DMC/DC/F.14/Comp.2333/2/2022/ 19th September, 2022

**O R D E R**

The Delhi Medical Council through its Disciplinary Committee examined a complaint of Smt. Sushila Devi, r/o- 237, Defence Colony Hisar, forwarded by the Directorate General of Health Services, Govt. of NCT of Delhi, alleging medical negligence and professional misconduct on the part of doctors of Max Super Specialty Hospital, FC-50, C&D Block, Shalimar Bagh, New Delhi-110088, in the treatment of complainant’s son Shri Krishi, resulting in his death on 29.04.2017.

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. Sushila Devi, r/o- 237, Defence Colony Hisar (referred hereinafter as the complainant), forwarded by the Directorate General of Health Services, Govt. of NCT of Delhi, alleging medical negligence and professional misconduct on the part of doctors of Max Super Specialty Hospital, FC-50, C&D Block, Shalimar Bagh, New Delhi-110088 (referred hereinafter as the said Hospital), in the treatment of complainant’s son Shri Krishi (referred hereinafter as the patient), resulting in his death on 29.04.2017.

The Disciplinary Committee perused the complaint, written statement of Medical Superintendent Max Super Specialty Hospital, joint written submissions of Dr. Sonal Gupta and Dr. Archana Bajaj, Medical Superintendent, Max Super Specialty Hospital, additional written statement of Dr. Archana Bajaj, Medical Superintendent, Max Super Speciality Hospital, copy of medical records of Max Super Specialty Hospital Post Mortem report No. 586/2017 dated 29.04.2017 and other documents on record.

The following were heard in person :-

1) Smt. Sushila Devi Complainant

2) Shri Jagvender Singh Husband of the complainant

3) Lt. Col. Mahipal Lather Son-in-law of the complainant

4) Dr. Sonal Gupta Director Neurosurgery, Max Super Specialty Hospital

5) Dr. Puneet Sharma Head Anaesthesia, Max Super Specialty Hospital

6) Dr. Rajeev Malhotra Assistant Director Radiology, Max Super Specialty Hospital

7) Dr. Davender Kumar Agrawal Consultant Cardiology, Max Super Specialty Hospital

8) Shri Shivam Thapliyal Assistant Manager, Max Super Specialty Hospital

9) Dr. Archana Bajaj Medical Superintendent, Max Super Specialty Hospital

10) Dr. Neeraj Kumar Garg Senior Medical Officer, Deen Dayal Upadhyay Hospital

At the outset, were are pained to note the deplorable conduct of Lt. Col. Mahipal Lather, son-in-law of the complainant who accompanied the complainant and was permitted to attend the Disciplinary Committee hearing, today. Lt. Col. Mahipal Lather not only created a ruckus, when asked by the staff of the Delhi Medical Council to mark his attendance, but also continued with his outbursts, before the members of the Disciplinary Committee. On repeated requests by the members of the Disciplinary Committee to exercise restraint and discipline and adhere to the Disciplinary Committee protocol/procedures, Lt. Col. Mahipal Lather refused to heed to the advice and continued with his tirade, casting aspersions on the members of the Disciplinary Committee. His unruly behaviour was disruptive, highly objectionable and unbecoming of person who claims to be part of the Armed Forces. We understand the emotional aspects associated with cases in which one has lost his loved one, but the recalcitrant attitude which Lt. Col. Mahipal Lather exhibited was contemptuous of a Committee exercising powers of Civil Court in terms of the provisions of the Delhi Medical Council Act, 1997 and Rules made thereunder. The Disciplinary Committee directed that the conduct of Lt. Col. Mahipal Lather be censured.

It is noted that as per the complaint, it is alleged that the complainant’s(Smt. Sushila Devi) son Shri Krishi (the patient) suffered an accidental fall from third floor. The patient was admitted in Max Hospital Shalimar Bagh on 28th April, 2017 at 7.21 a.m. in the morning. After the CT scan and MRI, the surgery of spine was advised and the same was done around 2.30 p.m. on 28th April, 2017. It was informed that the surgery was successful but the patient required ventilator support in ICU. On seeing the patient’s condition, it was apparent that he was not alive, yet the doctors kept on giving false assurances about his condition and even were hesitant to share the investigation reports with the attendants. In the night, it was informed that his heart and kidney were not working. They were sure that he was dead and suggested organ donation, but the doctors kept on giving false assurance just to make money. Around 2.30 a.m., the patient was declared dead. The body was subjected to the post-mortem. The post-mortem revealed the cause of death as head injury, for which, no treatment was given at Max Hospital. Further, the CT scan of head done at Max Hospital had suggested mild injury to the head, of which, no cognizance was taken. The post-mortem also reported the heart and kidneys to be normal, whereas, Max Hospital has given heart failure as reason for the cause of death. In view of the above, it is requested that strict action be taken against the doctors of the Max Hospital for their acts of medical negligence.

Shri Jagvender Singh, Husband of the complainant stated that his son Shri Krishi (the patient) suffered an accidental fall from third floor. The patient was admitted in Max Hospital Shalimar Bagh on 28th April, 2017 at 7.21 a.m. in the morning. After the CT scan and MRI, the surgery of spine was advised and the same was done around 2.30 p.m. on 28th April, 2017. It was informed that the surgery was successful but the patient required ventilator support in ICU. On seeing the patient’s condition, it was apparent that he was not alive, yet the doctors kept on giving false assurances about his condition and even were hesitant to share the investigation reports with the attendants. In the night, it was informed that his heart and kidney were not working. They were sure that he was dead and suggested organ donation, but the doctors kept on giving false assurance just to make money. Around 2.30 a.m., the patient was declared dead. The body was subjected to the post-mortem. The post-mortem revealed the cause of death as head injury, for which, no treatment was given at Max Hospital. Further, the CT scan of head done at Max Hospital had suggested mild injury to the head, of which, no cognizance was taken. The post-mortem also reported the heart and kidneys to be normal, whereas, Max Hospital has given heart failure as reason for the cause of death. In view of the above, it is requested that strict action be taken against the doctors of the Max Hospital for their acts of medical negligence.

Lt. Col. Mahipal Lather stated that the attendants were not explained about the surgical procedure nor the complication associated with such a procedure, thus, the consent taken was not Informed Consent. They were also not provided the CT and MRI films conducted at Max Hospital. He further alleged that even though, the post-mortem findings were suggestive of hematoma and fracture in the head, the doctors of Max Hospital did not take cognizance of these injuries and remained focused on spinal injuries only. As a result, no treatment was provided for the brain injury, which was the cause of the death of the patient. This shows that the doctors acted negligently and, thus, strict action be taken against them.

Dr. Sonal Gupta, Director Neurosurgery, Max Super Specialty Hospital stated that the patient Shri Krishi, 24 years male, obese was brought to the triage of the hospital on 28th April, 2017 on complaints of a fall from the fourth floor of his flat, followed by loss of consciousness for 5-10 minutes and not able to move both limbs. The patient was initially admitted with DDU Hospital, Delhi where he was catheterized and was referred to the hospital for further management. On examination, it was found that the patient has sutured wound of 10 cm over left parieto occipital area, no pallor, icterus, cyanosis, tongue moist pallor (no pallor or icterus), icterus and also abrasion of 10 x 10 cm over thoracic area, tenderness + in thoracolumbar area. The patient was in GCS 15, fully conscious and alert with suture parieto occipital CLW with abrasion on the lower dorsal back region with flaccid paraplegia. In view of the history of LOC and CLW on the scalp and history of fall from 4th floor, CT scan head was done, which revealed no parenchymal injury or extra axial hematoma, with linear parieto occipital fracture. MRI spine showed D12 subluxated fracture dislocation with severe cord compression with thin cord tissue still in continuity with L4 fracture with no compression. USG abdomen and x-ray chest were also done. Upon reviewing the x-ray, no obvious bony injury was seen, x-ray RT Femur showed united # Shaft Femur Rt. Side Implant I/L Nail in SITU. No urgent active Ortho. intervention was required. The pre anaesthetic check-up was normal and the patient was planned for the surgery. The patient was taken-up for urgent decompression with fixation for D12 fracture, in view of unstable spine with no major component of injury elsewhere in the body and the patient being hemodynamically stable. The family was informed about the procedure and informed the following risks; 10% chances of improvement in paraplegia and sphincter disturbances. Implant failure, infection and hematoma. Also, due to the high risk, as mentioned above in the procedure, a family meeting was conducted and the patient specific risks on the surgery were clearly explained to the family. The patient was conscious, obeying when wheeled into the OT, general anaesthesia was administered in the presence of two anaesthesia consultants and standard monitoring. After an uneventful induction of general anaesthesia, the patient was turned prone for the surgical procedure and the surgery was started. The patient maintained normal vital haemodynamic parameters for around forty five minutes after the start of the surgery. Sudden fall in end tidal carbon dioxide concentration and ventricular tachycardia was noted. Immediately, ventilation and ventilator connections were checked. 100% oxygen was administered. Peripheral pulses were not palpable. The surgery was stopped. Sterile packs were inserted in the surgical wound and the patient was made supine and on shifting trolley. In the meantime, further help from cardiologist, senior consultant and the anaesthetist was called in to the operating room. Due to the cardiac episode in the OT, further decompression and fixation was deferred. The patient’s relatives were briefed about the patient’s condition and the treatment plans. Subsequently, the patient was shifted to ICU. The patient was put on ventilator support in ICU after administering muscle relaxants. The chest x-ray in ICU suggested pulmonary edoema. Oxygen haemoglobin saturation (SPO2) decreased to 85-89% despite using different strategies of ventilation. The patient developed severe metabolic acidosis, hypotension and decreased urine output despite all efforts. The patient was managed in SICU with elective ventilation with 100 FiO2 and PEEP and full inotrope support but O2 saturation was constantly low, inspite of all active measures. The patient was put on ventilator support at the ICU after administering muscle relaxants. The chest x-ray in ICU suggested pulmonary edema. Oxygen haemoglobin saturation (SPO2) decreased to 85-89% despite using different strategies of ventilation. The patient developed severe metabolic acidosis, hypotension and decreased urine output. The patient had persistent acidosis, hypoxia and hypotension despite best measures and resuscitation. The patient had asystole at 2:05 a.m., CPCR was started as per ACLC protocol; despite of all efforts, the patient could be not be revived and declared dead at 2:35 a.m. It is submitted that the cause of death of the patient was due to cardio-respiratory failure due to pulmonary edema. The patient’s family was explained in detail about the condition of the patient and also the risks involved in the surgery. It is further submitted that as requested by the family, the hospital immediately took steps to raise an MLC form which was done outside the hospital.

She further submitted in response to the post-mortem report findings that she has perused the post-mortem report dated 29th April, 2017 wherein the cause of death is mentioned as ‘the cause of death is due to cario cerebral injury (head injury) as result of forceful impact upon head subsequent to fall from height (3rd Floor) injuries are ante mortem in nature and of same duration’. Further, the post-mortem report states about the internal examination of brain, meninges and vessels as, ‘massive subdural hematoma present on the left parietal region, occipital rgion and vertex lobes of brain with heamorrhagie and contusion on the left parietal and occipital lobs of cerebrum with generalized brain oedema’. It is stated that the patient presented to the triage at around 07.30 a.m. with history of injury the previous night. The patient was conscious and alert at the time of arrival in the triage. In view of sutured wound of 10 cm over left parieto occipital area and alleged history of fall from the third floor, CT scan head was done, inspiteof GCS 15 (8-9 hrs. after the injury). The CT scan revealed right occipitomastoid fracture (Assc. to PM report ‘left hight parietal fracture’) extending to petrous temporal with blood in the right mastoid air cells and middle ear cavity with no intra-parenchymal brain injury (no contusions/haemorrhage’s in the brain parenchyma) or extra-axial hematoma. The treating doctor followed the trauma protocol on arrival of the patient in the triage. The patient was fully conscious, alert and obeying when he was wheeled in the OT for emergency spine surgery (for severe cord compression with unstable spine), so there was no clinical suspicion of evolving intracranial hematoma/edema/contusion. Further, after administering general anaesthesia, the patient was positioned prone for spine decompression and fixation. As spine decompression was in progress, the patient suddenly developed cardiac arrest arrhythmia in the form ventricular tachycardia. In view of sudden cardiac event, the patient was immediately turned supine on the trolley without even suturing the spine wound. The patient was seen by the cardiologist in the OT and managed in the OT during the episode of ventricular tachycardia and cardiac arrest, wherein ECG and ECHO were suggestive of coronary event. So following the right protocol of management, the patient was first revived from the episode of cardiac arrest and cardiac arrhythimia and then the patient was shifted for CAG after detailed counselling to the family- father and one more adult attendant-in the recovery area of the OT complex. The team of the doctors can manage the patient as per the clinical picture. In this case, there was nothing in the clinical picture to suggest SDH. So, the patient was managed for acute spine injury and then cardiac event which finally lead to acute pulmonary edema from which the patient could not be revived and succumbed to death in spite of aggressive critical care management in the ICU. It is submitted that the treating doctor has followed the trauma protocol and a CT scan of head was done wherein no subdural haematoma was suggested on the left parietal region, occipital region and vertex lobes. Further, the CT scan was not suggestive of any contusion also. It is pertinent to mention here that the GCS score of the patient was 15 at that time before going to OT and the patient was not showing any clinical or physical symptoms to suggest any subsequent development of subdural haematoma or contusion. The patient was hemodynamicaly stable since his admission to triage till the cardiac event happened during the spine surgery. Since the patient has a GCS score of 15 and was hemodynamicaly stable; there was no suspicion of any subsequent brain event to suggest to the clinician for a repeat CT. It is stated that, as per detailed review of the medical literature, routine repeat head CT is indicated for patients with deterioration in GCS. Further, it is also established medical study that all patient that required neurosurgical intervention were identified by clinical changes rather than via repeat imaging. Further the study suggests that in vast majority of cases, clinical monitoring alone is safe and sufficient in patient in order to avoid exposure to repeat radiographic imaging. If there would have been a gradual development of SDH between morning CT scan and induction of GA, the patient would have shown signs of neurological deterioration or features of raised increased intracranial pressure (ICP), which includes headache, nausea, vomiting, increased blood pressure, decreased mental abilities, double vision etc. however in this case the patient never showed any of these symptoms. Thus, there was nothing clinically or physically present for the treating doctor to suspect any subsequent bran event post the morning CTS scan. It is pertinent to note that acute subdural hematoma rarely causes cardiac rhythm abnormalities-particularly ventricular tachycardia, as in this case which lead to an episode of cardiac arrest in the OT. But none the less any polytrauma can produce stress induced arrythmias or cardiac changes. In view of the above, it is submitted that the subdural haematoma, as found in the post mortem report, can be subsequent brain event happened post the morning CT scan, for which the patient had never shown any signs or symptoms of any deterioration or raised ICP between the morning CT scan and administration of GA. Further, the cause of death, as mentioned in the Death Summary was due to cardio respiratory failure due to pulmonary edema. It is however, known that pulmonary edema can also be neurogenic and is a clinical syndrome characterized by the acute onset of pulmonary edema following a significant central nervous system insult. In the present case, there were no symptoms or signs present between morning CT scan and GA which could have suggest onset of neurogenic pulmonary edema.

Dr. Puneet Sharma, Head Anaesthesia, Max Super Specialty Hospital stated that during the surgery, sudden fall in end tidal carbon dioxide concentration and ventricular tachycardia was noted. Immediately, ventilation and ventilator connections were checked. 100% oxygen was administered. Peripheral pulses were not palpable. The surgery was stopped. Sterile packs were inserted in the surgical wound and the patient was made supine and on shifting trolley. Cardiopulmonary resuscitation was administered. Defibrillator shocks were administered. Arterial and central venous lines were established without compromising the resuscitation protocols. Arterial blood gas samplings revealed severe metabolic acidosis. Sodium bicarbonate and amiodarone infusion were started. Normal sinus rhythm cardiac activity at 110/min. was noted. Oxygen haemoglobin saturation improved to 89% but there were significant ECG ST segment changes. The blood-pressure improved to 130/90 mmHg. Echocardiography done by the cardiologist, revealed severe global hypokinesia of cardiac chambers. Injection morphine and injection Lasix was administered. Insulin was started as blood sugar was found to be high. Coronary angiography was advised by the cardiologist on urgent basis. Wound was closed in lateral position. Echo in the OT showed Global LV hypokinesia, more marked in LAD territory. 12 lead ECG-ST elevation in anterior and lateral leads with reciprocal changes imp-acute ST elevation MI. Once patient was hemodynamically stable on inotropes and ventilator, the patient was turned lateral and single layer suturing of the wound was done.

Dr. Davender Kumar Agrawal, Consultant Cardiology, Max Super Specialty Hospital stated that Echo in the OT showed Global LV hypokinesia, more marked in LAD territory. 12 lead ECG-ST elevation in anterior and lateral leads with reciprocal changes imp-acute ST elevation MI. Due to the cardiac episode in the OT, further decompression and fixation was deferred. The patient was shifted for angiography which revealed recanalized LAD territory. The patient maintained blood-pressures and oxygen haemoglobin saturation during the angiography procedure with high ionotropic support and 100% oxygen.

Dr. Neeraj Kumar Garg, Senior Medical Officer, Deen Dayal Upadhyay Hospital who had prepared the post-mortem report No.586/2017 dated 29.04.2017 of late Shri Krishi, on enquiry from the Disciplinary Committee as to explain his terminology ‘massive haematoma, as is reflected in his finding relating to ‘brain, meninges and vessels viz. massive subdural haematoma present on the left parietal region, occipital region and vertex lobes of brain with haemorrhagic contusion on the left parietal and occipital lobes of cerebrum with generalized brain oedema’; stated that whilst observing on the condition of the brain during post-mortem, the specific size or dimensions of any subdural haematoma which has been noted, is not mentioned, as the same is not required as per the Standard Protocol of the post-mortem examination. The term ‘massive subdural’ haematoma implies that it covered the parietal occipital lobes of the brain, i.e. traverses from one lobe of the brain to other.

The Medical Superintendent, Max Super Speciality Hospital in it’s written statement averred that the patient Shri Krishi, 24 years male, obese was brought to the triage of the hospital on 28th April, 2017 on complaints of a fall from the fourth floor of his flat, followed by loss of consciousness for 5-10 minutes and not able to move both limbs. The patient was initially admitted with DDU Hospital, Delhi where he was catheterized and was referred to the hospital for further management. On examination, it was found that the patient has sutured wound of 10 cm over left parieto occipital area, no pallor, icterus, cyanosis, tongue moist pallor (no pallor or icterus), icterus and also abrasion of 10 x 10 cm over thoracic area, tenderness + in thoracolumbar area. The patient was in GCS 15, fully conscious and alert with suture parieto occipital CLW with abrasion on the lower dorsal back region with flaccid paraplegia. In view of the history of LOC and CLW on the scalp and history of fall from 4th floor, CT scan head was done, which revealed no parenchymal injury or extra axial hematoma, with linear parieto occipital fracture. MRI spine showed D12 subluxated fracture dislocation with severe cord compression with thin cord tissue still in continuity with L4 fracture with no compression. USG abdomen and x-ray chest were also done. Upon reviewing the x-ray, no obvious bony injury was seen, x-ray RT Femur showed united # Shaft Femur Rt. Side Implant I/L Nail in SITU. No urgent active Ortho. intervention was required. The pre anaesthetic check-up was normal and the patient was planned for the surgery. The patient was taken-up for urgent decompression with fixation for D12 fracture, in view of unstable spine with no major component of injury elsewhere in the body and the patient being hemodynamically stable. The family was informed about the procedure and informed the following risks; 10% chances of improvement in paraplegia and sphincter disturbances. Implant failure, infection and hematoma. Also, due to the high risk, as mentioned above in the procedure, a family meeting was conducted and the patient specific risks on the surgery were clearly explained to the family. The patient was conscious, obeying when wheeled into the OT, general anaesthesia was administered in the presence of two anaesthesia consultants and standard monitoring. After an uneventful induction of general anaesthesia, the patient was turned prone for the surgical procedure and the surgery was started. The patient maintained normal vital haemodynamic parameters for around forty five minutes after the start of the surgery. Sudden fall in end tidal carbon dioxide concentration and ventricular tachycardia was noted. Immediately, ventilation and ventilator connections were checked. 100% oxygen was administered. Peripheral pulses were not palpable. The surgery was stopped. Sterile packs were inserted in the surgical wound and the patient was made supine and on shifting trolley. In the meantime, further help from cardiologist, senior consultant and the anaesthetist was called in to the operating room. Cardiopulmonary resuscitation was administered. Defibrillator shocks were administered. Arterial and central venous lines were established without compromising the resuscitation protocols. Arterial blood gas samplings revealed severe metabolic acidosis. Sodium bicarbonate and amiodarone infusion were started. Normal sinus rhythm cardiac activity at 110/min. was noted. Oxygen haemoglobin saturation improved to 89% but there were significant ECG ST segment changes. The blood-pressure improved to 130/90 mmHg. Echocardiography done by the cardiologist, revealed severe global hypokinesia of cardiac chambers. Injection morphine and injection Lasix was administered. Insulin was started as blood sugar was found to be high. Coronary angiography was advised by the cardiologist on urgent basis. Wound was closed in lateral position. Echo in the OT showed Global LV hypokinesia, more marked in LAD territory. 12 lead ECG-ST elevation in anterior and lateral leads with reciprocal changes imp-acute ST elevation MI. Once patient was hemodynamically stable on inotropes and ventilator, the patient was turned lateral and single layer suturing of the wound was done. Due to the cardiac episode in the OT, further decompression and fixation was deferred. The patient’s relatives were briefed about the patient’s condition and the treatment plans. The patient was shifted for angiography which revealed recanalized LAD territory. The patient maintained blood-pressures and oxygen haemoglobin saturation during the angiography procedure with high ionotropic support and 100% oxygen. Plan to shift the patient to intensive care unit for stabilisation was made and the patient was transferred to the ICU. The patient was put on ventilator support in ICU after administering muscle relaxants. The chest x-ray in ICU suggested pulmonary edoema. Oxygen haemoglobin saturation (SPO2) decreased to 85-89% despite using different strategies of ventilation. The patient developed severe metabolic acidosis, hypotension and decreased urine output despite all efforts. The patient was managed in SICU with elective ventilation with 100 FiO2 and PEEP and full inotrope support but O2 saturation was constantly low, inspite of all active measures. The patient was put on ventilator support at the ICU after administering muscle relaxants. The chest x-ray in ICU suggested pulmonary edema. Oxygen haemoglobin saturation (SPO2) decreased to 85-89% despite using different strategies of ventilation. The patient developed severe metabolic acidosis, hypotension and decreased urine output. The patient had persistent acidosis, hypoxia and hypotension despite best measures and resuscitation. The patient had asystole at 2:05 a.m., CPCR started as per ACLC protocol; despite of all efforts, the patient could be not be revived and declared dead at 2:35 a.m. It is submitted that the cause of death of the patient was due to cardio-respiratory failure due to pulmonary edema. The patient’s family was explained in detail about the condition of the patient and also the risks involved in the surgery. It is further submitted that as requested by the family, the hospital immediately took steps to raise an MLC form which was done outside the hospital.

It is further noted that Dr. Archana Bajaj, Medical Superintendent in her additional written statement has averred that that they have perused the postmortem report no. 586 of 2017 dated 29th April 2017, wherein the cause of death is mentioned as “the cause of death is due to carnio cerebral injury (head injury) as a result of forceful impact upon head subsequent to fall from height (3rd floor) injuries are ante mortem in nature and of same duration”. Further, the post-mortem report states about the internal examination of brain, Meninges and vessels as, “massive subdural haematoma present on the left parietal region, occipital region and vertex lobes of brain with harmorrhagie and contusion on the left parietal and occipital lobs of cerebrum with generalized brain oedema”. The patient presented to the triage at around 7:30 a.m. with history of injury the previous night. The patient was conscious and alert at the time of arrival in the triage. In view of sutured wound on the high parietal region and alleged history of fall from the third floor, CT scan head was done inspite of GCS 15 (8-9 after the injury). The CT scan revealed fracture line and no intra parenchymal brain injury (no contusions/hemorrhage’s in the brain parenchyma) or extra-axial hematoma. The treating doctor followed the trauma protocol on arrival of the patient in the triage. The patient was fully conscious, alert and obeying when he was wheeled in the OT for spine surgery, so there was no clinical suspicion of evolving intracranial hematoma/edema/contusion. As mentioned in their earlier response after administrating general anesthesia, the patient was positioned prone for spine decompression and fixation. As spine decompression was in progress, the patient suddenly developed cardiac arrhythmia in the form ventricular tachycardia. In view of sudden cardiac event, the patient was immediately turned supine on the trolley without even suturing the spine wound. The patient was seen by the cardiologist in the OT and managed in the OT during the episode of ventricular tachycardia and cardiac arrest, where in ECG and ECHO were suggestive of coronary event. So following the right protocol of management, the patient was first revived from the episode of cardiac arrest and cardiac arrhythmia and then the patient was shifted for CAG after detailed counseling to the family father and one more adult attendant in the recovery area of the OT complex. The team of the doctors could manage the patient as per the clinical picture. In this case there was nothing in the clinical picture to suggest SDH. So, the patient was managed for acute spine injury and then cardiac event, which finally led to acute pulmonary edema from which the patient could not be revived and succumbed to death inspite of aggressive critical care management in the ICU. The detail of the treatment given and procedure followed by the cardiologist was mentioned in their earlier response and has not been repeated for the sake of brevity. It is submitted that the treating doctor has followed the trauma protocol and a CT scan of head was done wherein no subdural heamatoma was suggested on the left parietal region, occipital region and vertex lobes. Further, the CT scan was not suggestive of any contusion also. It is pertinent to mention here that the GCS score of the patient was 15 at that time before going to OT and the patient was not showing any clinical or physical symptoms to suggest any subsequent development of subdural heamatoma or contusion. The patient was hemodynamicaly stable since his admission to triage till the cardiac event happened during the spine surgery. Since the patient has a GCS score of 15 and was hemodynamically stable, there was no suspicion of any subsequent brain event to suggest to the clinician for a repeat CT. It is stated that as per the detailed review of the medical literature, routine repeat head CT is indicated for the patients with deterioration in GCS. Further, it is also established in the medical study that all patient that required neurosurgical intervention were identified by the clinical changes rather than via repeat imaging. Further, the study suggests that in vast majority of the cases, clinical monitoring alone is safe and sufficient in the patient in order to avoid exposure to repeat radiographic imaging. If there would have been a gradual development of SDH between morning CT scan and induction of GA, the patient would have shown signs of the neurological deterioration or features of raised increased intracranial pressure (ICP), which includes headache, nausea, vomiting, increased blood pressure, decreased mental abilities, double vision etc., however, in this case the patient never showed any of these symptoms. Thus, there was nothing clinically or physically present for the treating doctor to suspect any subsequent bran event post the morning CT scan. It is stated that acute subdural hematoma rarely causes cardiac rhythm abnormalities particularly ventricular tachycardia, as in this case which lead to an episode of cardiac arrest in the OT. Acute SDH is not reported to have cause sudden ventricular tachycardia and arrest. It is stated that the neurogenic pulmonary odema has very clear clinical features which includes the patient being highly variable, mild SOB, acute fulminating pulmonary odema (actually dyspneie, tachypheie and hypoxie with minutes), sympathetic search: fever, tachycardia and hypertensive. The study nowhere suggests of arrhythmia as a presentation, which was present in the case in hand. It is standard medical protocol that the patient at risk of Traumatic Brain Injury (TBI), are identified clinically at the time of initial presentation. In view of the above, it is submitted that the subdural heamatoma, as found in the post-mortem report, can be subsequent brain event happened post the morning CT scan, for which, the patient had never shown any signs or symptoms of any deterioration or raised ICP between the morning CT scan and administration of GA. Further, the cause of death, as mentioned in the death summary was due to cardio-respiratory failure due to pulmonary edema. It is, however, known that the pulmonary edema can also be neurogenic and is a clinical syndrome characterized by the acute onset of pulmonary edema, following a significant central nervous system insult. In the present case, there were no symptoms or signs present between morning CT scan and GA which may suggest of neurogenic pulmonary edema. It is submitted that the allegations made in the complaint are inappropriate and do not have any basis. The Max Super Speciality Hospital, Shalimar Bagh is a premier healthcare facility and is one of the biggest tertiary care facilities in Delhi. The doctors who were part of the treating team are well known in their respective fields and have consecrated their lives to humanity. The health of the patients to whom the treatment is rendered, are of utmost importance and is of paramount consideration. In this case also, the team of the doctors as well as the hospital have performed their duties bonafide and diligently and further, advised and consulted the patient and his relatives on the risks as well as progress of the patient during his course of the treatment at the hospital from 28th April, 2017 to 29th April, 2017.

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

1. It is noted that the patient Shri Krishi, a 24 years old male, with history of fall from height (3rd floor), Janta Flats Sectpr-16 B Dwarka, was brought to the DDU Hospital in night of 27th April, 2017. He was admitted in the DDU Hospital vide MLC No.003085/17 at 11.30 p.m. Thereafter, the patient was shifted to the Max Hospital, Shalimar Bagh and admitted on 28th April, 2017 at 7.21 a.m. The patient underwent MRI spine on 28.4.2017, which revealed cord depression at D12 level and fracture at D12 and L4 level. The CT head dated 28th April, 2017 reported no significant abnormality in brain parenchyma. The patient was diagnosed as case of D12 post traumatic fracture with severe cord compression and underwent surgical procedure of D12 laminectomy with partial L 1 Laminectomy with removal of extruded D11-D12 large disc fragment, under consent on 28th April, 2017 at 5.00 p.m. The procedure was conducted by Dr. Sonal Gupta. Intra-operatively, the patient had hemodynamically unstable ventricular tachycardia which needed CPR and DC Shock. The patient was revived, cardiology consultation was taken. The ECHO showed global LV hypokinesia, more marked in LAD territory. 12 lead ECG-ST elevation in anterior and lateral leads with reciprocal changes. CAG revealed recanalized LAD. The patient was shifted to the surgical ICU on ventilator and inotropes. The patient had persistent acidosis, hypoxia and hypotension. Despite administration of resuscitative measures with fluids inotropes, soda bicarb and ventilation, the patient had asystole at 02.05 p.m. CPR was initiated but the patient could not be revived and declared dead at 2.35 a.m. (29.4.2017).

The cause of death as per Max Hospital was cardio-respiratory failure due to pulmonary edema. However, the post-mortem report no.586/2017 dated 29th April, 2017 of DDU Hospital opined the cause of death due to cranio cerebral injury (head injury) as a result of forceful impact upon head subsequent to fall from height(3rd floor). The time since death was consistent to time of hospital death as mentioned in death summary.

2) The patient had sustained head injury due to fall from height (3rd Floor) which is significant height to produce fracture and hematoma formation in brain as well as any other part of body. The patient had a stitched wound on left parieto-occipital area. At the time of admission in Max Hospital, the patient had GCS 15/15, and had no neurological deficits. A CT scan brain was done on 28th April, 2017 at 11.53 a.m. which revealed no significant abnormality in brain. A fracture of right occipital vault petro-sigmoid was noticed. The patient had fracture of spine D12, L4 vertebra, for which, a surgical intervention was planned. The consent for the surgery was taken.

 The patient while undergoing surgery developed ventricular tachycardia with fall of EtCO2. The patient’s vitals deteriorated, he became pulse-less. The surgery was stopped; resuscitations measures were initiated, incorporating the help of cardiologist and the anaesthetist. Unfortunately, the patient did not revive, despite measures.

 The post-mortem report documented massive subdural hematoma on left parieto occipital region with haemorrhagic contusion in brain parenchyma. The same was attributed as cause of death in the post-mortem.

 The fact that the patient was absolutely normal with GCS 15/15 neurologically, intact, was so taken-up for spine surgery. He developed events during the surgery for the first time, which is more likely to be cardiac-pulmonary in origin. Moreover, besides normal C.T. brain, pre-surgery ECG and USG were also normal. The post-mortem report has not categorically defined the meaning of the word used i.e. “massive subdural hematoma on left parietal region, occipital lobes of cerebrum”. There is no mention of thickness of subdural hematoma.

 Upon enquiry from the person who conduct the post-mortem, it was informed to the Disciplinary Committee that he meant massive subdural hematoma when it is present beyond one part of brain lobe and spread to other lobe as well.

 Since, subdural space is large, and continous, any subdural hematoma is likely to traverse larger area and may appear to be massive. Even a thin hematoma can transgress from one lobe to another and may appear to be as massive. It may not be of much significance to produce clinical deterioration. Pre-op CT scan showed no such hematoma, hence, it is likely that this subdural hematoma formed later on, and is not a missed hematoma (head injury).

 Delayed hematoma formation in brain after Head Injury is very well known in medical literature. Both coup and counter coup hematoma can form in cases of Head injury. It is likely that delayed hematoma occurred in this case as well, which could have formed after C.T. scan was done on 28th April, 2017. Such hematoma can expand slowly over hours due to slow ooze of blood, which was observed by the post-mortem finding. There was no clinical indication to repeat C.T. scan brain as per standard practice, as the patient was on O.T. table. The patient was managed adequately after event of ventricular tachycardia was noticed by the treating team.

The cause of deterioration of the patient due to ventricular tachycardia and fall of EtCO2 is not likely to be due to intracranial hematoma formation, which was observed by the post-mortem report.

3) It is observed that the post-mortem confirmed that the time since death was consistent to time of hospital death, as mentioned in Death Summary of Max Hospital.

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, in the treatment of complainant’s son Shri Krishi.

Complaint stands disposed.

 Sd/: Sd/: Sd/:

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

Chairman, Eminent Publicman Delhi Medical Association

Disciplinary Committee Member, Member,

 Disciplinary Committee Disciplinary Committee

Sd/:

(Dr. Daljit Singh)

Expert Member

Disciplinary Committee

The Order of the Disciplinary Committee dated 08th April, 2022 was taken up for confirmation before the Delhi Medical Council in its meeting held on 29th April, 2022 wherein “*the Council observed that since in this case, the forensic expert had not participated in the Disciplinary Committee proceedings, the Order be reverted back to the Disciplinary Committee with request to deliberate the same in consultation with a forensic expert.”*

The Order of the Disciplinary Committee dated 08th April, 2022 in complaint No.2333 was taken up for re-consideration before the Disciplinary Committee of the Delhi Medical Council in its meeting held on 29th July, 2022 in terms of the Council minutes dated 29th April, 2022.

The Order of the Disciplinary Committee dated 29th July, 2022 is reproduced herein-below-:

The Order of the Disciplinary Committee of the Delhi Medical Council dated 08th April, 2022 in complaint No.2333 of Smt. Sushila Devi, r/o- 237, Defence Colony Hisar, forwarded by the Directorate General of Health Services, Govt. of NCT. of Delhi, alleging medical negligence and professional misconduct on the part of doctors of Max Super Specialty Hospital, FC-50, C&D Block, Shalimar Bagh, New Delhi-110088, in the treatment of complainant’s son Mr. Krishi, resulting in his death on 29.04.2017, was taken up for re-consideration in terms of the Council minutes dated 29th April, 2022 wherein the Council observed that since in this case, the forensic expert had not participated in the Disciplinary Committee proceedings, the Order be reverted back to the Disciplinary Committee with request to deliberate the same in consultation with a forensic expert.

On re-consideration, the matter was deliberated by the Disciplinary Committee in consultation with expert in Forensic and Neurosurgery. The experts concurred with the observations made in the Order dated 08th April, 2022. After detailed deliberations, the Disciplinary Committee reiterated and reaffirmed the Order dated 08th April, 2022.

Complaint stands disposed.

Sd/: Sd/: Sd/:

(Dr. Maneesh Singhal) (Dr. Satish Tyagi) (Dr. Daljit Singh)

Chairman, Delhi Medical Association Expert Member,

Disciplinary Committee Member, Disciplinary Committee

 Disciplinary Committee

Sd/:

(Dr. Anil Kumar Mittal)

Expert Member

Disciplinary Committee

The Orders dated 08th April, 2022 and 29th July, 2022 of the Disciplinary Committee, were placed before the Council in its meeting held on 10th August, 2022 for confirmation.

The Council after due deliberations, confirmed the Orders dated 08th April, 2022 and 29th July, 2022 of the Disciplinary Committee.

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

 By the Order & in the name of

 Delhi Medical Council

 (Dr. Girish Tyagi)

 Secretary

Copy to :-

1. Smt. Sushila Devi, r/o- 237, Defence Colony Hisar, Haryana.
2. Dr. Sonal Gupta, Through Medical Superintendent, Max Super Specialty Hospital, FC-50, C&D Block, Shalimar Bagh, New Delhi-110088.
3. Medical Superintendent, Max Super Specialty Hospital, FC-50, C&D Block, Shalimar Bagh, New Delhi-110088.
4. Medical Superintendent, Nursing Home Cell, Directorate General of Health Services, Govt. of NCT of Delhi (Nursing Home Cell), F-17, Karkardooma, Delhi-110032-w.r.t. letter No.F.23/NH/Compt./DGHS/HQ/NH/2017/238909-11 dated 10.01.2018-**for information**.

 (Dr. Girish Tyagi)

 Secretary