DMC/DC/F.14/Comp.2228/2/2022/ 27th May, 2022

**O R D E R**

The Delhi Medical Council through its Disciplinary Committee examined a complaint of Smt. Shalini Sharma, r/o- 9/2491, Street No.1, 18A, Kailash Nagar, New Delhi-110031, alleging medical negligence on the part of doctors of Max Super Specialty Hospital, 108A, Indraprastha Extension, Patparganj, New Delhi-110092, in the treatment administered to complainant’s husband Shri. Anand Sharma, resulting in his death on 11.09.2017.

The Order of the Disciplinary Committee dated 08th April, 2022 is reproduced herein-below :-

The Disciplinary Committee of the Delhi Medical Council examined a complaint of Smt. Shalini Sharma, r/o- 9/2491, Street No.1, 18A, Kialash Nagar, New Delhi-110031(referred hereinafter as the complainant), alleging medical negligence on the part of doctors of Max Super Specialty Hospital, 108A, Indraprastha Extension, Patparganj, New Delhi-110092 (referred hereinafter as the said Hospital), in the treatment administered to complainant’s husband Shri. Anand Sharma, resulting in his death on 11.09.2017.

The Disciplinary Committee perused the complaint, joint written statement of Dr. Bachan Singh, Dr. Arun Puri, Dr. Kapil Gupta, Dr. V.P. Singh, Dr. Hamender Singh, Dr. Dilip Bhalla and Dr. Nidhi Saxena, Medical Superintendent, Max Super Speciality Hospital, copy of medical records of Max Super Specialty Hospital, post Mortem report no.1503/17 and other documents on record.

The following were heard in person :-

1) Dr. Hamender Singh Assistant Surgeon, Max Super Specialty Hospital

2) Dr. Bachan Singh Consultant Surgeon, Max Super Specialty Hospital

3) Dr. Arun Puri Consultant Anaesthesiology, Max Super Specialty Hospital

4) Dr. Y.P. Singh Director, Critical Care Medicine, Max Super Specialty Hospital

5) Dr. Dilip Bhalla Director Nephrology, Max Super Specialty Hospital

6) Dr. Kapil Gupta Consultant, Vascular Surgery, Max Super Specialty Hospital

7) Shri Vishal Ahlawat Hospital Staff, Max Super Specialty Hospital

8) Dr. Nidhi Saxena Medical Superintendent, Max Super Specialty Hospital

The Disciplinary Committee noted that the complainant Smt. Shalini Sharma failed to appear before the Disciplinary Committee, inspite of notice.

In the interest of justice, the Disciplinary Committee decided to proceed with the matter in order to determine it on merits.

The Disciplinary Committee noted that the complainant Smt. Shalini Sharma in her complaint has alleged that on 18th August, 2017, the complainant consulted Max Super Specialty Hospital for epigastric pain. He underwent Ultrasound and the CT-KUB which revealed 4mm of calculus in the right kidney. He was told that he did not require surgery and was advised to follow up in O.P.D. On 29th August, 2017 the patient complaint of pain in upper abdomen and was thus admitted in Max Super Specialty Hospital. He was treated conservatively. On 01st September, 2017 his B.P. was said to be low, thus he was shifted to ICU. In the ICU he was administered some injection in the back by Dr. Bachan Bharthwal, after which he never opened his eyes. On 01st September, 2017 he was taken up for laparotomy, without consent. On 02nd September, 2017 he was re-explored and family was apprised of the intra operative findings that there was lack of blood supply to the small intestines but the surgery was successful and the patient will become conscious in 24 hours. On 03rd September, 2017, the patient did not regain consciousness. It was told that his kidney was not working and he required dialysis which would cost Rs. 1.5 lakhs daily. The money was arranged and deposited. Till 08th September, 2017 almost eleven lakhs were deposited and doctors kept on giving assurances that patient will be alright. On 09th September, 2017 ICU staff demanded deposit of additional five lakhs. Since money could not be arranged his treatment was stopped and because of which and negligence of the doctors the patient died on 11th September, 2017. It is requested that strict action be taken against the concerned doctors and ICU staff.

Dr. Bachan Singh, Dr. Arun Puri, Dr. Kapil Gupta, Dr. V.P. Singh, Dr. Hamender Singh, Dr. Dilip Bhalla and Dr. Nidhi Saxena, Medical Superintendent, Max Super Speciality Hospital in their joint written statement averred that the patient Shri Anand Sharma, 44 yr old male came to the emergency of their hospital on 18th August, 2017 at around 11:30 p..m with chief complaints of epigastric pain radiating to the back (7/10 in intensity), not associated vomiting or nausea or per rectal bleeding, with no history of chest pain, shortness of breath, fever, altered bowel or bladder habits. There was no other relevant systemic history. The patient was examined and on examination, the patient’s per abdomen findings were as follows: non distended, soft, tender in epigastric region, bowel sound present and murphy's sign negative. The patient was gradually improving on conservative management and was symptomatically better. The history of recent abdominal scan 3 months back was told by the attendant (as documented in the ER progress note on 19.08.2017) which revealed a calculus in the right kidney. The patient was informed that the present USG performed does not reveal any calculi and a CT-KUB could be done to r/o any obvious cause. CT KUB was done and revealed the following findings: Horse shoe kidneys seen with lower pole of both the kidneys united by renal parenchymal band anterior to aorta resultant medial rotation of both the kidneys seen. The left renal parenchyma is showing variable thickness with mild thinning near superior pole. A non obstructive calculus measuring up-to 4 mm is seen within the inferior calyx of right kidney. Pelvicalyceal system appears normal on both sides. Both the ureters are normal in course and calibre. Both the vesicoureteric junctions appear normal. Urinary bladder is normal in size and shape. Prostate is normal in size and shape. No evidence of free fluid is seen in the pelvis. Since the patient was feeling better and the pain score was 1/10, the patient was then discharged from emergency with advice of follow up in Urology OPD. It is submitted that the patient did not visit the OPD for follow up. The patient again came to the Emergency Department of the hospital on 29th August 2017 at around 11:30 a.m. with complaints of pain upper abdomen on and off since one month and recent pain since 1 day with 2 to 3 episodes of vomiting. The vitals were stable. The patient was assessed by team of doctors in ER. Per abdomen was soft, tender, bowel sounds were present and there was no organomegaly. The patient was recently diagnosed with Horseshoe kidney with right sided calculi. The patient also gave history of chronic alcoholism, smoking and hypertension since 20 years. The Patient was also obese. Based on history and clinical examination, the patient was planned for evaluation for ureteric stone and pancreatitis hepatitis. The relevant investigations were sent (CBC, LFT, Amylase, Lipase and USG Whole Abdomen) and conservative management was immediately started. USG whole abdomen revealed: Liver is enlarged in size (17.2 cms) and shows diffuse increase in parenchymal echogenicity suggestive of fatty liver (grade-I). No focal lesion is seen. No intra hepatic biliary radicle dilation seen. Gall bladder is well distended and is normal. Portal vein and CBD are not dilated. Pancreas is normal in size, shape and echogenicity. Spleen is normal in size, shape and echogenicity. Bilateral kidneys are normal in echogenicity. Corticomedullary differentiation is maintained. Bilateral pelvicalyceal systems are not dilated. Both kidneys are malrotated and appears to fused in midline anterior to aorta likely horseshoe kidney. Urinary bladder is partially distended. Pelvic examination is inadequate. No free fluid is seen in the abdomen. The patient was then seen by General Surgery Team and was admitted under their care. On 30th August, the patient had complained of on off episodic pain, the patient was afebrile, vitals were stable and abdomen was soft, non tender. Conservative management was continued. In the evening of 30th August, the patient had some distension of abdomen and CECT Abdomen was ordered. On the morning of 31st August, the patient was seen by team of doctors from General Surgery Department, the patient was stable, afebrile and abdomen was soft, non tender, no guarding and bowel sounds were present. Based on history and Clinical findings, a provisional diagnosis of acute abdomen with suspected Ischemia was made and to confirm the same patient was taken for CECT abdomen. CECT was suggestive of the biliary passages, pancreas, spleen and adrenals are within normal limits. The stomach, small and large bowel loops do not show any abnormality. There is horse-shoe kidney with the isthmus lying at the level of lower border of L3 vertebra. No lymph node enlargement or free fluid is seen in the abdomen pelvis. The urinary bladder and seminal vesicles are normal. Prostate appears mildly enlarged calcified plaques seen scattered all along the abdominal aorta from infradiaphramatic until bifurcation on both sides. Thrombus is seen along the walls of abdominal aorta at multiple sites with most severe narrowing seen at L2-3 level at the level of original of superior mesenteric artery. The thrombus is extending into the proximal segment of SMA as well for length o about 3.6 cms. More thrombus is seen further downstream in the distal SMA as well. In abdominal aorta maximum narrowing is up-to 90% in SMA nearly 100 % the entire length of IMA appears to be completely thrombosed.Urgent vascular surgery referral was sought, a diagnosis of chronic mesenteric ischaemia was made and cexane was added in the treatment. Thereafter, the patient developed severe pain on 1st September followed by breathlessness, abdominal distension and fall in blood pressure. The patient was shifted to ICU and started on inotropes. It is further submitted that the patient was wheeled to ICU as per the protocols of the hospital and did not walk to the ICU, as alleged by the complainant. In view of clinical and radiological suspicion of mesenteric ischaemia with bowel gangrene, the patient was taken for urgent laparotomy. Intra-operatively gangrene present involving 5 cm from dj up-to hepatic flexure. Arterial pulsation absent in mesentry. In view of very poor condition of the patient, it was decided in consultation with the vascular surgeon (on table) not to proceed any further and laparostomy was done. Post operatively, the patient was shifted to ICU and was taken for re exploration on 2nd September after taking informed consent. Intra operative findings were: intestinal gangrene from 4th part of duodenum up-to hepatic flexure of colon. Resection of intestine from 4th part of duodenum upto hepatic flexure of colonanastomosis of proximal intestine with distal end of intestine and resection from dj flexure to mid transverse colon with duodeno (3rd part of duodenunm) colic (transverse) anastomosis was done. In post operative period patient continued to be on mechanical ventilation. Vitals were stabilized, abdomen was soft, wound site did not show any soakage and Total parentral nutrition was given. In view of Acute Kidney Injury, the patient was started on dialysis. In view of bronchospasm, refractory hypoxaemia and peripheral cyanosis, Pulmonology referral was sought on 6th September. There was bleeding from tracheal site and Air entry was reduced. FFP and platelets were transfused. Bronchoscopy was hold in view of high risk of bleeding during the procedure. The patient continued to be on conservative management and CRRT with poor urine output. The family was briefed everyday about the poor prognosis. From 9th September onwards, the patient's attendants were not interested in any further dialytic intervention and were out of reach when called (same has been documented in progress notes) and there were continuous negative consent for any further intervention on 10th September (documented in progress notes of 10.09.2017). The patient was treated under the care of general surgery team, critical care team, vascular surgery team and team of multi disciplinary doctors. The patient developed hyperkalemia with acidosis while being on ventilator, with triple inotropic support for low blood pressure, antibiotics, intravenous fluid and other supportive care. Need for urgent CRRT and risk of death was explained to the attendant (Mr. Jatin- Brother In law) but he bluntly refused to carry this out. It is submitted that the family was briefed daily about the poor prognosis of the patient (documented in family meeting records). Inspite the negative consent from the family, the doctors took a call for a life saving CRRT and planned the procedure. Before CRRT was carried out, the patient developed arrhythmias, for which, cardioversion done twice on 11th September. The patient had ventricular tachycardia at 10.45 p.m. followed by CPCR done as per ACLS protocol but the patient could not be resuscitated and expired on 11th September 2017 at 11:27 p.m. It is submitted that at no point of time, the treatment or care was delayed or halted for financial reasons. All protocols were followed irrespective of the finances. It is also pertinent to mention that the total bill raised towards the medical treatment of the patient was Rs. 15,34,198/- out of which only Rs. 9,66,362/- was paid and the rest of the amount is still unpaid. It is submitted that hospital and its doctors continued to give best possible medical treatment care and inspite of the best efforts of the hospital and its doctors, the patient could not be saved. The treatment administered to the patient while admission during their hospital was in line with set medical practice in India or globally under the facts and circumstances and conditions of the patients, there is no question of negligence attributed to the hospital and treating team of doctors of whatsoever nature. In view of above submissions, they outrightly deny all allegations of medical negligence and wrong doing in toto, further no action lies against the hospital or its doctors, the present complaint is devoid of merit and should be dismissed.

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

1. The patient Shri Anand Sharma, 44 years old male was admitted in Max Hospital, Patparganj, Delhi on 29th August, 2017 at about 10:57 a.m. with history of pain abdomen. CECT abdomen was done and it showed thrombi of various sizes at different sites in abdominal aorta. Conservative management was started but the patient developed severe pain abdomen, breathlessness and exploratory laparotomy was done on 01st September, 2017 which showed gangrene extending from duodenal-jejunum to hepatic flexure, absent arterial pulsation of mesentery and two litres of haemorrhagic fluid. As the patient was in poor condition, laparostomy was done. On 02nd September, 2017 re-exploratory laparotomy was done with resection from DJ flexure to mid transverse colon with duodeno-transverse colon anastomosis and B/L abdominal drain placement. Post operatively, the patient was put on dialysis. The patient expired on 11th September, 2017 at 11:27 p.m.

The cause of death as per post mortem report No.1503/17 of Department of Forensic Medicine, UCMS and Guru Teg Bahadur Hospital, was multiple organ failure due to septicaemic shock as a result of peritonitis.

1. It is noted, as per the records of the patient that the CECT done on 31st August, 2017 revealed findings suggestive of extensive thrombosis in abdominal aorta and the superior mesenteric artery leading to mesenteric ischemia. A considered decision was taken by a team of doctors including a vascular surgeon to do exploratory laparotomy on the 01st September, 2017. On exploration, extensive bowel gangrene was found and options available to the surgeon at that moment were either to resect the whole gangrenous bowel or to abandon the procedure and stabilize the physiology of the patient in the ICU with re-exploration and resection within 48 to 72 hours of initial exploration.

Such case of acute mesenteric ischemia are rare and complex and can require repeated surgeries due to development of further gangrenous bowel segments due to propagation of the existing arterial thrombus. The decision of whether to go for extensive bowel resection in first laparotomy depends largely on the clinical condition of the patient. If the patient is unstable, a decision for stabilizing the patient in ICU after doing a temporary closure of abdomen(laparostomy) can be taken. All protocols in the management of such complex and rare surgical condition were by and large adhered to.

3) It is noted that as per record, the consent for surgical procedures were taken. Further, from time to time, the prognosis of the patient was also briefed to the family member.

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 the doctors of Max Super Specialty Hospital, 108A, Indraprastha Extension, Patparganj, New Delhi-110092, in the treatment administered to complainant’s husband Shri Anand Sharma

Complaint stands disposed.

Sd/: Sd/:

(Dr. Maneesh Singhal) (Dr. Anil Kumar Yadav)

Chairman, Eminent Publicman

Disciplinary Committee Member,

Disciplinary Committee

Sd/: Sd/:

(Dr. Satish Tyagi) (Dr. Amit Gupta)

Delhi Medical Association, Expert Member

Member, Disciplinary Committee

Disciplinary Committee

The Order of the Disciplinary Committee dated 08th April, 2022 was confirmed by the Delhi Medical Council in its meeting held on 29th April, 2022.

By the Order & in the name of

Delhi Medical Council

(Dr. Girish Tyagi)

Secretary

Copy to :-

1. Smt. Shalini Sharma, r/o- 9/2491, Street No.1, 18A, Kialash Nagar, New Delhi-110031.
2. Medical Superintendent, Max Super Specialty Hospital, 108 A, Indraprastha Extension, Patparganj, New Delhi-110092.

(Dr. Girish Tyagi)

Secretary