and the medical team was well prepared to handle the same. Given the patient’s condition, the VSD closure was not carried out the same day.

In regard to the allegation that renal failure and hypoxia was due to recklessness of Dr. Neeraj Awasthy causing hypotonia and weakness in the mouth muscles, it is vehemently denied that the patient suffered renal failure and hypoxia due to his (Dr. Neeraj Awasthy) recklessness. The renal failure is common and well-known risk of bypass and the same was accordingly addressed by the medical team. It is pertinent to mention that Dr. Neeraj Awasthy and team had duly appraised the patient’s family about the risks involved in the procedure. With respect to the abnormal movements and weakness in mouth muscles, the same were addressed by the neurologist when the patient was well enough to run tests. During early discussions with the patient’s parents, it was discovered that there was a history of developmental delay and delayed neck holding was elicited. Furthermore, the family had asked whether the surgery would improve the same and were informed that there may not be any significant correlation between the two. The CT scan that was done for the neurological assessment was suggestive of chronic ceberal atrophy, likely to cause chronic illness for the patient which is completely unrelated to the present issue at hand for VSD closure. He (Dr. Neeraj Awasthy) had involved the neurologist right from the start as per general protocol and in view of the persistent concerns of the family, additional neurological consults were sought from other doctors and all were satisfied with the neurological status of the child. There was transient decreased movement of the left upper limb which has shown significant improvement over the course of time.

In regard to the allegation for taking access of the patient’s neck and both femoral arteries which badly bruised his private parts, he (Dr. Neeraj Awasthy) stated that the complainant was informed regarding the need to electively take the multiple venous accesses including the neck access and the femoral arterial and venous access considering the complexity of the procedure including the risk of neurological injury, local site injury, temponade, need for immediate surgery and mortality. Appropriate consents including a high-risk consent were sought and signed by the parents of the patient for the procedure.

In regard to the allegation that Dr. Neeraj Awasthy mentioned under CCTV camera and audio recording that the patient was not meant for device closure, it is vehemently denied that he (Dr. Neeraj Awasthy) had made any statement on CCTV regarding his decision or its impact on his career. Post the chest infection of the patient, it was he (Dr. Neeraj Awasthy) who electively waited for the inflammation to settle and then consider for VSD closure. The diagnosis of the patient on the surgical table was same as the pre-operative diagnosis and; hence, there was no misdiagnosis by him.

In regard to the allegation of editing of the document and medical reports, it is vehemently denied that there was any editing done on the documents or the medical reports of the patient. The complainant is making false accusations and should be directed to provide proof in support of such baseless allegations. The hospital is totally committed in providing the best possible care to their patients with sincerely and diligence, in the instant case also, the patient was given the best possible treatment as per his prevailing clinical condition. The attendants were kept informed, from time to time, about the clinical condition of the patient. The doctors, nurses, and other para-medical staff at the hospital are highly qualified and immensely experienced in their respective fields. They have consecrated their lives to the service of humanity. They maintain utmost respect for human life and practice their medical profession with conscience and dignity. Health of their patient is their first consideration. They prescribe regimens for the benefit and good of the sick according to the best of their ability and judgment within the set medical protocols. They never do injustice or harm anyone. They always keep themselves far from ill-doings. In the instant case also, the treating doctors and other staff performed their duties bonafide, promptly and diligently and to the best of their ability and judgment. In the present case, the treating doctors and other staff had performed their duties bonafide and to the best of their ability and judgment. In view of the aforesaid submissions and in light of the medical records, being provided alongwith the statement of defence, it is humbly submitted that allegation of medical negligence made by the complainant, is not admissible qua the hospital, its treating doctors and its staff, and is liable to be dismissed.

Dr. Pranav Shankar Medical Superintendent Max Super Specialty Hospital reiterated the stand taken by Dr. Neeraj Awasthy.

Dr. Neeraj Awasthy, Max Super Specialty Hospital in his written submission stated that the patient suffered from mid-muscular VSD with left to right shunt. The patient was not gaining weight despite optimization of decongestive therapy and feeding advice. His weight as on admission was 5.6 kg against expected weight of 8 kg. The patient had significant chest infection. Despite receiving optimum therapy, the patient was suffering from persistent congestive heart failure which among other symptoms, indicated need to close the VSD. The standard recommended guidelines published by the Pediatric Cardiac Society of India (PCSI) recommends closure of the midmuscular VSD with device as class 1 indication for children above 5 kgs. In addition to the above, the associated lesions on the left heart such as mitral valve involvement and borderline aortic arch made surgical closure riskier than device closure. In his experience and opinion, the above made the patient a fit case for device closure of VSD.

He further stated that the size of sheath had never been challenged by the complainant. Notwithstanding the same, he submit that selection of sheath was decided after ultrasound, as he undertake ultrasound guided punctures. The initial access for diagnostic evaluation and AV loop formation was chosen as 4f for the artery, 5f each for the right femoral vein and right IJV (neck vein). The sheath size was subsequently upgraded sequentially to 7f for the venous side. 7f venous sheath corresponds to diameter of 2.3 mm. This would have facilitated the 10/1 2 Konar device (or upto 12 mm VSD device) deployment if needed. The sheath size was selected as per the vein size. The weight of the patient at the time of the procedure was 5.6 kg. The expected vascular size of femoral vein in a child expected to weight 5.6 kg is likely to be 4.01 mm. Neck vessels are greater than femoral vein and thus the size of sheath (2.3 mm) was less than the neck vessel. The size sheath is routinely used for other procedures such as PDA.

He also stated that he had been involved in about 250 cases of VSD device closures in patients belonging to varying age groups and have performed multiple intervention in preterm babies, immediate newborns including PDA stenting, RVOT perforation, RVOT stent, pulmonary valvotomy, coarctation ballooning etc. He had been the speaker on various national and international platforms for the VSD device closure and related procedure. He had been appointed as the Proctor for VSD closure workshops across India in cities viz. Jaipur, Dehradun, Imphal, Varanasi, Jammu, Nasik, Vijayawada, Indore, Firozpur, Shimla, Ranchi, Raipur etc as well as in Bangladesh, Nepal etc. He had also been appointed as a proctor for preterm Picollo device and ado2 as device. He has been a faculty at CSI Frankfurt: Topic vascular access in VSD device closure, 2021, Master class in VSD device closure PCSI 2023, Moderator for VSD device session and Panellist for VSD device closure session.

He added that the patient was a high-risk case which had been acknowledged by the complainant by signing a high-risk consent form.

He further stated that he has filed medical literature in support of the assertions he had made hereinabove.

Dr. K. S. Dagar CTVS Surgeon, Max Super Specialty Hospital in his written statement averred that on 21st March, 2022, he and his team were in the operation theater when they received an urgent call from the catheterization lab that a patient developed hemodynamic instability while undergoing device closure of muscular VSD. He released Dr. Pratap from his team who immediately responded and performed emergency sternotomy for cardiac tamponade. Dr. Pratap opened sternum of the patient on the catheterization table and the rent in the RA was identified and repaired with prolene sutures. Pursuant to the surgery, the patient had two episodes of ventricular fibrillation for which defibrillation was done. He stated that the patient was shifted to the paediatric ICU with splinted sternum as he was hemodynamically unstable and unable to tolerate sternum closure. The next day on 22nd March, 2022, he was involved for a possible VSD closure and it was unlikely that the patient could be weaned off the ventilator with hemodynamically significant lesions. The patient was born with heart defects and had other abnormalities making him a high risk case. He counselled his parents about the history of the underlying disease and suggested emergent VSD closure with decompressing PFO. He informed the parents in detail about the risks and complications about the proposed surgery. The parents acknowledged the risk and agreed to go ahead for the high risk surgery. The complainant and her husband signed the Counseling Note. The patient was taken for VSD closure on 22nd March, 2022 and underwent emergent Dacron patch VSD closure plus direct closure of additional muscular VSDs and PDA ligations. During the surgery, it was found that the patient’s unique VSD anatomy consisted of a large mid vascular VSD which had multiple overlying muscle bundles supporting the Tricuspid Valve subvalvular apparatus along with large apical VSD crisscrossed by muscle bundles obscuring the true margins and additional multiple tracks in the apical septum. Ideally, dividing the muscle bundles trabeculae criss-crossing the muscular VSD improves the exposure and facilitates delineation of true edge defect. However, due to the attachment of Tricuspid valve leaflets subvalvular apparatus to the overlying muscle bundles they could not be divided. The inability to divide the Trabeculae added another level of complexity to an already difficult subset. Accordingly, the available anatomic landmarks were followed. As per medical literature for multiple VSD’s the widely accepted tenants of a good anatomic repair are achieve single stage repair, complete obliteration of the VSD’s, void heart block and arrhythmia and avoid ventricular dysfunction. Accordingly, during the surgery the patch over the large mid muscular VSD was anchored to the stable muscle bundles with interrupted sutures to achieve a secure closure. There was no shunt across the patch on repeated ECHOs. The shape and orientation of the patch was dictated by the underlying anatomy and the availability to secure attachment points for anchoring the patch without leaving any residual defects. The apical tracts were further obliterated with additional interrupted sutures. No shunt was observed on pressuring the LV and the TV was found to be competent. The patient’s PFO was deliberately dilated to gain access to the left side of the heart to identify additional VSDs by probing and pressuring the LV. A small hole in the atrial wall was left as it is to act as a pop off valve in case of elevated right heart pressure which the patient was suffering from. The surgery was uneventful. Thereafter the child came off pump uneventfully in sinus rhythm, with tiny residual shunts and good ventricular function using standard and established surgical techniques to achieve the surgical goals of no residual defects, good function and no heart block. Thereafter the patient was shifted to the ICU on IPPV with stable hemodynamically on vasoactive support and the parents were counselled about the good uneventful anatomic repair, the need to observe the Multiple Organ Dysfunction Syndrome and neurologic recovery, pulmonary arterial hypertension and bleeding. On 24th March, 2022, he examined and found the patient to be hemodynamically stable. His ECHO showed good VSD closure and no shunts. The parents were explained about possible renal derangement and possible seizures. Renal derangement is a known complication in patients undergoing bypass surgery specially with a history of preexisting hemodynamic compromise needing CPR. On April, 2022, the patient remained hemodynamically stable. In view of continuous stability, he advised the hospital to shift the patient to ward and seek paediatric neurology review. The patient was discharged on 11th April, 2022 in a stable condition.

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

1. The patient Master Sahil Ahuja, a 06 months old baby, weighing 5.6 kg, was admitted in the said hospital on 20.03.2022. He was a diagnosed case of Congenital Heart Disease, Large muscular VSD additional apical muscular VSDs, PDA, PFO, Hammock mitral valve with hypoplastic aortic arch (insignificant gradient). He was taken up for VSD device closure on 22.03.22 after all procedure investigations and pre-anesthetic checkup, under consent. The procedure was conducted by Dr. Neeraj Awasthy Pediatric Cardiologist. During procedure he developed sudden onset bradycardia and desaturation with echocardiography showing features of pericardial tamponade. He was managed with immediate resuscitation protocols and emergency sternotomy with RA rent repair. Child was shifted to Pediatric CTVS ICU on high inotropic support with splinted sternum on IPPV support. The patient was cooled for neuro protection. He was continued on inotropic support and monitored for neurological status over next 24 hours. Neurological status couldn’t be assessed fully but pupils were determined to be normal in size and normally reacting to light. The patient was moving all four limbs. Child was administered second line antibiotics: meropenem and targocid in view of splinted sternum. He was diagnosed as case of failed VSD device closure with tamponade (needing sternotomy and repair). Patient attendants were counseled about the need for surgery along with the possible risk and benefits. He underwent emergent Dacron patch VSD closure and Direct closure of additional muscular VSD and PDA ligation on 22.03.22. The surgery was performed by Cardiac Surgeon, Dr. K.S. Dagar, under consent. Hemodynamics were stable in postoperative period. Post operative ECHO was consistent with good anatomic repair. Inotropes were given in form of Adrenaline (0-5th POD), Dopamine (0-2nd POD), Levosimendan (0-3rd POD) and Dobutamine (0-10th POD) to optimize cardiac output. There was evidence of AKI (oliguria and worsening KFT) by 02nd POD which necessitated peritoneal dialysis. Renal protective therapies were instituted. Oliguria persisted till 5th POD after after which the urine output gradually picked up with resolution of renal injury. The patient also developed SIRS and third spacing secondary to hypoalbuminemia and clinical sepsis, both of which were adequately addressed. Cultures were sent and antibiotics were upgraded to Gefemax, Linezolid and Voriconazole after consultation with microbiologist. An appropriate course of these antibiotics was given with clinical resolution of third spacing, improving, TLC and platelet counts. Mechanical ventilation was continued till 4th POD when baby was extubated to nasal cpap uneventfully. He was then gradually weaned to room air by 17th POD. Associated bilateral basal patchy atelectasis and concurrent bronchorrhoea was managed with chest physiotherapy, frequent nebulizations, suction and intermittent peep and lung recruitment strategies. The saturation on room air Varied between 86% to 95 %.No respiratory distress or recessions was noted. Child was noted to have abnormal movements on POD1.Child was started on anti epileptic therapy. Neurological opinion was taken, MRI was deferred as it would have lead to hemodynamic instability, Once child stabilized, CT head was done and neurological advice was incorporated. There were no new adverse neurological event. Parents were counselled by the neurologist regarding the present status and future prognosis. Physiotherapists were involved in administering limb physiotherapy and parents involvement in executing the same is being encouraged. Minimal feeds were started on 1st POD and it was gradually built up to fortified oral feeds. He was also given supplements in the form of multivitamins, vitamin C and calcium. The patient was discharged on 11.04.2022, on medication with advice to follow up with Pediatric, Cardiologist and neurologist.
2. It is observed that since in the present case the VSD was large muscular VSD it is a indication for closure of VSD through Trans catheter VSD device, as was done in the present case.
3. Further, the weight of the patient was more than 5 kg (5.3 kg at the time of surgery) which as per the medical literature is cut off for Trans Catheter VSD device closure procedure.
4. It is noted that as per the notes related to the procedure of Trans Catheter VSD device closure done on 21st March, 2022, that the diagnosis is mentioned as ‘*PFO with left to right shunt large mid muscular VSD with left to right shunt, tiny additional muscular VSD, hammock mitral valve, flow turbulence in mitral valve, no MR single PAP muscle, mildly dilated VSD LV, Biscuspid Aortic valve (RCC+NCC Fusion) adequate LV/RV systolic function posterior shelf in arch, arch gradient of: 18 mmhg, no diastolic tailing. The weight of the child is mentioned as 5.3 kg. The catheter used were pigtail 4F/RCA 5F/6F snare and the wires/ device used by Terumo 0.35, 260 cm. There was gradient of 15 mmhg on pullback from arch to descending Aorta. LV Angiogram done using 4F pigtail catheter in LAO 45 cranial 20 view showed presence of large mid muscular VSD measuring about 9.5mm. Thus, it was decided to use 12 mm muscular VSD device. Aortic root angiogram done in LAO 30 view showed left arch with normal branching pattern, no APW, no PDA, prominent posterior shelf. The VSD was crossed retrogradely using a 4 Fr RCA catheter with a 0.035 Terumo guidewire and the wire was parked in distal LPA. The terumo wire was snared off from LPA and taken out from right internal jugular vein forming an AV loop. Over this wire 7F Amplatzer delivery sheath was taken and tried to cross the VSD but child developed desaturation and bradycardia. The AV loop was immediately released, echocardiography was done which revealed large pericardial effusion and decreased contractility of heart. Pericardiocentesis was done immediately and resuscitation protocols were started. Paediatric cardiac surgical intervention was sought and emergency sternotomy with RA rent repair was done. The child was shifted to paediatric CTVS ICU on high inotropic support with chest open*’.

In light of the above, it is observed that the size of the sheet used for the VSD procedure was as per standard protocol.

1. During the Trans catheter VSD device closure procedure the patient suffered from tamponade, which is a known complication associated with the said procedure; the complication was identified and timely managed as per standard protocol in such cases.
2. It is noted that a copy of the consent form of Max Super Specialty Hospital relating the Trans catheter VSD device closure procedure was filed by Dr. Pranav Shankar Medical Superintendent Max Super Specialty Hospital. The consent has been the admittedly signed by the complainant’s husband. It does have details of the risk/ complication associated with the said procedure. Further, on the possible alternatives to the said procedure it also mentions ‘Surgical VSD closure’.
3. The VSD closer surgery done subsequent to the failed VSD device closure with tamponade (needing sternotomy and repair) was done as per accepted professional practices in such cases.

In light of the observations made herein-above, it is the decision of the Disciplinary Committee that no medical negligence can be attributed on the part of Dr. Neeraj Awasthy of Max Super Specialty Hospital, Press Enclave, Saket, New Delhi-110017, in the treatment administered to the complainant’s son Master Sahil.

Complaint stands disposed.

Sd/: Sd/: Sd/: (Dr. Maneesh Singhal) (Dr. Satish Tyagi) (Dr. Vimal Mehta)

Chairman, Delhi Medical Association, Expert Member,

Disciplinary Committee Member, Disciplinary Committee

Disciplinary Committee

Sd/:

(Dr. V.K. Gupta)

Expert Member,

Disciplinary Committee

The Order of the Disciplinary Committee dated 13th February, 2024 was confirmed by the Delhi Medical Council in its meeting held on 21st February, 2024.

By the Order & in the name of

Delhi Medical Council

(Dr. Girish Tyagi)

Secretary

Copy to:-

1. Dr. Preeti Ahuja, r/o- 5-E, Chander Nagar, Near Radha Krishan Mandir, Saharanpur-247001, Uttar Pradesh.
2. Dr. Neeraj Awasthy, Through Medical Superintendent, Max Super Specialty Hospital, Press Enclave, Saket, New Delhi-110017.
3. Medical Superintendent, Max Super Specialty Hospital, Press Enclave, Saket, New Delhi-110017.
4. Station House Officer, Police Station Saket, New Delhi-110017- w.r.t. letter No.708/SHO/Saket dated 24.06.2023.-**for information & necessary action.**

(Dr. Girish Tyagi)

Secretary