DMC/DC/F.14/Comp.2442/2/2023/ 28th November, 2023

**O R D E R**

The Delhi Medical Council through its Disciplinary Committee examined a complaint of Shri Amit Yadav, s/o Shri Dhanvir Singh, r/o- B-3/223, Paschim Vihar, New Delhi-10063, alleging medical negligence on the part of the doctors of Sri Balaji Action Medical Institute, FC-34, A-4, Paschim Vihar, New Delhi-110063, in the treatment administered to the complainant’s mother Smt. Chander Kala, resulting in her death.

The Order of the Disciplinary Committee dated 31st October, 2023 is reproduced herein-below :-

The Disciplinary Committee of the Delhi Medical Council examined a complaint of Shri Amit Yadav, s/o Shri. Dhanvir Singh, r/o- B-3/223, Paschim Vihar, New Delhi-10063 (referred hereinafter as the complainant), alleging medical negligence on the part of the doctors of Sri Balaji Action medical Institute, FC-34, A-4, Paschim Vihar, New Delhi-110063 (referred hereinafter as the said Hospital), in the treatment administered to the complainant’s mother Smt. Chander Kala (referred hereinafter as the patient), resulting in her death.

The Disciplinary Committee perused the **complaint, written statement of Medical Superintendent, Sri Balaji Action Medical Institute, enclosing therewith written statement of Dr. Ruby Sehra, Dr. Meenakshi Bansal, Dr. Sandeep Gupta, copy of medical records of Sri Balaji Action Medical Institute and other documents on record.**

The following were heard in person:-

1) Shri Amit Yadav Complainant

1. Shri Dhanvir Singh Father of the complainant
2. Dr. Ruby Sehra Consultant, Obst. & Gynae. Sri Balaji

Action Medical Institute

1. Dr. Meenakshi Bansal Gynaecologist, Sri Balaji Action Medical

Institute

1. Dr. Sandeep Gupta Surgeon, Sri Balaji Action Medical

Institute

1. Shri K.N. Gulati G.M., Sri Balaji Action medical Institute
2. Dr. Sunil Sumbli Medical Superintendent, Sri Balaji Action

Medical Institute

The complainant Shri Amit Yadav alleged that on 01.04.2015, the patient Smt. Chander Kala mother of the complainant went to the Surgery and Gynae care Clinic for consulting with Dr. Meenakshi Bansal(Consultant Obstetrical Gynecologist and Endoscopic Surgeon) because she was experiencing certain changes in her body. She was diagnosed by Dr. Meenakshi Bansal, who told the patient that the changes she was experiencing were not simply symptoms of menopause and advised the patient that she has to undergo surgery for removal of uterus as there was no other treatment available for the same. That the patient further visited Dr. Meenakshi Bansal on 19/04/2015, 21/04/2015 and 22/04/2015 for undergoing various tests, further clarification and medical advice, if there was any scope to avoid the surgery. However, Dr. Meenakshi Bansal strongly advised her that the surgery cannot be avoided. Dr. Meenakshi Bansal then told the patient and him that the surgery should be done at a big hospital where all the modern equipments and facilities would be available, and then suggested the name of Balaji Action Medical Institute (referred as hospital hereafter). Dr. Meenakshi Bansal further enticed him and his mother (the patient) by impressing upon him that the hospital has doctors, nurses, equipment and facilities matching world class standards and the surgery would be performed by Dr. Ruby Sehra who has performed more than 100 such surgeries. Dr. Meenakshi also informed the patient that the surgery is of minor nature but it is of urgent nature and there is no need to worry. The patient and her husband met Dr. Ruby Sehra, and she agreed to operate on the patient with the support of her team at Sri Balaji Action Medical Hospital. When the patient enquired about the costs/expenses involved for the surgery, it was disclosed that the surgery will cost Rs. 75,000/- (Rs. 40,000/- for Dr. Ruby and rest for the team supporting her). Dr. Meenakshi Bansal then informed the patient that date for surgery is fixed for 05.05.2015 at the hospital and asked the patient to carry original medical insurance papers and medical test records of the patient on that day. Though the appointment for the surgery was for 05.05.2015, but the patient received a call from Dr. Meenakshi Bansal on 04/05/2015 that the patient should get admitted to the hospital on 04/05/2015 itself. They admitted the patient on 04/05/2015 as they followed the instructions of Dr. Meenakshi blindly and in good faith. But later to their shock and surprise it was revealed that the patient was called on 04/05/2015 because some other patient booked on that day did not turn up on 04/05/2015. On 05/05/2015 after routine tests the patient was taken to Operation theatre and full body anesthesia was administered. A team of three doctors and two nurses carried out the operation. He was informed that operation will be carried out by Dr. Ruby Shera. After sometime Dr. Meenakshi came and informed him and his father that the surgery was successful and the patient would recover soon. That Rs. 75000/- was claimed by the hospital from the Insurance Company. On 06/05/2015 the patient experienced severe pain in her abdomen. He informed the doctor about the same but no doctor visited the patient for diagnosis and she was given medication for stomach disorder/gas. The patient after taking the medicine still experienced severe stomach and abdomen pain. The same was reported to the hospital staff but still they did not take the situation seriously and patient was given pills to induce sleep and relaxation. Neither Dr. Sehra nor Dr. Meenakshi visited the patient and the patient was made to bear continuous pain throughout the night due to the utterly negligent, callous and careless behavior of the hospital staff. On 07/05/2015, the condition of the patient aggravated due to the absence of proper diagnosis of her situation and treatment. No tests were conducted on the patient to find out the root cause of pain she was experiencing after the operation. He along with his father approached the C.E.O. Devi Prasad Saraswat and M.S. Pinky Yadav of the hospital and made them aware of the situation but still no efforts were made from their side. The hospital staff, C.E.O. Devi Prasad Saraswat, doctors and M.S. Pinky Yadav all acted in an unprofessional manner and wasted valuable time in routine treatment which amounts to gross medical negligence. On 07/05/2015 itself in absence of proper treatment the patient went into shock after feeling difficulty in breathing. The patient's stomach swelled and she became unconscious. It was at this stage that Dr. Meenakshi Bansal came forward and when they asked her to call Dr. Ruby Sehra, she told them that Dr. Ruby Sehra is unavailable at that time. On inquiring further, they were informed that Dr. Ruby Sehra was out of the city and cannot be contacted at that point of time. After this the condition of the patient worsened and the hospital had to outsource another doctor namely Dr. Sandeep Gupta. After some tests and procedural investigation, Dr. Sandeep Gupta disclosed that one of the intestines was punctured/damaged at the time of conducting the first surgery and was leaking. He also disclosed that it may result in fatal and irreparable loss. The patient's family members were made to sign on some blank forms and Dr. Sandeep Gupta performed the second surgery on the patient in order to repair the punctured intestine that got damaged during the first surgery. After the completion of the second surgery, the patient was put on life support systems. The names of Dr. Sandeep Gupta, Dr. Meenakshi Bansal and Dr. Ruby Sehra were mentioned on the forms for the second surgery. After the completion of the second surgery Dr. Sandeep Gupta informed him that the surgery was successful and the patient is out of danger and they need not worry as the mistake of the doctors who performed the first surgery has been rectified. Hospital claimed further Rs. 75,000/- from the insurance company and his father was made to sign claim papers for the same. Total payment received by the hospital till that point of time was Rs. 1,50,000/-. On 21/05/2015, the patient again complained of increased pain in abdomen. On further diagnosis it was revealed that there was again leakage from the intestine and without any consent from the patient or her family members, the damaged part of the intestine was removed in grossly unprofessional and negligent conduct. After this they asked the hospital staff and doctors that they refer her to some other hospital but they were told that the patient is in good and competent hands at that hospital and moving the patient in her current condition was very risky. On 25.05.2015 the patient complained of heart pain. They were told by the doctors that the infection has spread to her entire body and therefore there was an urgent need for a third surgery involving cardiologist to save the life of the patient. They were again made to sign on a blank form. They were not informed who carried out the third surgery. After the completion of the third surgery as usual they were informed that the surgery was successful and the patient is out of danger. The patient was again kept on life support systems after the third surgery. They were consoled regularly that the health of the patient was improving but the ground reality was never disclosed despite repeated inquiries from their side to the doctors, support staff, C.E.O. and the M.D. Finally, on 25/05/2015 they were informed by Dr. Meenakshi Bansal that the patient is suffering from multiple organ failure, while at the time of admission the patient was not suffering from any such ailments. Ultimately at 9 a.m. it was declared that Ms. Chandrakala Yadav, the patient is no more. The doctors, C.E.O., M.S. and support staff of the hospital cooked false and baseless facts to save their skin and escape from their responsibility. After the patient expired, Dr. Ruby Sehra came to their residence to offer her condolences. It was then revealed to their absolute shock and horror that Dr. Ruby Sehra did not perform any of the surgeries performed on the patient. The hospital staff and Dr. Meenakshi Bansal were just using the name of Dr. Ruby Sehra to extract more money from the patient as a part of a preplanned conspiracy. He has come to know that there are various complaints/cases of gross medical negligence and unprofessional conduct against the hospital. The conduct and acts done by the all the accused is covered under Criminal Act as they have carried gross negligence while conducting surgery.

The complainant further alleged that surgery of his mother which was conducted at Balaji Action Institute was an elective surgery i.e. a routine surgery and there was no life danger in that surgery, then how come his mother expired after the surgery. His mother was declared fit for pre-anesthetic checkup prior to the surgery, then how come the surgery became fatal to his mother. During the surgery, there is no mention of iatrogenic perforation in operation theatre notes, though the doctor conveyed to the attendant verbally about the same, hence, the same is also a gross negligence. No surgical opinion was taken intra-op in the case of his mother’s operation, though the same is mandatory that whenever doctors remove adhesions from intestine and urinary bladder, surgical opinion is to be taken intraop. Why contamination of perforation was done by the hospital and the same is breach of steriority procedure. The documents of the treatment of his mother indicate that there was infection after the operation, how come the infection comes when his mother was under the proper care and custody of the hospital. The hospital has also issue discharge certificate to him after the first operation, though his mother was ever discharged, it shows how carelessly the hospital has performed its duty.

Kindly consider all the above said facts while considering his complaint.

Dr. Meenakshi Bansal, Consultant, Obst. & Gynae. in her written statement averred that on 1st April 2015, the mother of the complainant first time visited at her clinic with her husband with chief complaint of bleeding per vagina off & on which was very disturbing for the patient. Patient was not normal. On asking patient's menstrual history, she revealed that she had her menopause for about five years. For last one and half year she is having bleeding per vagina off and on, which was abnormal. After examination and history, she asked patient to go for TVS (ultrasound for pelvic organs) & then endometrial biopsy. Patient revealed that she had already undergone both of these tests, during her prior consultation with Dr. Sanjivini Khanna, Sr. Consultant Fortis Hospital in January 2015 who has already advised the patient for Surgery TLH & BSO. Further patient reveled that she is a known case of diabetes, but she is not taking any medical treatment. Confirming the TVS report which clearly showed thickened ET i.e. 11.6 (cut off normal after menopause is 3.5 to 4 mm) and Adenomyotic changes. Then she asked the patient for Hysteroscopic D&C. Patient and her husband told that she has undergone likewise test and showed him the report of biopsy which showed cystic glanudar hyperplasia, and as there was still having abnormal recurrent bleeding after menopause, she was also of the same opinion for surgery that is removal of uterus & bilateral ovaries i.e. Hystectomy By open or Laparoscopic Technique. Shaws's Textbook of Gynaecology 16th Edition p77postmenopausal Bleeding managemen "*if the women continue to bleed or bleeding reoccurs, it is advisable to perform laparotomy or otherwise Hystrectomy with bilateral salpingo oophrectomy & specimen should be sent for histopathology* ". Bulletin of American Cancer society clearly outlines age, diabetes, age and a history of having been diagnosed with endometrial hyperplasia as the risk factors for development of endometrial carcinoma. Novak's Gynecology Thirteenth Edition Chapter on Uterine Cancer page 1143-1144 also clarifies the risk percentage of endometrial hyperplasia in cases of women with hyperplasia, obesity and diabetes mellitus. It outlines the risks factors for endometrial cancer, the risk of the development of endometrial cancer may be as much as four times in women with diabetes and twice more likely in obese women and women with endometrial hyperplasia has a chance of 1-29% of developing uterine cancer. Collectively because of endometrial hyperplasia along with obesity as well as diabetes, the Patient was at very high risk of developing deadly disease of endometrial cancer. Hence, the decision of performing the surgery was taken after thorough consideration of all the risk factors. Further the surgical treatment & Technique was explained in detail with associated risks including complications involved both in TAH & TLH, as this is a major surgery. After knowing the entire complexities and information, patient preferred for laparoscopic surgery TLH & BSO. Patient left the clinic by saying that she has understood all the details, risks and complications involved and will discuss with the family. That on 19th April 2015 after taking opinions from other doctors and all discussions the patient and her husband came self-motivated on their own with preset mind for major surgery, then she was advised to get all her necessary investigations done prior to a major surgery and pre-anaesthesia checkup ie PAC. It was never expressed that surgery is of minor in nature. Rather this is one of the major surgeries in gynaecology to be done by a team of doctor and at well-equipped hospital preferably with ICU and blood bank facilities, so suggested for Sri Balaji Action Medical Institute (SBAMI) an NABH accredited Hospital. It was further stated that no major surgery is free from complications and risks including risk to life. Same were clearly informed to patient and her husband in earlier visit on 01.04.2015. Thereafter, on 21st April, 2015 the patient again visited along with her husband with all prescribed reports done at Maharaja Agrasen Hospital, Punjabi Bagh and PAC checkup report from Shri Balaji Action Medical Institute done by Dr. Chandan on 21st April,2015. At PAC checkup patient has disclosed that she is suffering from high BP and she is not on any medical treatment. Moreover, the report showed highly uncontrolled blood sugar lever fasting 216mg% post-prandial 340mg% of the patient. Patient was advised urgent physician reference for control of sugar and surgery was deferred. Patient was already having recurrent post-menopausal bleeding; according to the standard text book of Gynaecology Text book of Gynaecology including contraception by D.C. Dutta Ed 4th page 329 “Obesity, hyper tension and diabetes are well known factor for developing caner endometrium collectively named as; “corpus cancer syndrome.” As per medical literature vulnerability to post-operative sepsis increases may folds with pre-existing co-morbid conditions like obesity/DM (Diabetes)/Blood pressure (hypertension) which are otherwise silent. Again patient & her husband were explained that she will be operated by a team of doctors headed by Dr. Ruby Sehra, Dr. Meenakshi Bansal being a member of the team at Sri Balaji Action Medical Institute (SBAMI), SBAMI is a multi-specialty 200 bedded hospital accredited by NABH & NABL providing standard care. At time of discussion, the expenditure involved the patient and her husband revealed that they had Parivar (family) medical insurance worth Rs.3.5 lakh with National Insurance company which comes under GIPSA. The patient took her first consultation on 01st April, 2015 and had surgery on 05th May, 2015 after one month so surgery was not done in any urgency. Complainant states & admit that they had met Dr. Ruby Sehra and had discussed for surgery at Sri Balaji Action Medical lnstitute New Delhi. The patient and her husband had applied for pre-authorization for cashless approval to undergo surgery at Sri Balaji Action Hospital which was approved by the TPA company on 02nd May, 2015 itself for the said amount of package to Rs. 60,858/- (sixty thousand eight hundred fifty-eight only). Patient was given date for surgery on 05.05.2015 with admission on 04.05.2018. The patient took an appointment for surgery on 05.05.2015 and had not turned up for admission till noon on 04.05.2015. As per standard surgical norms patient is advised to get admitted one day prior to major surgery so as to carry out pre-operative surgery preparations like bowel preparation, physician checkup, review Preanasthesia checkup (PAC) especially in a patient with co-morbid diseases like obesity, diabetes and hyper tension so that necessary arrangements are done well in time. This completely denies the false allegation of not following the set protocols for surgery care. Patient was taken care of very well from very beginning. On 04.05.2015 after admission the patient was admitted in the room and examined by Gynae team, pre-operative preparations, bowel preparation was started, physician opinion advised. Patient and her husband were again explained about the surgery details and associated complications risk involved including injury to internal organs (perforation to bowel), bleeding, sepsis & fatal risks, consent was given voluntarily, after reasonable understanding of the complications & without any misrepresentation of the procedure which were duly signed by the patient Mrs. Chanderkala Yadav and her husband in presence of Dr. Meenakshi Bansal as per performa of informed consent. On the day of surgery i.e. 05th May, 2015 the patient was visited in the morning, then she was shifted to pre-operative room which is in OT complex itself. Her investigation records were further verified by the anesthesia team of doctors and patient was taken up for surgery i.e. laparoscopic hysterectomy with bilateral salphingo oophorectomy under general anesthesia. All set protocols of surgery sign in, sign out, were done, prophylactic antibiotics were given. The surgery was performed by Dr. Ruby Sehra assisted by Dr. Meenakshi Bansal and staff nurse sister Jeena with anesthesia team doctors as per acceptable medical norms with due caution and care. During the surgery there were adhesions encountered, adhesiolysis was done and laparoscopic hysterectomy with bilateral salphingo oophorectomy was completed. The procedure was uneventful without any complications. Operation was conducted in accordance with set medical norms, utmost care and caution was taken in surgery. It is a set surgical norm to brief the relatives after surgery about the surgery and condition of the patient and to show the specimen removed. Patient relations were duly informed at that time by Dr. Ruby Sehra and Dr. Meenakshi Bansal. After surgery, the patient was kept in post recovery room and her vitals were checked regularly (at interval of every 15 minutes) and found absolutely in normal range. Patient was being duly seen from time to time by anesthesia doctors’ team, the patient was seen by Dr. Meenakshi Bansal in evening rounds. Patient's vitals per abdomen, examination and urine output were is normal range. Patient was kept NPO as per standard protocols. Thereafter, patient was seen by Dr. Neha who is well qualified MBBS, DNB Gynecology doctor, in labour room complex. Thereafter, on same day patient was seen by Dr. Gurpreet Kaur who is well qualified MBBS, MD Gynecology doctor in labour room complex, patient was kept NPO, was on intravenous fluids keeping in mind her diabetic status. Overnight her vital, chart record, urine output, blood sugar levels were checked at regular intervals (as per standard norms). Blood sugar levels were high at times so required doses of injection insulin were given to patient as advised by physician. On 06th May 2015 in the morning Gynae team examined the patient, recorded her vitals urine output, per abdomen check-up. Patient's bowel sounds were present. On finding all within satisfactory range, she was allowed to take diabetic clear liquids by mouth. Allowing liquids to be taken by mouth is an indication of recovery of patient as per expectations at that time. Patient was stable and comfortable. She underwent physiotherapy session as well. On 6th May 2015 at 11:50 a.m. Doctor had visited the patient on 06.05.2020. On 06th May 2015 evening around 05:00 PM again Gynae-doctor team visited patient. Patient was comfortable and was having no complaints. Her vitals were normal. She again underwent physio-therapy session. Patient was not having complaints of pain abdomen on 06.05.2015 at that time. Around 09:00 PM on 06th May 2015 patient was again examined by Gynae-doctor Dr. Neha who is qualified MBBS, DNB(Gynae) doctor. Patient was comfortable at that time also with all her vitals, urine output and per abdomen examination findings were well within normal range. Patient's vitals chart monitoring and blood sugar level assessment continued at regular intervals as, per standard post-operative protocols. On 07th May 2015, early morning, 2nd post op day patient complained of pain upper abdomen for which she was immediately attended by Gynae-doctor, Dr. Neha who is qualified MBBS, DNB (Gynae) doctor. Patient was advised to keep NPO and intravenous fluids were administrated. Antacid, anti-emetics and pain killer injections were given so as to relieve the patient of her pain. Required blood investigation were sent at that very time only, pulse oximeter monitoring was started. Again, in morning on 07th May 2015, patient was examined by Gynae- doctor team Dr. Ruby Sehra and by Dr. Meenakshi Bansal. Patient complained of acidity and flatulence, though her vitals parameters were stable. On examination patient had developed soft distension. Here it is to state that abdominal pain and flatulence in recovery phase is common and normal and quite expected on early post-operative days. Treatment to relieve the patient continued. To avoid any missing, the expert opinion for abdominal condition from General surgeon was sought for which Dr. Subhash Aggarwal, Sr. Consultant and Head of Surgery department and Team was informed for further evaluation and management of the patient. Meanwhile, investigation reports were collected, patient was continued to be given required treatment. Dr. Subhash Aggarwal and team examined the patient in the morning itself (around 10:00a.m.). Dr. Subhash Aggarwal and team examined the patient in the morning itself (around 10:00a.m.). Patient had complained of distension abdomen and non- passage of flatus. On examination patient was afebrile with pulse rate 84/min. They found the abdomen soft and distended with bowel sounds increased. On per rectal examination, there was soft faecal matter. They clinically provisionally diagnosed it to be Ileus or intestinal obstruction. For which they recommended NPO and I/V fluids. TLC was decreased so antibiotics were changed to higher ones. They advised for PC enema, Ryles tube aspiration, input output charting, blood investigation and CT-scan abdomen; patient to be reviewed with the reports. The expert opinion was taken and advice duly followed. Meanwhile, doctor on duty who is well qualified MBBS doctor supervised the patient and started following the instructions as advised by surgical experts. Again at 12:00 PM on 07th May 2015, Dr. Ruby Sehra and Dr. Meenakshi Bansal attended the patient so as to know the condition and the progress of the patient. As urine output was less at this time and blood urea and creatinine were on higher side, the radiology department required nephrology clearance for CECT abdomen. Dr. Rajesh Aggarwal, Senior Consultant Nephrology was informed. Meanwhile, patient passed motion and fluid was aspirated through Ryle's tube, patient got some relief. The decision for operating again on the patient cannot be taken without evidence or proper diagnosis. Patient was continuously observed by doctor on duty (in ward) by bed side monitor. Dr Meenakshi was around & kept on managing the reference orders and to get CT-Scan done as was advised by surgical expert. Dr Meenakshi contacted Dr. Rajesh Aggarwal to examine the patient and for clearance for CT-scan. lnspite of monitoring in ward, her urine output was decreasing as was her BP, patient was advised to be shifted to ICD. Patient was seen by Dr. Rajesh Aggarwal (Nephrology) with abdomen distension and decreased urine output. He also advised for CVP monitoring and shifting of patient to ICU, and to avoid Nephrotoxic agents including IV contrast. Dr Meenakshi who was attending the patient since morning, shifted her to SICU immediately. Abdominal distension was increased, Dr. Subhash Aggarwal & team (surgery unit-I) was immediately contacted. They were busy in major surgery in OT. In good interest of patient, another Sr. consultant surgeon, Dr. Sandeep Gupta who is equally well qualified and experienced, was contacted telephonically for expert opinion and management in present condition. Dr. Massani (lntensvist)& critical care team took care of patient. Dr. Sandeep Gupta examined the patient in Surgical ICU he advised for exploratory laprotomy and proceeds on clinical judgment in interest of patient. After duly informing and taking high risk consent from the husband, patient was shifted to OT immediately. Meanwhile, patient's relatives were well informed of the existing condition and suspicion of Internal bleeding or some intestinal perforation by Dr. Sandeep Gupta. All risks and possible outcome were explained Patient was treated in accordance with prevailing standard of care. On 07.05.2015 in operation theatre patient underwent exploratory laparotomy done by Dr. Sandeep Gupta, Dr. Ruby Sehra and Dr. Meenakshi Bansal under general anesthesia along with anesthetist team Dr. Neeta Taneja, Dr. Manisha and Dr. Gautam. Per operatively, there was no bleeding inside. There was a pin head size perforation at anti-mesenteric border of small intestine. Rest of Bowel was thoroughly checked and found it to be normal and healthy. After thorough lavage, as the perforation seemed of recent origin so primary closer of perforation was decided, perforation was closed by the General surgeon. Drains were put bilaterally and abdomen was closed. As per Text book of Gynecology, ed 16th, page.208 "*It is not uncommon to perforate the bowel with veress needle or trocar. The use of cautery or laser during laparoscopic surgery can cause burns to the intestine. This will be detected about 5-7 days later. when the woman returns with peritonitis and ileus. Intestinal injuries are increasingly reported following laparoscopic surgery when cautery and laser are used*.” Detecting and managing the Intestinal injury within 36-48 hours after laparoscopic surgery with help of General surgeon is itself an indication that patient was managed with high care. In other words same cannot be correlated as the act of negligence or carelessness on the part of operating surgeon. Again, as per standard surgical norms, patient husband and other relatives were duly informed by Dr. Sandeep Gupta in presence of Dr. Ruby Sehra and Dr. Meenakshi Bansal. They were informed about bowel perforation, closure of perforation, that it is known complication of laparoscopic surgery as was prior informed. It is a well-known fact that during laparoscopic surgery small serosal injuries do happen which may represent after 5-7days of surgery. (Ref Shaws Text book of Gynecology, ed 16th, page.208). "*Bowel perforation is one of the known complications of laparoscopic hysterectomy.*" (Berek & Novak's Gynaecology 14th Ed.chapter 21 p:776,777,779 - 783) (Te Linde's operative Gynaecology 10th Ed P:741 (Shaws Text book of Gynecology, ed 16th, p:100). (Shaw's Textbook of Operative Gynaecology 6th Ed p:138,139). After surgery, the patient was shifted to SICU for further monitoring and was put on ventilator.

There is no act of negligence as alleged by the complainant, patient was timely taken care by treating doctors with help of surgical expert doctors. All known observation and or set protocols of surgery were followed. As patient was already suffering from uncontrolled, diabetes, & obesity, which increased the sepsis in multi-folds in short span of time. This was explained to the patient and complaints before time and after surgery also. There was no gross negligence in first surgery, as patient was monitored by set and accepted medical norms. It is again to state that the risk of pre-existing co-morbid conditions like obesity, diabetes mellitus and hypertension, which are otherwise silent, but significantly spread the sepsis in post-surgery patient affecting the patient in a catastrophic manner. That complaint has hidden the facts that in ICU patient's condition started improving. Patient was intensively monitored in SICU by the critical care team of Dr. Meenakshi Bansal and Dr. Devan Juneja and others. Patient was continuously seen by respiratory physician Dr. Animesh Arya, medicine unit- I, Nephrology Team (Dr. Rajesh Aggarwal), Surgery team Dr. Sandeep Gupta and Gynae doctor team Dr. Ruby Sehra and Dr. Meenakshi and ICU team and patient was showing signs of improvement. On 09th May 2015, a complaint of AF (Atrial fibrillation) & FVR (fast venricular responses) heart failure for patient underwent 2D Echo showing concentric LVH mild LVEF 45%. On 09.05.2015 at 4.30 pm Patient was examined by cardiologist due to sudden bradycardia and hypotension, serum electrolytes, trop T, CPK, ABG were done patient was immediately revived. Patient relatives and attendants were duly informed about the ongoing conditions and treatment about the patient. On 10th May 2015 patient's relative requested for treatment summary for having second opinion. As per their request case summary was given to the husband of the patient on 10th May, 2015. Patient's attendants have consulted about the patient condition elsewhere. Husband have mentioned satisfaction with the ongoing treatment and care of patient with due endorsement. With untiring efforts of doctor's teams in SICU patient's conditions showed improvement and was shifted to CPAP. On 12th May, 2015, patient further showed improvement in her condition and was shifted from CPAP to T-piece. Dr Sandeep Gupta Senior Surgeon & Team has already taken up the case since 07th May 2015, there was continues uninterrupted and untiring support from Gynae unit Ill. On 12th May, 2015, Dr. Ruby Sehra had to go out of India on leave due to some personal commitments. Patient's care was diligently taken by Dr. Meenakshi Bansal as other teams daily and was discussed with other Sr. consultant Gynecologist Dr. Uma Swain. On 13th May 2015 ET tube culture and sensitivity report showed Pseudomonas Aerugenosa which was pan resistant to all the antibiotics. Patient was given good parental support along with albumin infusion. In a patient who is suffering from Diabetes, a bacterial growth of pseudomonas aerugenosa is not good. Harrison's Principles of Internal medicine 16th Edition P:2169 Patient was on higher antibiotics as per critical care team. On 13th May 2015, evening all untiring efforts of the doctors proved good as patient was extubated and was off the ventilator support. All the other parameters had also improved. On 14th May, 2015, morning, patient was conscious, well oriented with all the parameters in normal range. Ryle tube feeding was started on 14th May, 2015. On 15th May, 2015 morning patient was conscious, well oriented and was started liquid diet on recommendation of surgery team. As patient's conditions improved a lot, the entire doctor's team who worked really hard and diligently were satisfied and relived along with relatives. The patient passed motion on 15th May, 2015 evening which further indicative of improved condition of patient. On 16th May, 2015 surgery team started soft diet for the patient and some arterial lines were removed, correction of hypoproteinaemia was being done. Patient was moved out of bed. On 17th May, 2015 the patient continues to be on soft diet, patient had improved a lot. She was well oriented and talking well. All monitoring and treatment were continued. The patient again passed motion. On 18th May, 2015, morning, the patient's was given albumin and blood transfusion, as advised by ICU teams for general building up of patient as guided by daily investigation reports of the patient. Patient continued tobe in SICU for monitoring and care. Case Discussed with Dr. Uma Swain (Senior Gynaecologist) on 18th May, 2015, the abdominal drains were removed by the general surgeon and daily dressing of the patient's abdominal wound continued along with diabetic control in ICU monitoring and management. Why there is no mention of patient's improvement part by the complaint? On 19th May, 2015, patient was advised to take high protein diet, potassium correction and albumin infusion, as advised by general surgeon team. Blood sugar levels went high, insulin infusion started. Physician, ICU team, surgery team and respiratory medicine team continually looked after the patient. Patient started showing signs of wound sepsis with discharge from abdominal suture site. "*The global consequences of diabetes to the patient are well recognized. Numerous clinical studies have noted increased rates of infection that occur in diabetic patients.*” Ref SABISTON Textbook of Surgery The Biological Basis of Modren Surgical Practice 17th Edition p;292). Ultrasound whole abdomen to see for any intra-abdominal collection was done. Wound showed high output around 400 ml indicative of enterocutaneous fistula (case discussed in detail with Dr. Uma Swain) (Entercutanous fistula are a commonly known happening in patients with sepsis, malnutrition and' immune suppression and diabetes after an abdominal procedure. Postoperative fistula is a serious problem that carries a mortality of 15-20% (Ref SABISTON Textbook Of Surgery The Biological Basis of Modren Surgical Practice 17th Edition.P:324). On 21st May, 2015, Gastro intestinal surgeon Dr. Pradeep Jain and team examined the patient and CECT whole abdomen was advised. Surgery Unit-III Dr. Sandeep Gupta and team examined the patient, continued wound dressing and soft diet of patient. On 21st May, 2015, patient's TLC dropped to 1.6, albumin 3.2, wound bag showed 1700 ml output. CT scan report showed enterocutaneous fistula without any peritoneal spillage. "*post- operative fistula is a serious problem that carries a mortality of 15-20%" (Ref SABISTON Textbook of Surgery The Biological Basis of Modren Surgical. Practice 17th Edition P;324)*) Patient's lCU care alongwith monitoring of vitals, sugar, blood investigations were continuously being done. The condition was being informed to husband and relatives from time to time on daily basis. Gl team reviewed the case end advised same treatment management. On 21st May, 2015, surgery Unit-III planned for exploratory laparotomy and lavage and ileostomy, as wound sepsis was increasing, after making necessary blood arrangements. Informed high risk of consent for surgery as well as high risk anesthesia was given by The Husband of patient after understanding everything 3 units PRBC, 4 units FFP were arranged as per the surgery team, the patient details discussed with Dr. Uma Swain. The gross negligence and unprofessional conduct are completely denied here again. Medicine unit-I, opinion taken for leucopenia & Neutropenia. On 22.05.2015 patient GC ·was critical as low TLC, deranged LFT, wound dehiscence, Resp & metabolic Acidosis, fever ,septicemia was taken up for surgery under high risk consent after explaining to the husband & son of patient regarding the need of exploratory laparotomy & proceed by the surgeon Dr. Sandeep Gupta and team alongwith the high risk consent for anesthesia for exploratory laparotomy after knowing and understanding the high risk to patient's life, during and after the surgery due to Diabetes Mellitus, hypertension, septicemia, hypoalbuminemia, with de-arranged coagulation profile by anesthesia team Dr. Sunil Gupta (senior consultant) and Dr Ajay, consent was duly signed by the complaint and his father after completely understanding the outcome, ventilator requirement etc. On 22.05.2015 patient underwent Exploratory laparotomy with resection anastmosis of small bowel & ileostomy by Dr Sandeep Gupta, Dr Ashish Sharma & Dr Kalpesh (Team Surgery-3) & shifted back to ICU on ventilator under critical care team. On 22.05.2015, the patient’s condition was critical on ventilator being monitored by intensivist, on infusions albumin, nutriflex etc. patient details discussed with Dr. Uma swain and the patient’s condition was explained to relations in detail with poor prognosis. Again, the critical condition of the patient was explained to relations in detail by critical care team intensivist. On 23.05.2018, the patient condition was critical, on ventilator with increasing vasopressin requirement, worsening LFT, high procalcitonin levels, worsening urinary output treatment as per intensive care team, grave prognosis explained to the relations by Dr. Devan Juneja (Senior intensivist) in detail, Operating Surgery -3 team explained the same to relations, Nephrology opinion taken for critical condition, treatment advice followed. SLED (dialysis) on, with high requirement of vasopresion support. Gastro opinion taken for deranged LFT. As the MODS (multi organ dysfunction syndrome has set in) Gynae team again explained the condition of patient to relations with all medical treatments on gonging to the attendant by the treating doctors, there were no professional miss conduct or unfair practice. Only standard guideline or establish medically accepted care & monitoring was done. On 24.05.2015 patient’s condition continues to be critical on ventilator with high support vasopressors, patient had fever high, poor renal function de-arranged LFT, overall condition was deteriorated she developed SEPSIS and followed by Multiple Organ Dysfunction Syndrome (MODS), as per Nephrology patient was unfit for RRT in view of haemodynamic un-stability and poor prognosis was explained to relatives. Critical care team, Nephrology team, Gastroenterology team, Medicine team, Respiratory team, General surgeon team, Gynae team & anesthesia team put their best efforts in managing the patient aggressively and to save the precious life of the patient. Unfortunately, in spite of special care and attention, patient deteriorated further as need for inotropic support increased and required hemodialysis patient conditions remain critical and had cardiac arrest on 25th May, 2015 at 08:45am. CPR started according to ACLS protocols. That in spite of best of best efforts, patient was unable to be revived and declared dead on 25th May, 2015 at 09:30am.

Everything was done diligently, prudently, with utmost due care and caution in treating the said patient. She hereby states that there was no negligence from the treating side. Because of her low immunity, diabetes, obesity and other high-risk factors, she could not survive severe acidosis, hyperbilirubinemia, electrolyte imbalance and severe sepsis. Patient was already suffering from uncontrolled diabetes, obesity, which increased the sepsis in multi-folds in short span of time. It is again reiterated that the risk of pre-existing co-morbid conditions like obesity, diabetes mellitus and hypertension, which are otherwise silent, but significantly spread the sepsis in post-surgery patient affecting the patient in a catastrophic manner. Throughout the admission proper and adequate care & monitoring was done by well qualified doctors and the staff. The patient was monitored as per set and medically accepted norms. In fact the cause of death of the patient was development and rapid spread of infection resistant to most of the antibiotics present, which was due to the patient's diabetes. In a patient who is suffering from DM, HTN, obesity a bacterial growth of pseudomonas Aerugenosa is bad infection. "Individuals with diabetes have a greater frequency and severity of infection. Many common infections are more frequent & severe in diabetic population"(ref Harrison's Principles of Internal medicine 16th Edition p:2169). The patients with diabetes are at a high risk for cardiovascular orbidity and for various infections including postoperative infections.

In view of the above facts and circumstances enumerated hereinabove, it is most humbly prayed that this Hon’ble Delhi Medical Council may graciously be pleased to reject and dismiss the complaint in the interest of justice, more so when the same is neither based on medical/scientific facts nor supported by any expert opinion or medical literature.

Dr. Ruby Sehra, Gynaecologist,, Sri Balaji Action Medical Institute in her written statement averred that the patient late Smt. Chanderkala Yadav, was admitted to the Hospital on 4.5.2015 with complaints of 3-4 episodes of post-menopausal bleeding since 1-1/1/2 year. The ultrasound report showed thickened endometrium of 11,7 mm (Normal values should be less than 3-4 mm after menopause) with a blood clot in the cavity, Myometrium also showed adenornyotic changes, in anterior wall and fundus. A histopathology report showed cystic glandular hyperplasia, which means that the patient had pre malignant lesion which has very high probability of developing into endometrial cancer. The patient took first consultation on 1.4.2015 from Dr. Meenakshi Bansal when she was advised for TLH with BSO (Total Laparoscopic Hysterectomy with Bilateral salpingo oophorectomy) considering her symptoms of recurrent bleeding after menopause, USG report, histopathology report and history of diabetes (Although she denied having diabetes due to insurance claim) and accidental finding of hypertension all of which are high risk factors for malignancy. Shaw's Textbook of Gynaecology 16th edition Page 77 Postmenopausal Bleeding Management "*if the woman continues to bleed, or bleeding recurs, it is advisable to perform Cl laparotomy Otherwise abdominal hysterectomy with bilateral salpingo-oophorectomy should be performed and the specimen sent for histopathological study*.” After taking opinions from other doctors and all discussions, the patient came, self-motivated, to Dr. Meenakshi's clinic after 19 days, on 19.4.2015, on her own where she was prescribed all the tests necessary for getting clearance for any major surgery. On examination that day, the patient was found to have a BP of 130/86 on 19.4.2016 prescription. The histopathology report which diagnosed the problem of cystic glandular hyperplasia was the basis for the recommendation of treatment plan of TLH-BSO was brought along with the patient herself on her first visit. It is pertinent to mention here that before coming to Dr. Meenakshi Bansal for consultation for the first time, the patient and her family had already taken an opinion from Dr. Sanjivini Khanna (Senior Consultant Fortis Hospital) who had prescribed the above-mentioned tests and had also arrived at the opinion that the patient needed to undergo the surgery of TLH with BSO. The reports of these tests ordered by Dr. Sanjivini Khanna dated 20.1.2015, which was long before the patient even met Dr. Meenakshi Bansal, were brought along by the patient on her first visit to Dr. Meenakshi Bansal. This fact contradicts with the statement of the complainant that the patient was rushed or forced for surgery. In fact, the patient and her husband had come to Dr. Meenakshi Bansal for a second opinion after being advised for the abovementioned surgery by Dr. Sanjivini Khanna. She would also like to mention here that as per her knowledge, the patient was always accompanied by her husband to the appointments to Dr. Meenakshi Bansal and not by the complainant herein. The patient again visited on 21.4.2015 accompanied by her husband along with all prescribed reports done at Maharaja Agarsen Hospital, Punjabi Bagh and PAC checkup report from Sri Balaji Action Medical Institute done by Dr. Chandan. At PAC check-up, the patient had disclosed that she is suffering from high BP and she was not on any medical treatment. Moreover, the report showed highly uncontrolled blood sugar level fasting 216mg% post-prandial 340mg% by the complainant with HbA1c of 10.8, which shows she had uncontrolled diabetes mellitus). The patient was advised urgent physician reference for control of sugar and blood pressure and surgery was deferred. When her blood sugar was reported to be 216 mg% fasting and PP- 340 mg% on 21.4.2015, she was referred to a physician for her blood sugar control and blood pressure control and to be reviewed after 1 week as it is not advisable to perform any kind of surgery until the blood sugars are brought back to normal. Accordingly, the patient was counseled properly by Dr. Meenakshi, nominal fees was charged, all investigations required prior to a major surgery were done. Blood sugar of the patient was properly controlled to 105 mg% before surgery. On considering the high risk of malignancy in postmenopausal woman because of post-menopausal bleeding, cystic glandular hyperplasia with obesity, hypertension and diabetes (which medically are collectively referred to as corpus cancer syndrome), a surgery was advised to the patient keeping in mind wellness of patient so as to save her from a miserable disease endometrial/uterine cancer. As per the Bulletin of American Cancer Society outlining the risks factors for endometrial cancer, the risk of the development of endometrial cancer may be as much as four times in women with diabetes and twice more likely in obese women and women with endometrial hyperplasia has a chance of 8-29% of developing uterine cancer. Novak's Gynecology Thirteenth Edition Chapter on Uterine Cancer page 1143-1144 also clarifies the risk percentage of endometrial hyperplasia in cases of women with hyperplasia, obesity and diabetes mellitus. Hence, collectively because of endometrial hyperplasia along with obesity as well as diabetes, the patient was at very high risk of developing deadly disease of endometrial cancer. Hence, the decision of performing the surgery was taken after thorough consideration of all the risk factors. The patient was already having recurrent post-menopausal bleeding. According to the standard text book of Gynecology, Obesity, hyper tension and diabetes are well known factor for developing cancer endometrium collectively named as; corpus cancer syndrome. As per medical literature vulnerability to postoperative sepsis increases many folds with pre-existing co-morbid conditions like obesity/DM (Diabetes)/ blood pressure (Hypertension) which are otherwise silent. The patient and her family were explained that she will be operated by a team of doctors consisting of her, Dr Meenakshi being at Sri Balaji Action Medical Institute (SBAMI), SBAMI is a multispecialty 200 bedded hospital accredited by NABH & NABL providing standard care. The patient took her first consultation on 1.4.2015 and surgery was done on 5.5.2015 and hence the surgery was not done in a hurry and in no way to extract money from the patient but in good faith to save the patient from complications of a dreadful disease of endometrial cancer and to save her life. The patient was admitted to the Hospital on 4.5.2015 in order to prepare her for the surgery next day. An utmost care was taken to bring her blood sugar level to normal before surgery to avoid any complications. All the risks and benefits of the procedure including but not limited to damage to internal organs, perforation, bleeding, sepsis, risks of anesthesia etc. were duly explained to the patient and her family in vernacular and informed consent was obtained in presence of Dr. Meenakshi. The patient was given peg lac on 4.5.16 to clear her bowel. Her blood sugar was controlled by physician. PAC was done which stated her to be fit for surgery and only then TLH with BSO was done by the team consisting of her and Dr. Meenakshi on 5.5.2015 under general anesthesia. All set protocols of surgery sign in, sign out, were done, prophylactic antibiotics were given. The surgery was performed by her and Dr. Meenakshi Bansal and staff nurse sister Jeena with anesthesia team doctors as per acceptable medical norms with due caution & care. During the surgery there were adhesions encountered, adhesiolysis was done and laparoscopic hysterectomy with bilateral salphingo oophorectomy was completed. The procedure was uneventful without any complications. Operation was conducted in accordance with set medical norms, utmost care and caution was taken in surgery. The surgery went uneventful and the patient was shifted to recovery room as her B.P and blood sugar remained normal throughout the surgery which lasted 2-2.5 hours The patient was conscious, comfortable and with stable vitals with adequate urine output on 5.5.2015 as seen by all doctors of gynecology team including her, Dr. Meenakshi and Dr. Ritu SR. In the recovery room, the patient's vitals were checked regularly (at interval of every 15 minutes) and found absolutely in normal range. Constant check was being kept on the patient by various doctors including anesthesia doctor’s team as per set protocol for this type of surgery. The patient was seen by Dr. Meenakshi Bansal in evening rounds. The patient's vitals per abdomen, examination and urine output were in normal range. The patient was kept nil orally as per standard protocols. Thereafter, the patient was seen by Dr. Neha who is a qualified MBBS, DNB Gynecology doctor, in labour room complex. Thereafter, on same day the patient was seen by Dr. Gurpreet Kaur who is qualified MBBS, MD Gynecology doctor in labour room complex, the patient was kept Nil Orally, was on intravenous fluids keeping in mind her diabetic status. Overnight her vital, chart record, urine output, blood sugar levels were checked at regular intervals (as per standard norms). Blood sugar levels were high at times accordingly required doses of injection insulin were given to the patient as advised by physician. On 06.05.2015, the patient was seen twice by the gynecology team who found her vitals to be normal with adequate urine output of 1400 ml with sluggish bowel sounds. The neutralizing drip of insulin was on flow. The Patient was shifted from the recovery room to the ward. The Patient's bowel sounds were present. On finding all within satisfactory range, she was allowed to take diabetic clear liquids by mouth. Allowing liquids to be taken by mouth is an indication of recovery of patient as per expectations at that time. The patient underwent physio-therapy session on 6.5.2015 at 11:50 am. Doctor had visited, the patient on 06.05.2015. On 6.5.2015 evening around 05:00 pm again Gynae-doctor team visited, the patient was comfortable and was having no complaints. Her vitals were normal. She again underwent physio-therapy session, the patient had no complaints of pain abdomen on 06.05.2015. Around 09:00 PM on 6.5.2015, the patient was again examined by Gynae doctor Dr. Neha. The patient was comfortable at that time also with all her vitals, urine output and per abdomen examination findings were well within normal range. The patient's vitals chart monitoring and blood sugar level assessment continued at regular intervals as per standard post-operative protocols. On 2nd post-operative day i.e. on 7.5.2015, early morning the patient, for the first time complained of pain in upper abdomen for which she was immediately attended by Gynae-doctor, Dr. Neha who is qualified MSSS, DNS (Gynae) doctor. The patient was advised to keep Nil orally and intravenous fluids were administrated, Antacid, anti-emetics and pain killer injections were given so as to relieve the patient of her pain. Required blood investigation were sent, pulse oximeter monitoring was started. The treatment to alleviate symptoms of pain and flatulence was started immediately. Again, in morning itself, the patient was examined by Gynae-doctor team including her and Dr. Meenakshi Bansal. The patient complained of acidity and flatulence, though her vitals parameters were stable. On examination, the patient had developed soft distension. It is pertinent to mention here that abdominal pain and flatulence in early recovery phase is common complaint in the patients who have had abdominal surgery and is quite expected during early post-operative days. On the basis of such complaints, a major decision of undertaking a second surgery of the patient would not have been the correct approach. Further investigation was warranted to get a clear diagnosis and as such there was no delay or negligence as alleged by the complainant or otherwise or at all. Hence, where on one hand treatment to relieve the patient from this pain was continued, side by side, the expert opinion for abdominal condition from General surgeon was sought from Dr. Subhash Aggarwal Sr. Consultant and Head of Surgery department and Team to rule out any complication from the surgery as well as and to decide further course of treatment and further evaluation and management of the patient. The details of visit of Surgery-I team and the treatment course recommended by them is recorded. Meanwhile, investigation reports were collected, the patient was continued to be given required treatment. Dr. Subhash Aggarwal & team examined the patient in the morning itself (around 10:00 AM). The patient had complained of distension abdomen and non-passage of flatus. On examination, patient was afebrile with pulse rate 84 per minute. They found the abdomen soft and distended with bowel sounds increased. On per rectal examination, there was soft faecal matter. They clinically provisionally diagnosed it to be ileus or intestinal obstruction for which they recommended Nil orally and I/V fluids. TLC was decreased so antibiotics were changed to higher ones. They advised for PC enema, ryles tube aspiration, input/output charting, blood investigation and C T - scan abdomen; Patient to be reviewed with the reports. The expert opinion was taken and advice duly followed. Meanwhile, doctor on duty who is qualified MBBS doctor supervised the patient and started following the instructions as advised by surgical experts. Again at 12:00 PM on 7.5.2015, she and Dr. Meenakshi Bansal examined the patient so as to know the condition and the progress of the patient. The visit details and findings were: As urine output was less at this time and blood urea and creatinine were on higher side, the radiology department required nephrology clearance for CECT abdomen. Dr. Rajesh Aggarwal, Head of Nephrology Department was informed. Meanwhile, Patient passed motion and fluid was aspirated through ryle's tube, the patient got some relief. The condition of the patient and the response to the treatment were recorded. The Patient was continuously observed by doctor on duty (in ward) by bed side monitor, kept on managing to get CT-scan done as was advised by surgical expert. Dr. Rajesh Aggarwal, nephrology, examined the patient and for clearance for CT-scan. Patient was seen by Dr. Rajesh Aggarwal (Nephrology unit-ll) with abdomen distension and decreased urine output. Patient blood pressure was 80 systolic. He advised for CVP monitoring and shifting of Patient to ICU and to avoid nephrotoxic agents including IV contrast. Patient was immediately attended by Gynae Team and was shifted to ICU. As her abdominal distension had increased, Dr. Subhash Aggarwal & team (surgery unit-I) was immediately contacted. As surgeon from surgery unit-I was busy in a major surgery, deciding not to waste any precious time another senior surgeon, who is equally well-qualified, Dr. Sandeep Gupta, Unit III, was consulted immediately telephonically for expert review in present condition. Meanwhile, the patient was shifted to surgical ICU second floor. Dr. Massani (intensvist) and team took care of the patient. Dr. Sandeep Gupta examined the patient in Surgical ICU, he advised for Exploratory laprotomy and proceed on clinical Judgment in the interest of patient along with resuscitative measures. The patient's family was informed about the patient's condition and the fact that she was having low blood pressure which gave rise to suspicion of intestinal perforation by Dr. Sandeep Gupta and high-risk consent was obtained from the patient's husband. The Patient was shifted to OT immediately. All risks and possible outcome were explained. The patient was treated in accordance with prevailing standard of care. In operation theatre the patient underwent exploratory laparotomy done by Dr. Sandeep Gupta, her and Dr. Meenakshi Bansal under general anesthesia along with anesthetist team Dr, Neeta Taneja, Dr, Manisha and Dr. Gautam. Per operatively, there was no bleeding inside. There was a pin head size perforation at anti-mesenteric border of small intestine. Rest of bowel was thoroughly checked and found it to be normal and healthy. After thorough lavage, as the perforation seemed of recent origin so primary closer of perforation was decided, perforation was closed by the general surgeon, drains were put bilaterally and abdomen was closed. Since the nature of injury was purely of a surgical domain, the decision of closure of perforation was made by the surgeon. It is pertinent to mention here that intestinal injury with presentation in 36-48 hours is a well-known risk when a patient undergoes a laparoscopic procedure. Reference can be made to various medical textbooks. Ref Shaws Text book of Gynecology, ed 16th, page. 208 states that: "*It is not uncommon to perforate the bowel with veress needle or trocar. The use of cautery or laser during /laparoscopic surgery can cause burns to the Intestine. This will be detected about 5-7 days later when the woman returns with peritonitis and ileus*”. The Shaw's Textbook of Gynaecology edition 16th also mentions on page 100 the various complications expected during a laparoscopic surgery. During a laparoscopic surgery, Veres needle and trocar injury to the small intestine may not be obvious because of small bowel redundancy and a tendency for small bowel to fall out of view (ref Te Linde's Operative Gynecology" (chapter diagnostic and operative laparoscopy under gastrointestinal injury page 282 and page 333) "Bowel perforation is one of the known complications of laparoscopic hysterectomy." (Berek & Novak's Gynaecology 15th Ed. chapter 23, 24) (Annexure 7). Same observations including the chances of developing a perforation of intestine are mentioned in Te Linde's Operative Gynaecology 10th Ed. Page 741,773, Shaws Text book of Gynecology, Ed 16th, page. 100 as well as Shaw's Textbook of Operative Gynaecology 6th Ed page 138,139. Again, as per standard surgical norms, the patient, her husband and other relatives were duly informed by Dr. Sandeep Gupta in presence of her and Dr. Meenakshi Bansal. They were informed about bowel perforation, closure of perforation, that it is known complication of laparoscopic surgery as was prior informed. After surgery the patient was shifted to SICU for further monitoring and was put on ventilator. Patient was intensively monitored in SICU by the critical care team of Dr. Masaani and Dr. Devan Juneja & others. Plaintiffs have hidden the facts that in ICU patient's condition started improving. Patient was continuously seen by respiratory physician Dr. Animesh Arya, medicine unit-I, Nephrology Unit-II (Dr. Rajesh Aggarwal), Surgery team Dr. Sandeep Gupta and Gynae doctor team (Her and Dr. Meenakshi). Patient was showing signs of improvement. On 8.5.2015 the vesopressor were stopped, blood sugar was near normal, drain showed minimal fluid. On 9.5.2015, the patient underwent 2D Echo showing concentric LVH mild LVEF 45 percent a complaint of AFFVR. The Patient was seen by cardiologist due to bradycardia and hypotension on 9.5.2015 at 4.30 pm, serum electrolytes, trop T, CPK, ABG were done, the patient was immediately revived. The Patient relatives and attendants were duly informed about the ongoing conditions and treatment about the patient. On satisfied with the ongoing treatment and care of the patient with due endorsement. Patient conditions showed improvement and was weaned off to CPAP mode of ventilation. When she visited the patient at 7.45 am on 10.5. 2015, The patient was stable with the pulse of 76 per minute and BP 110/80 and soft abdomen with drain in situ and urine output of 50 ml/hour. She explained the condition of the patient to a lady who introduced herself as sister-in-law of the patient. She had some personal important work in the USA for which she had applied for a leave in advance as per the procedure and the Hospital protocol. The Hospital was informed and the patient was handed over to Dr. Uma Swain, senior consultant Gyn-I who is a doctor of equal competence and caliber, and Dr. Sandeep Gupta. She was in constant touch with Dr. Meenakshi about the patient and came to know that the patient was off the ventilator on 13.5.15, was conscious, responding to verbal command. She was given oral feeds, passed flatus and motion on 18.5.2015. She was hemodynamically stable and her urine output normal i.e. 3240 ml/day. The patient was put on soft diet by surgery III. On 17.5.2015 the patient's surgical wound dressing was soaked and drain fluid also showed Klebsiella pneumonia and pus culture also showed klebsiellapneumonae with ET secretion done on 14.5.2015 also showing pseudomonas aeruginosa that was PAN-resistant. Antiseptic dressing was badly soaked on 18.5.2015 when wound bag was applied by Dr. Sandeep Gupta as the drain was already removed by Surgery III. There was wound soakage on 19.5.2015 and 20.5.2015 in the wound bag of around 750 ml when Dr. Pradeep Jain, gastrointestinal surgeon, was consulted who advised for C'T abdomen which showed enterocubaneous fistula Reference may be drawn here from SABISTON Textbook of Surgery The Biological Basis of Modern Surgical Practice 17th (Annexure 10) Edition where it mentions that postoperative fistula is a serious problem that carries a mortality of 15-20%. Another exploratory laparotomy with resection anastomosis with ileostomy was done by surgery III on 22.5.2015 around 10 am. After the surgery, there was no soakage in the bag and the patient had passed motion on 23.5.2015 as mentioned in Dr. Meenakshi's notes on 10 am. The Patient was continuously monitored by Dr. Uma Swain, senior consultant gynecologist, Dr. Meenakshi when the patient was sick and on ventilator. All the necessary investigation was done and good ICU care was given. Unfortunately, the patient's condition continued to deteriorate despite all care and she went in to multiple organ failure with serum creatinine of 2.1, urea of 89 and the patient went into septicemia and hyper bilirubinemia. Because of her low immunity, diabetes, obesity and other high-risk factors, she could not survive severe acidosis, hyperbilirubinemia, electrolyte imbalance and severe sepsis. As, patient was already suffering from uncontrolled diabetes, obesity, which increased the sepsis in multi-folds in short span of time. It is again re-iterated that the risk of pre-existing co-morbid conditions like obesity, diabetes mellitus and hypertension, which are otherwise silent, but significantly spread the sepsis in post-surgery patients affecting the patient in a catastrophic manner. All proper and adequate care & monitoring was done by well qualified doctors & staff in first 24 hours and thereafter, patient was monitored as per set & medically accepted norms. In-fact the cause of death of the patient was development and rapid spread of pseudomonas aeruginosa that is PAN-resistant infection, i.e. it is resistant to most of the antibiotics present, which was due to the patient's diabetes. According to textbook Harrisons principles of Internal Medicine 17 page 2166 and 2169 the patients with diabetes are at a high risk for cardiovascular morbidity and for various infections including post-operative infections.

She is a duly qualified laparoendosopic surgeon with vast experience. The patient needed and was advised TLH with BSO (Total Laparoscopic Hysterectomy with Bilateral Salpingo oophorectomy) as she was suffering from post-menopausal bleeding and on biopsy myometrium also showed adenomyotic changes in anterior wall and fundus. She (the patient) and her family were explained about procedure of operation and all its side effects and complication (including perforation). She consented for operation and signed consent form taking into account of medical and surgical risks. Her pre- anesthetic checkup was done and operation was delayed till her blood sugar was controlled. Her operation was done at well-equipped operation theatre at ultra-modern hospital with all facilities. The qualified anesthetist team was there. Her operation was uneventful. She was given good post-operative care. Her complication was detected in time as she was under best operative care by a duly qualified team. Her complication was attended in time and for correction, she was referred to a duly qualified surgeon. The surgeon attended the operation and did the repair of intestine. But because of co-morbidities like diabetes and hypertension, patient did not respond well to the treatment. In spite of best clinical efforts, patient landed in multi-organ failure and died. The patient came with co-morbidities like diabetes and hypertension. She suffered from complications which she consented as she took medical and surgical risk of operation. Her complications were detected in time and were responded as per standard protocol. It is unfortunate that she could not withstand complication and died because of co-morbidities like diabetes and hypertension. She (Dr. Ruby Sehra) has her utmost sympathies for her (patient) and family members. Her all treatment was done as per standard protocol.

Dr. Sandeep Gupta, Consultant Surgeon, Sri Balaji Action Medical Institute in his written statement averred that on 07.05.2015 around 2.30 p.m. he received a call from Dr. Ruby Sehra to opine one of the patients in surgical ICU. On examination patient was with low urine output & low BP, there was generalized guarding & rigidity of the abdomen, on removing surgical clips from umbilicus there was bile-stained fluid discharge. Since CECT scan as advised earlier was not possible because of Azotemia & General condition, So Exploratory Laparotomy & proceed was planned on clinical judgment in interest of the patient. Patient was shifted for Operation with detail explaining the risk & outcome of the said surgery & informed consent was taken. On 07.05.2015 in operation theatre patient underwent exploratory laparotomy done by Dr. Sandeep Gupta, Dr. Ruby Sehra and Dr. Meenakshi Bansal under general anesthesia along with anesthetist team Dr. Neeta Taneja, Dr. Manisha and Dr. Gautam. On Exploratory laparotomy there was no bleeding inside, there was a perforation of ileum at antimesentric boarder, margins of perforation were healthy and there was minimal contamination. Rest of the bowel thoroughly checked found normal & healthy, Ileal perforation margin freshened & perforation was closed in layers with onlay omental patch. Through abdominal lavage with normal saline done & 2 abdominal drains were placed one in pelvis & other in Morrison's area. *Farquharson's Text Book of Operative General Surgery 9th Ed. Emergency laparotomy chapter 14 page233-246; Hystrectomy procedure, Complications and Alternatives by Deborah J. Shimizu, Surgical complications in Laparoscopic hysterectomy, page 113-118*. In post operative area patient's relations were duly informed about the per operative finding & the procedure done. Patient was shifted back to surgical ICU on ventilator support. Post operatively patient was on inotropic support & her general condition was sick. The TLC count went to 1800. In surgical ICU patient was managed by Intensive care team. As patient was already suffering from uncontrolled diabetes & obesity, which might have increased the sepsis in multifold in short span of time. On 09.05.2015 patient had sudden tachycardia followed by bradycardia, intensivist did CPR, cardiologist diagnosed it to be Atrial fibrillation (FVR) On 12th May there was gradual improvement in the patient's condition, patient support to CPAP on ventilator then to T piece. On 13th May patient was extubated off ventilator. On 14th May, 2015, morning, patient was conscious, well oriented with all the parameters in normal range. Ryle tube feeding was started on 14th May2015. On 15th May, 2015 morning patient was conscious, well oriented and was started liquid diet. The patient passed motion on 15thMay, 2015 evening which is further indicative of improved condition of patient. On 16th May, 2015 patient was started soft diet, mobilization of patient out of bed was started she was regularly given albumin & blood transfusions. On 17th May, 2015 the Patient continues to be on soft diet, Patient had improved a lot. She was well oriented and talking well. All monitoring and treatment were continued. The patient again passed motion. On 18th May, 2015 abdominal drains were removed, patient was given albumin and blood transfusion as advised by the ICU teams for general building up of patient as guided by daily investigation reports of the patient. Daily dressing of the patient's abdominal wound continued along with diabetic control in lCU monitoring and management patient was in good recovery. On 19th May 2015, patient was advised to take high protein diet, potassium correction and albumin infusion. Blood sugar levels went high, insulin infusion started. Physician, ICU team, surgery team and respiratory medicine team continually looked after the patient. Patient started showing signs of wound sepsis with discharge from abdominal suture site. On 19.05.2015 there was some pus discharge from the suture site, a wound manager drainage bag was applied to wound site. "The global consequences of diabetes to the patient are well recognized. Numerous clinical studies have noted increased rates of infection that occur in diabetic patients. " Ref SABISTON Textbook of Surgery The Biological Basis of Modren Surgical Practice 11" Edition p;292) On 22.05.2015 an Abdominal Ultra sound was done to see any intra-abdominal collection, there was no intraabdominal collection. There was gradual increase in wound output from 400ml to 1700 ml. CECT scan abdomen was done, which showed Enterocutanous fistula without any intraperitoneal spillage. However, there was extensive skin induration Cellulitis at wound site, TLC count dropped to 1600. On discussion with Gastroenterologist and GI surgeon patient was planned for exploratory laparotomy & proceed (to make a controlled fistula as wound sepsis with excoriation cellulitis & septicemia has set in), for surgery under high-risk consent was taken after explaining the critical condition of the patient(Entercutanous fistula are a common known happening in patients with sepsis, malnutrition and immune suppression and diabetes after an abdominal procedure. Postoperative fistula is a serious problem that carries a mortality of 15-20 % (Ref SABISTON Textbook of Surgery The Biological Basis of Modren Surgical Practice 17th Edition.P:324). On 22.05.2015 patient was operated by Surgery Unit III on exploratory laparotomy, for enterocutanous fistula the ileal loop was densely adherent to peritoneum & surrounding tissue While separating the ileal loop there were some iatrogenic perforations in intestine segment so a localized resection of the ileal segment with proximal ileostomy & abdominal lavage was done for local collection. The relations were duly informed about the procedure & patient was shifted back to ICU on ventilator under critical care team. " Ref SABISTON Textbook of Surgery The Biological Basis of Modren Surgical Practice 20th Edition p;1288) On 23.05.2018 patient condition was critical, on ventilator with increasing vasopressm requirement, worsening LFT, high procalcitonin levels, worsening urinary output treatment as per intensive care team, grave prognosis explained to the relations in detail.

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

1. The patient Chander Kala, aged 60 years old female, known case of diabetes mellitus –Type II was admitted on 04.05.2015 at the said Hospital. She was diagnosed as a case of postmenopausal bleeding with cystic glandular hyperplasia and underwent total laparoscopic hysterectomy with BSO on 05.05.2015. The surgery was performed by Dr. Ruby Sehra and Dr. **Meenakshi Bansal. The p**atient was progressing well, but on 07.05.2015, patient had pain abdomen and developed distension of abdomen. General Surgeon opinion was taken. As patient went into shock, patient was immediately transferred to SICU followed by very urgent exploratory laparotomy (along with all resuscitation measures) with repair of pin head size small intestinal perforation and peritoneal lavage done. The surgery was performed by Dr. Sandeep Gupta, Dr. Ruby Sehra and Dr. Meenakshi Bansal. Patient was shifted from OT post exploratory laparotomy in intubated condition, and on high vasopressor support and soda bicarb infusion in view of severe metabolic acidosis. Post op investigations revealed leucopenia and deranged KFT. Expert opinion from the Nephrologist was taken in view of deranged KFT. Patient was stabilized and vasopressor support was tapered off, and ABG improved. FFP was also transfused in view of raised PT/INR. Blood and urine culture was sterile. Later patient developed AF with FVR for which Cordorone infusion was started and sinus rhythm was attained. Subsequently Echo was done which revealed Concentric LVH with mild global LV hypokinesia with EF 40%. CXR s/o B/L Pulmonary infiltration. On 09.05.2015 patient suddenly developed bradycardia HR- 40/min immediately patient was resuscitated as per ACLS protocol and ROSC achieved. Again, vasopressor support was started. Expert opinion from cardiologist, Pulmonologist was taken and advice implemented. Gradually there was improvement in her condition. Her vasopressor requirement decreased and she was weaned off mechanical ventilator and extubated on 13.05.2015. Her ET secretion culture dated 10.5.2015 was positive for resistant pseudomonas aeruginosa and she was continued on high end antibiotics. Her condition gradually improved and she was allowed liquid orally. Regular wound dressing was done. On 17.5.2015, leakage from surgical wound was noted which was initially managed conservatively. Her antibiotics were revised as per culture sensitivity reports. There was persistent leak from the surgical wound for which gastro-surgery opinion was taken on 20.5.2015 and CECT abdomen was done on 21.5.15. CT revealed extravasation of luminal contrast in to ventral abdominal wall through enterocutaneous fistula. On 22.5.2015, exploratory laparotomy and ileostomy was done, after proper written consent. Post operatively patient was shifted back to SICU in intubated state with vasopressor support. Patient was transfused two units PRBC and four units FFP post operatively. There was gradual deterioration in her condition. Her LFT and KFT started deteriorating. Patient was on high support which went on increasing. Nephrology opinion was taken for metabolic acidosis and decreased urine output and advice followed. Gastroentrology opinion was taken for deranged LFT and advice followed. In view of worsening metabolic acidosis nephrology review was taken and RRT was done on 23.05.2015. There was progressive decline in her general condition, her vasopressor requirement went on increasing and metabolic acidosis kept on worsening. On 25.05.2015 at 8:45 am patient developed bradycardia followed by asystole, immediately CPR was started which continued till 9:30 am but patient could not be revived and was declared dead at 09.30a.m.
2. The patient had been counselled regarding the various management options for treatment of cystic glandular hyperplasia, she choose to get the surgery done (Ist surgery). Besides this advantages of laparoscopic surgery like short recovery time,less hospital stay and less pain was explained to her. It was with written consent that surgery was done.
3. Complication of gut injury which is associated with procedure of laparoscopic surgery was detected in time and measures were taken as per the standard protocol.
4. Once the perforation of intestine is suspected or detected exploratory laparotomy (2nd Surgery) has to be done. This is done to prevent fecal peritonitis which eventually may lead to septicaemia.

Enterocutaneous fistula was operated (3rd Surgery) or she could have developed peritonitis and/or necrotizing fasciitis.

1. As per the records (OT notes of Total Laparoscopic Hysterectomy) available, adhesions were present and adhesolysis was done. However, the O.T. notes do not mention the site of adhesions and how the adhesions were taken care of, whether with scissors or by energy source.
2. Overall patient management was as per standard protocol.

In light of the observations made hereinabove, it is the decision of the Disciplinary Committee that no medical negligence can be attributed on the part of the doctors of Sri Balaji Action medical Institute,in the treatment administered to the complainant’s mother Smt. Chander Kala; however, the doctors are advised to be mindful of the fact that proper record keeping is part of good medical practice, hence, be exercised due diligence in this regard, for future.

Complaint stands disposed.

 Sd/: Sd/: Sd/:

(Dr. Maneesh Singhal) (Dr. Satish Tyagi) (Dr. Vijay Zutshi)

Chairman, Delhi Medical Association, Expert Member,

Disciplinary Committee Member, Disciplinary Committee

 Disciplinary Committee

Sd/: Sd/:

(Dr. Ashok Kumar) (Dr. Rajdeep Singh)

Expert Member, Expert Member,

Disciplinary Committee Disciplinary Committee

The Order of the Disciplinary Committee dated 31st October, 2023 was confirmed by the Delhi Medical Council in its meeting held on 06th November, 2023.

 By the Order & in the name of

 Delhi Medical Council

 (Dr. Girish Tyagi)

 Secretary

Copy to :-

1. Shri Amit Yadav, s/o Shri Dhanvir Singh, r/o- B-3/223, Paschim Vihar, New Delhi-10063.
2. Dr. Ruby Sehra, Through Medical Superintendent, Sri Balaji Action Medical Institute, FC-34, A-4, Paschim Vihar, New Delhi-110063.
3. Dr. Meenakshi Bansal, Through Medical Superintendent, Sri Balaji Action Medical Institute, FC-34, A-4, Paschim Vihar, New Delhi-110063.
4. Dr. Sandeep Gupta, Through Medical Superintendent, Sri Balaji Action Medical Institute, FC-34, A-4, Paschim Vihar, New Delhi-110063.
5. Medical Superintendent, Through Medical Superintendent, Sri Balaji Action Medical Institute, FC-34, A-4, Paschim Vihar, New Delhi-110063.

 (Dr. Girish Tyagi)

 Secretary