DMC/DC/F.14/Comp.2359/2/2022/ 23rd March, 2022

**O R D E R**

The Delhi Medical Council through its Disciplinary Committee examined a representation from Police Station, Pandav Nagar, seeking medical opinion in respect of death of Smt. Meenu allegedly due to medical negligence in the treatment administered to late Meenu at Jeevan Anmol Hospital, Mayur Vihar Phase-1, Opp. Pratap Nagar, Delhi-110091, resulting in her death on 14.01.2018.

The Order of the Disciplinary Committee dated 18th February, 2022 is reproduced herein-below:-

The Disciplinary Committee of the Delhi Medical Council examined a representation from Police Station, Pandav Nagar, seeking medical opinion in respect of death of Smt. Meenu allegedly due to medical negligence in the treatment administered to late Meenu (referred hereinafter as the patient) at Jeevan Anmol Hospital, Mayur Vihar Phase-1, Opp. Pratap Nagar, Delhi-110091(referred hereinafter as the said Hospital), resulting in her death on 14.01.2018.

The Disciplinary Committee perused the representation from police, written statement of Dr. Neera Sondhi, Medical Superintendent of Jeewan Anmol Hospital enclosing therewith written statement of Dr. Ajay Goyal, Consultant Surgeon, copy of medical records of Jeewan Anmol Hospital, Post Mortem report no. 81/18 and other documents on record.

The following were heard :-

1. Shri Ajay Kumar Complainant
2. Dr. Ajay Goyal Consultant Surgeon, Jeevan Anmol Hospital

The Disciplinary Committee noted that the complainant Shri Ajay Kumar presented before the Disciplinary Committee in person.

The Disciplinary Committee further noted that the Medical Superintendent, Jeevan Anmol Hospital failed to join the Disciplinary Committee’s proceedings, inspite of notice.

It is noted that as per the police representation, it is stated that a PCR call vide DD No. 39A was received at PS-Pandav Nagar, Delhi regarding the death of a lady at Jeevan Anmol Hospital, Mayur Vihar-I, Delhi on 14.1.2018. During the spot enquiry,it was found that Smt. Meenu w/o Shri Ajay Kumar aged 33 years, was admitted in Jeevan Anmol Hospital on 12.1.2017 for surgery of stone in Gall Bladder. The patient was discharged from the hospital on 14.1.2018 in afternoon, after surgery. The relatives of the patient took her to their resident. In late night of 14.1.2018, the condition of the patient Meenu became critical and her relative again took her to Jeevan Anmol Hospital, where the patient Meenu was declared brought dead by the doctors vide MLC no. 785 dated 14.1.2018. The post mortem of the deceased was conducted by Medical Board, Department of Forensic Medicine, UCMS & GTB Hospital, Delhi vide PM No. 81/18. The cause of death was given by the doctors of the said board as “Shock due to biliary Peritonitis produced as a result of leakage of bile from right hepatic duct”. The relatives of the deceased raised a doubt that the death of the deceased Meenu was caused due to negligence of doctors of Jeevan Anmol Hospital, Delhi. Therefore, it is requested to Delhi Medical Council to provide the opinion whether the death of deceased Meenu is a case of medical negligence on the part of doctors of Jeevan Anmol Hospital or not.

The complainant Shri Ajay Kumar stated his wife Smt. Meenu was admitted in Jeevan Anmol Hospital on 12th January, 2018 for surgery of stone in gall-bladder. On the next day i.e. 13th January, 2018, she complained of pain in the abdomen and also suffered from fever. On 14th January, 2018, she was discharged from the hospital in the afternoon, even though, she had pain and fever. At home, his wife had many bouts of vomiting. On telephonic enquiry from Dr. Ajay Goyal, it was advised that she may take the medicines which were written on the Discharge Summary. Since, his wife continued to deteriorate; she was brought back in the night to Jeevan Anmol Hospital where they pronounced her dead. He further stated that his wife died due to negligence of the doctors of Jeevan Anmol Hospital and strict action be taken against them.

Dr. Ajay Goyal, Consultant Surgeon, Jeevan Anmol Hospital in his written statement averred that Smt. Meenu w/o Shri Ajay Kumar was admitted with diagnosis of cholelithiasis on 12.1.2018 for laparoscopic cholecystectomy, after necessary pre-operative investigations and PAC fitness, in the Jeevan Anmol Hospital in his care. After proper consent, the patient underwent surgery on the same date i.e. on 12.1.2018. It was a case of chronic cholecystitis with gross adhesions and thickened gall bladder wall. However, during surgery there was no complications (no bile leak, no major bleeding). Hence, drain was not placed. Hemostasis was maintained and port closure was done. During post-operative period, the patient had fever 2-3 times on next day i.e. on 13.1.2018, which was considered as post-operative fever; however, her vitals remained stable. The patient was regularly examined by him and resident doctors from time to time. The patient was kept in the Hospital till 14.1.2018 and discharged in stable condition. The patient was advised to follow up on 20.1.2018 in surgery OPD. She was also advised to come or contact casualty in case of any emergency/or any difficulty as recorded in discharge sheet. On the same day at home at night, the condition of the patient Meenu worsens and her relatives again brought her to Jeevan Anmol Hospital, where the patient was declared brought dead by the casualty doctor and MLC was made. (MLC no. 785 dated 14.1.2018). Post mortem of the deceased was conducted and to their uttermost surprise the cause of death, given by the board of doctors who conducted post-mortem is shock due to biliary peritonitis produced as a result of leakage of bile from right hepatic duct (intra hepatic) portion. The relatives of the deceased raised a doubt that the death of the deceased Meenu was caused due to negligence of doctors of Jeevan Anmol Hospital. This was really an unfortunate event and he has duly sympathize with the deceased Meenu’s relatives. No, doctor would like to lose his patient, but he as a doctor sometimes has to face that. This was really unfortunate incident and he has full sympathy, full emotions with the patient’s relatives. He is routinely performing laparoscopic cholecystectomies and other major and minor surgeries and till incident, nothing such had happened. He is sincere to his profession and his first concern is always interest, safety and quality to his patients. As stated earlier the patient underwent surgery on 12.1.2018 after proper consent, which includes complications like CBD injury, bilioma (bile collection), infection etc. Her intra operative findings were gross adhesions, thickened GB wall suggestive of chronic cholecystitis, however, surgery went well. There were no intra operative complications or difficulty. There was no biliary leak during surgery. As also found in post mortem report that 2 metallic staples present over cut end of cystic duct and 2 metallic staples present over cut end of cystic artery, which also further supports that both the vital structures were identified well and clips were placed well. As per post mortem report there was a tear in right hepatic duct (intra hepatic) portion. Right hepatic duct is not visualized during routine laparoscopic cholecystectomies and it is almost virtually impossible to reach the intra hepatic portion of right hepatic duct during dissection of gall bladder. It must be either an aberrant duct from liver bed, duct of Luschka or leak from liver bed. As these injuries usually occurs during dissection of gall bladder from liver bed, or while maintaining hemostsis with electroacutery. These types of injuries usually manifest late because of delayed coagulation necrosis and usually go undetected during intra operative period and constitute Type 1 injuries of the biliary duct. CBD injury is a well known complication and always remains an inherent risk during laparoscopic cholecystectomy. Almost every textbook of surgery mentions CBD injury as a risk and a complication of laparoscopic cholecystectomy and there is always more chances of CBD injury in cases of difficult or dense adherent Calot’s. The incidence of CBD injury during laparoscopic cholecystectomy varies from 0.3% to 0.8% even in safe experienced hands. Sabiston textbook of surgery, the rate of minor and major CBD injury, during laparoscopic cholecystectomy as per national database is 0.85%. Nyhus Mastery of surgery states that incidence of CBD injury is 0.5% in laparoscopic cholecystectomy. The patient was kept in recovery room after surgery of approx one hour. The patient remains stable throughout that period and shifted to ward. During post-operative period, the patient was regularly attended by him and resident doctors from time to time and progress notes were placed in daily progress records sheet. During post operative period, the patient had fever on next day of surgery for which inj. Paracip was given. However, she never had any complaint of severe pain abdomen, vomiting or any respiratory difficulty. Her vitals remain stable throughout the post operative period. Her abdomen remains soft with minimal tenderness. There were no signs of guarding or rigidity. Her bowel sounds return to normal within 24 hrs after surgery, after which she was allowed liquid diet. She was passing flatus and her urine output was adequate as she was regularly passing urine and there were no complaints of decreased urination or oliguria. The patient was tolerating liquid diet orally well and there were no complaint of any vomiting or abdominal distention after liquid diet. Her dressings were dry and there was no leakage from any dressing site or port site. She was discharged on 14.1.2018. The patient was completely stable at that time as there was no fever, vomiting or pain abdomen. Her vitals were stable and abdomen soft, non tender and accepting liquid diet well. The patient got discharged at 1.10 pm on 14.1.2018, from hospital in stable condition. She was also advised to attend casualty in case of experiencing any difficulty or in case of any emergency. The patient was brought dead at 11.15 p.m. at casualty in Jeevan Anmol Hospital by her relatives. What happened at home/ whether she was having any discomfort or experiencing any difficulty/how her condition became so critical/ why she was not brought earlier if she was having any discomfort or was it a sudden collapse of the patient? Is still unknown to them.It was really an unfortunate event and to their uttermost surprise the post mortem findings revealed bile collection from leakage of right hepatic duct. In immediate post operative period, it is really difficult to assess whether the patient was recovering from surgery or having symptoms and signs of early sepsis. In this case, the patient had not shown any alarming clinical symptoms or signs to raise the suspicion of biliary peritonitis and the need for further investigations before discharge. Even the patient of bilioma peritonitis with large amount of collections usually manifests symptoms and signs, several days after surgery and present with septicemia or multi organ failure not usually in shock leading to death. So this was really a surprise, even to them how a stable patient’s general condition deteriorated too fast leading to death. He would like to support his view with literature; Biliary Imaging, RSNA, bile leaks have been associated with a number of surgical procedure, including open or laparoscopic cholecystectomy. Significant bile leaks have been reported in upto 1% of the patient undergoing laparoscopic cholecystectomy. The most common cause of bile leak include slippage of cystic duct ligature, leaks from gall bladder or a friable and adherent gall bladder due to chronic cholecystitis can also predispose to post operative bile leakage. Bile leaks often manifests within 1 weak of surgery. On occasions they may not manifest clinically for upto 30 days after intervention. As clinical signs and symptoms of bile leaks are non specific especially after recent surgery and may be attributed to other more frequently encounter post operative complications. Postcholechystectomy abdominal bile collection, Arch Surg. 2000;135(5), symptoms caused by bile collections were often quite subtle. Most patient with bile collection did not present with peritonitis, instead had bile ascites, with mild, relatively non specific symptoms. Many of the patients who became seriously ill never passed through a phase that included abdominal pain and tenderness. It was not possible to distinguish those who would become critically ill from those who would not, based on early clinical presentation. Abdominal pain and tenderness develops in the patients with abdominal bile collections. Best practice: BMJ: Jeff House, post operative fever is defined as a temperature >1000 F on 2 consecutive days or>102.20 F on any one post operative day. It is a common problem encountered by both surgeons and medical consultants. The reported incidence varies, but can be expected in about 13-14%. Most cases are self- limiting, requiring only observation. The most common cause of fever within the first 48 hrs is a pyretic response to surgery, which is self limiting. Post operative fever, MellisaK. Johnson post operative fever is defined as a temperature elevation greater that 101 F. Fever is common in the post operative period, occurring in upto 50% of the patients. Early postoperative fevers within 48 hrs are usually due to the inflammatory response to surgery and are not associated with infections. It was really an unfortunate incident, where there was a sudden collapse in general condition of the patient after being discharged in stable condition from hospital, leading to death of the patient Meenu at home only, as the patient was brought dead at 11:15 pm in the hospital. There was no lack of care or professional misconduct from his side. Hence, no medical negligence was done from his side and from hospital authorities in the management of the patient as suspected by the patient’s relatives.

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

1. It is noted that the patient Smt. Meenu, 33 years old, female, with a diagnosis of cholelithiasis underwent laparoscopic cholecystectomy and laparoscopic adhesiolysis on 12.1.2018 under consent, after PAC (done on 12.1.2018) at the said Hospital. The findings of operation were :- distended gall bladder, multiple calculi, gross adhesions and thickened GB wall. In the post operative period, the patient was noted to have fever 101.20 F at 8.30 a.m. on 13.1.2018, 990 F (08:30 p.m. 13.1.2018) and on 14.1.2018 at 5.00 a.m.- 101.30 F, at 06.00 a.m.-1010 F,at 07.00 a.m.-100O F. However, at 11:20 a.m.(14.1.2018), she was noted to be afebrile, vital stable, P/A- soft, non tender, urine and flatus passed. Accepting oral feed/liquid diet well and no vomiting and, hence, was discharged at 13:10 p.m. on 14.1.2018 with advise to review on 20.1.2018. Apparently, as per the MLC no.785 of Jeevan Anmol Hospital, the patient was brought again at 11:15 p.m. on 14.1.2018 when she was declared brought dead. The cause of death as per post mortem report no.81/18 dated 16.1.2018 of Department of Forensic Medicine, UCMS & GTB Hospital; Delhi was shock due to biliary peritonitis produced as a result of leakage of bile from right hepatic duct.
2. It is observed that the post-mortem findings of Bile duct injury is a known complication of Laparoscopic cholecystectomy and can be missed at the time of initial surgery. The treating doctor, had periodically checked the progress of the patient in the post-operative period and had advised medications for symptoms of fever which is a common immediate symptom after any surgical procedure due to physiological stress. He advised that the patient was hospitalized for an additional day owing to the fever and after being satisfied that she was afebrile and stable a decision to discharge her was taken.
3. There appear to be lack of communication between the treating team and the patient/patient’s relatives; it is advised that Medical Superintendent develop a more robust mechanism of communication between the hospital and the patients. They are also advised to keep the patient records as per the standard procedure laid down.
4. The patient had fever in the initial post-operative period and was kept in the hospital for an additional day i.e. 13.1.2018 due to it. But on the day of discharge i.e. 14.1.2018, these symptoms had settled and the patient was stable. As per the records, the patient was afebrile, vitals stable, Per-abdominal examination within normal limits, and no vomiting was noted at 11:20 a.m. on 14.1.2018. Therefore, the decision to discharge the patient at 13:10 p.m. on second post-operative day is justified.

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 Jeevan Anmol Hospital, in the treatment administered to the patient late Smt. Meenu.

Matter stands disposed.

Sd/: Sd/: Sd/:

(Dr. Maneesh Singhal) (Dr. G.S. Grewal) (Shri Bharat Gupta)

Chairman, Delhi Medical Association, Legal Expert,

Disciplinary Committee Member, Member,

Disciplinary Committee Disciplinary Committee

Sd/:

(Dr. Amit Gupta)

Expert Member, Disciplinary Committee

The Order of the Disciplinary Committee dated 18th February, 2022 was confirmed by the Delhi Medical Council in its meeting held on 24th February, 2022.

 By the Order & in the name of

 Delhi Medical Council

 (Dr. Girish Tyagi)

 Secretary

Copy to :-

1. Shri Ajay Kumar, House No.10/74, Trilokpuri, Delhi-110091.
2. Dr. Ajay Goyal, Consultant Surgeon, Through Medical Superintendent, Jeevan Anmol Hospital, Mayur Vihar Phase-1, Opp. Pratap Nagar, Delhi-110091.
3. Medical Superintendent, Jeevan Anmol Hospital, Mayur Vihar Phase-1, Opp. Pratap Nagar, Delhi-110091.
4. SHO, Police Station, Pandav Nagar, Delhi-110091(w.r.t No. DD No.4 A, dated 15.01.2017, PS-Pandav Nagar, Delhi)-**for information**.

 (Dr. Girish Tyagi)

 Secretary