DMC/DC/F.14/Comp.2585/2/2022/ 22nd March, 2022

**O R D E R**

The Delhi Medical Council through its Disciplinary Committee examined a complaint of Shri Sudesh Julka, r/o- WZ-253/A, Street No. 08, Sadh Nagar, Palam Colony, New Delhi-110045, alleging medical negligence on the part of Dr. Anil Dhall of Venketeshwar Hospital, Sector-18A, Dwarka, New Delhi-110075, in the treatment administered to the complainant’s wife Smt. Sunanda Julka), resulting in her death on 17.08.2018.

The Order of the Disciplinary Committee dated 11th February, 2022 is reproduced herein-below :-

The Disciplinary Committee of the Delhi Medical Council examined a complaint of Shri Sudesh Julka, r/o- WZ-253/A, Street No. 08, Sadh Nagar, Palam Colony, New Delhi-110045 (referred hereinafter as the complainant), alleging medical negligence on the part of Dr. Anil Dhall of Venketeshwar Hospital, Sector-18A, Dwarka, New Delhi-110075 (referred hereinafter as the said Hospital), in the treatment administered to the complainant’s wife Smt. Sunanda Julka (referred hereinafter as the patient), resulting in her death on 17.08.2018.

The Disciplinary Committee perused the complaint, written statement of Dr. Anil Dhall, Cardiologist, Dr. Rajiv Malhotra, Director- Medical, Venkateshwar Hospital, copy of medical records of Venkateshwar Hospital, rejoinder of Shri Sudesh Jullka and other documents on record.

The following were heard :-

1. Shri Sudesh Julka Complainant
2. Shri Gitin Suri Son-in-law of the complainant
3. Dr. Anil Dhall Cardiologist, Venketeshwar Hospital
4. Dr. Chandan Kumar Medical Superintendent, Venketeshwar Hospital

The complainant Shri Sudesh Julka alleged that that his wife late Sunanda Julka (the patient) was admitted in the Venketeshwar Hospital on 15th August, 2018 at 12.25 p.m. after she was having vomiting sensation. She went walking to the emergency of the hospital and got some first aid treatment. After conducting few tests, the doctor in emergency ward advised them to admit the patient and he was asked to deposit Rs.30,000/-and after that he shifted his wife to the ICU. On 15th August, 2018 in the ICU, they conducted some more tests and told that it’s some gastro problem only and nothing is related to the cardiology. On 15th August, 2018, evening when he visited his wife in the ICU she was looking very uncomfortable. He was surprised to see that she came in the hospital walking and now she was totally exhausted. On 15th August, 18, whole day and night, no senior doctor examined the patient; they were given the excuse of National Holiday, although, the hospital comes under essential services. On 16th August, 2018, Dr. Anil Dhall visited the ICU and told his (the complainant) son-in-law that it is a gastro problem and nothing related to the stent which he (Dr. Anil Dhall) inserted on 12th July, 2018 after examining his wife, after that he (Dr. Anil Dhall) conducted some more tests and in the afternoon of 16th August, 2018, he (Dr. Anil Dhall) informed his (the complainant) son-in-law that there is no problem in the heart but he (Dr. Anil Dhall) never took any remedial action to give some relief to the patient as the patient was getting worst and worst. When he visited the ICU on 16th August, 2018 at 04.00 p.m., his wife was looking very-very tired, upset, and uncomfortable in pain and looking like half dead. He told his son-in-law that he should request Dr. Anil Dhall to shift the patient from ICU to private ward but unfortunately for them, Dr. Anil Dhall was busy whole day in the operation theatre for other surgeries and they were unable to reach him(Dr. Anil Dhall). At 08.00 p.m. on 16th August, 2018, his son-in-law succeeded in meeting Dr. Anil Dhall and requested that the patient is feeling very lonely and becoming worst and requested that the patient be shifted to private room. Dr. Anil Dhall told him (the complainant’s son-in-law) that tomorrow on 17th August, 2018 by afternoon he (Dr. Anil Dhall) will examine the patient and let him know about the exact picture of the case and improvement. He (Dr. Anil Dhall) also assured that the patient was fine and there was nothing to worry. They all family members more than dozens of people were in the hospital but nobody was able to help the patient. Then, he(the complainant) made a special request to the Duty Manager of the hospital at 09.00 p.m. that he should be allowed to meet his wife, with great difficulty they allowed him to see his wife for two minutes, when he entered to meet her at 09.00 p.m. on 16th August, 2018, there he noticed after meeting her that she was almost half dead and looking worse. She was looking at his face with helplessness. In his (the complainant) presence Dr. Anil Dhall visited the ICU at the same time and attended his wife just for forty five seconds and moved to the next patient. He also told him (Dr. Anil Dhall) that she is becoming worst but he (Dr. Anil Dhall) showed his (Dr. Anil Dhall) over confidence and told him that he (Dr. Anil Dhall) has already spoken to his (the complainant) son-in-law and he will get back to them by tomorrow afternoon. He spent about ten minutes with his wife in the ICU and noticed her body language like she was begging for her life but Dr. Anil Dhall never understood and never wanted to understand because he (Dr. Anil Dhall) was too tired after doing many surgeries the very same whole day in the operation theatre. This was told to him (the complainant) by the nurse of ICU that Dr. Anil Dhall is very tired, as he (Dr. Anil Dhall) was occupied entire day in the surgeries in the operation theatre. He (Dr. Anil Dhall) ignored his wife, as he(Dr. Anil Dhall) was planning to do the surgeries next day in the afternoon as discussed with his son-in-law. Very sorry to say that the doctors like Dr. Anil Dhall (Sena Medal) is occupied in meeting targets of private hospitals and forgetting patients who are in a need of timely treatment, he think that is very scary for others as well. They stayed in the hospital on 16th August, 2018 night and all of sudden 17th August, 2018 early morning at 05.30 a.m., they received a call that there is a cardiac arrest and when they reached ICU in a while, they found the patient declared dead. What shocking news?? She died because of Dr. Anil Dhall who was meeting his targets on 16th August, 2018 and took her granted for his mercy. Now please notice the negligence of Dr. Anil Dhall. He (Dr. Anil Dhall) gave them a death summary which says that the patient was planned for CAG at 05.00 a.m. on 17th August, 2018. How such a sena medal doctor wrote total lies in the death summary of a patient. Hospital never asked them to deposit any money with them if CAG is to be conducted at 05.00 a.m. Dr. Anil Dhall repeatedly told them that he (Dr. Anil Dhall) will examine the patient in the afternoon of 17th August, 2018. As he mentioned that he only deposited Rs.30,000/- at the time of hospitalization and hospital never asked them to deposit money for the so called planned CAG. It is very shameful for such highly professional person to tell lies that too on the dead person. He (Dr. Anil Dhall) wanted to hide his negligence and made a false death summary. He (Dr. Anil Dhall) is also confident that no one will ask him (Dr. Anil Dhall) anything and he (Dr. Anil Dhall) can go up-to any extent. Nobody can ask him (Dr. Anil Dhall) that why false death summary was made. At the time of the death of the patient, there was no cardiologist present in the ICU. It is very shameful for Dr. Anil Dhall as well as for the hospital who claims that they are world class. He (the complainant) read on Google that if any patient who got stent inserted in his/her body and got any vomiting sensation, it can be very dangerous for the patient but Dr. Anil Dhall never bothered and took the things very lightly that too at the cost of a life of the patient.

Dr. Anil Dhall, Cardiologist, Venketeshwar Hospital in his written statement averred that the patient late Sunanda Julka was first brought to Venketeshwar Hospital on 11th July, 2018 at 2052 hours. She complained of chest pain and breathlessness for the preceding twenty four hours. She was diagnosed to have acute infero-posterior myocardial infarction and was admitted at 2144 hours on 11th July, 2018. In view of the ongoing chest pain and hemodynamic instability, she was rushed to the cardiac catheterization lab immediately. The hospital’s cardiology team, including him (Dr. Anil Dhall) promptly attended to her and performed an emergency coronary angiography and intervention. The coronary angiography (CAG) revealed left main 50 % ostial disease, left anterior descending artery proximal 100 % occlusion, left circumflex 80 % disease and right coronary artery 100% occlusion. On review of the anatomy, it was felt that though the patient had triple vessel disease, the right coronary artery (which may have been supplying collaterals to the left system) had got acutely occluded. It was felt that re-vascularizing right coronary artery may improve the clinical situation hemodynamic instability. Accordingly, the family was informed and counseled, and after taking their consent, percutaneous coronary intervention with drug eluting stent to the right coronary artery was performed achieving TIMI 3 flow. The PTCA caused definite clinical and hemodynamic stabilization (for the sake of completeness it is stated that the patient had vagal reaction during the procedure and intra-aortic balloon counter-pulsation pump/temporary pacemaker insertion was also kept on standby). Though, there had been a significant delay from the onset of symptoms to the time when the patient reported to the hospital, their prompt response and intervention helped salvage the situation. The Echo at admission showed left ventricular ejection fraction of 0.35 with moderate to severe mitral regurgitation. After a clinical salvage, in view of 3-vessel disease, LV dysfunction and mitral regurgitation, the patient was referred to CTVS for CABG+/- mitral valve replacement at 2255 hours on 11th July, 2018 itself. The family was duly counseled that percutaneous coronary intervention with drug eluting stent was only an emergency life-saving procedure and the treatment was not complete. The patient improved clinically, though, she was found to have acute delirium (confabulations, hallucination, ICU phychosis) and, therefore, a neurological consult was also requested. Comprehensive cardiac surgery review was done on the next day i.e. 12th July, 2018 at 1030 hours. The surgical suggestion was for an initial conservative approach followed by high risk CABG+/- MVR after reassessment of clinical status and mitral regurgitation. On the advice of the neurologist, an MRI of the brain was also done and the same was found to be normal. Thereafter, the patient improved gradually. Echo on 13th July, 2018 showed left ventricular ejection fraction of 0.45 with moderate MR with RVSP 44+RAP. It is pertinent to mention that the family did not proceed with advised surgical revascularization. As she stabilized clinically, and the CTVS had suggested initial conservative approach with medical management, the patient was discharged on 15th July, 2018. The patient was in a stable condition and was prescribed Aspirin and Clopidogrel. On 23rd July, 2018, the patient was reviewed in the OPD, wherein further definitive treatment was re-emphasized, however. However, the patient and the complainant did not proceed with the advised treatment.

He further averred that the patient visited the emergency room (ER) of the hospital on 15th August, 2018 at 09.43 hours. The patient complained of abdominal discomfort and persistent vomiting since the night of 14 August, 2018. The patient did not complain of chest pain, shortness of breath of palpitations. The notes of the doctor on duty in the ER of the hospital and hospital records recorded that the patient had also come to the ER earlier at 0443 hours on 15th August, 2018 with similar complaints. The treating team of the hospital was aware of her cardiac history/status and the same was factored in while planning her triage. Accordingly, the cardiologist on duty in the hospital was called for a consultation. The duty cardiologist of the hospital reviewed her. The ECG did not show any fresh change and the Echo did not reveal any fresh wall motion abnormality. The patient’s vitals were stable. As per the recorded notes of the ER doctor, the patient and her family were not keen to get her admitted and wanted to go home against medical advice. The duty cardiologist asked for a troponin test. The troponin T was 0.089 (normal up-to 0.060). Given the borderline elevated troponis, by way of abundant caution, the patient and family was counseled by the team in attendance and admitted into the cardiac ICU. A CKMB test was also done, which revealed that it was not elevated. Her infective markers, however, were raised with a TLC of 14.78 with neutrophilia. The patient was treated symptomatically. It was considered that an intra-abdominal pathology was higher on the differential diagnosis and for which, a gastroenterology consultation was sought at admission. A bedside ultrasound of the abdomen and serum lipase and amylase was done at 1510 hours on 15th August. 2018. CBC and routine biochemical profile were done, which revealed polymorphonuclear leukocytosis. Creatinine at admission was 1.03 (normal) but serum potassium was 5.73. The hospital’s radiologist performed a bedside ultrasound examination which showed a small right kidney but was otherwise non-contributory. A repeat examination was suggested for the following morning in the radiology department. The patient was reviewed several times by the duty cardiologist. On the morning of 16th August, 2018, the patient was reviewed by consultant cardiologist, who noted increase of serum creatinine from 1.03 to 1.44 and mild increase in Troponin-T from 0.089 to 0.10, he also noted the normal CKMB. The patient’s clinical profile was dominated by retching, vomiting and abdominal discomfort with no chest pain or breathlessness. The consultant cardiologist asked for repeat CKMB, department echo and requested for a gastroenterology consultation. The Echo done in the non-invasive cardiology (Echo) lab of the hospital in the morning revealed that there were not fresh wall motion abnormalities and in fact the mitral regurgitation observed in the index admission had decreased. It was surmised that an acute coronary event was less likely cause of her presentation. As the patient was in the Echo lab at that time of his ICU rounds, he reviewed the patient in the Echo lab itself at 11.45 a.m. alongwith other cardiologists. In view of the clinical profile, he again requested a gastro consultation. In view of the borderline cardiac biomarker status, he called up the duty nurse in the ICU of the hospital and asked him to send another blood sample to the ER where the hospital has a different rapid reader biomarker assay. This report was also mildly elevated i.e. Troponin I 0.75 (n < 0.5) CKMB 7.95 (n<5), but with normal myoglobin. The ultrasound scan was repeated in the radiology department and showed a small right kidney but there was no other gross abnormality. The patient did not have any chest pain or shortness of breath; however, she continued to have abdominal discomfort and occasional vomiting. During his review visits, he did notice that her heart rate was around 100 bpm. The patient’s condition was discussed in detail in the cardiology department to decide the approach and next course of action. The family was counseled that her clinical profile was not entirely clear, required further investigation, observation and gastro opinion. A coronary angiogram to clarify the position was discussed with the family. The family was counseled that the presentation of abdominal pain, vomiting and polymorphonuclear leukocytosis was more suggestive of an intra-abdominal pathology, which could be inflammatory or vascular. Ultrasound examination had been performed twice and was not contributory. The cardiology department was aware of the clinical history and condition of the patient, inter alia : her coronary anatomy, recent MI and recent PTCA; she had undergone lifesaving PTCA to RCA one mother ago; she had severe disease in the left coronary system, which was dependent on collaterals from the RCA; her revascularization was incomplete; A RCA stent thrombosis in a patient whose entire coronary circulation depended on that one vessel would usually have had a more catastrophic/cataclysmic clinical presentation with definitive abnormalities in ECG, Echo biomarkers. The patient repeatedly denied having history of chest pain or shortness of breath. The ECG was unchanged, repeated echocardiography did not show any fresh wall motion abnormality and the mitral regurgitation had actually reduced, biomarkers were mildly or only borderline elevated (which may also be explained on the basis of an intra-abdominal pathology). The patient required further evaluation and observation. A coronary angiogram was planned, as it would have helped rule out a cardiac etiology of her current symptoms, if unchanged since previous admission or, it would have clarified the current coronary anatomy to facilitate definitive pending revascularization. However, her creatinine had increased from 01.03 to 01.44 and they were awaiting a gastro consultation. This clinical dilemma was explained to the family member, individually and collectively. Later in the evening on 16th April, 2018, the patient’s son and son-in-law were briefed by him that the cause of her symptoms was not yet clear, that gastro evaluation and the investigations were ongoing and, in any case, definitive treatment and complete revascularization required reassessment of her current coronary status. The family was reticent about consenting to an invasive procedure and instead suggested a CT angiogram. Even after convincing them in a detailed briefing, they met him in the staircase asking if a CT angiogram would suffice and he advised them that it was not appropriate in her situation, especially given her rising creatinine levels. They were counseled that a conventional catheter angiogram would be more appropriate in the given circumstances. They were counseled in detail that a CT angiogram was not appropriate, as it would involve higher contrast burden without the ability for any therapeutic intervention. After detailed counseling, they finally consented and a coronary angiogram was planned for the next morning. This was planned only after hydration and renal protection with a view to minimize kidney injury due to contrast, after reviewing renal and abdominal status and after obtaining gastroenterology opinion. The coronary angiogram was planned for the next day i.e. 17th August, 2018 because the family was initially reticent to consent to the procedure and agreed to the procedure only after detailed counseling. There was no clear and compelling clinical/investigative indication for an emergency angiogram, which in any case needed to be planned after hydration and reviewing the renal and clinical parameters of the patient. He wanted to proceed with extreme caution while conducting an invasive procedure on the patient and was awaiting a gastroenterology consultation and opinion because the profile was ambiguous. The hospital’s gastroenterologist reviewed the patient on evening of 16th August, 2018 and advised further radiological investigations, which the patient apparently declined. Further, the family requested for transfer of the patient from the ICU to a private room of the hospital. The family was counseled that the patient required close observation and was not fit to be shifted to a private room. Unfortunately, at 05.00 hours on 17th August, 2018 during a bout of vomiting, the patient probably aspirated and had a cardiac arrest. ACLS protocol was initiated but despite combined efforts of the cardiologist and anaesthesiologist on duty, she could not be revived. On the basis of the facts stated above and from the para-wise reply setout herein below, it is evident that the patient was attended to with utmost diligence, care and caution and was given all the required medical attention by him and other members of the cardiology team and there was no negligence on their part whatsoever.

Dr. Rajiv Malhotra, Director- Medical, Venkateshwar Hospital in his written statement reiterated the stand taken by Dr. Anil Dhall.

Dr. Chandan Kumar, Medical Superintendent, Venketeshwar Hospital also reiterated the stand taken by Dr. Anil Dhall.

In the rejoinder the complainant Shri Sudesh Julka claimed that they were never properly prognosticated about the patient’s condition by Dr. Anil Dhall. Further, they never refused to abide with the advice of the doctors regarding the CABG procedure or any other treatment which the patient required.

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

1. It is observed that the patient Smt. Sunanda Julka was brought at the Venkateshwar Hospital on 11th June, 2018 for chest pain and breathlessness. She was diagnosed to have acute infero-posterior myocardial infarction. The coronary angiography revealed triple vessel disease with left main 50 % ostial disease, left anterior descending artery proximal 100 % occlusion, left circumflex 80 % disease and right coronary artery 100% occlusion. She underwent primary angioplasty of right coronary artery at the said Hospital. The procedure was performed by Dr. Anil Dhall. After the procedure, the patient was referred to the CTVS team for CABG + valve repair. The CTVS team suggested for an initial conservative approach followed by high risk CABG + MVR. The patient was discharged on 15th July, 2018. The patient was reviewed on 23rd July, 2018 in OPD, however, the patient did not undergo the surgery.
2. The patient again presented in the said Hospital’s emergency on 15th August, 2018 with complaint of abdominal discomfort and vomiting since one day. The patient was investigated thoroughly with ECG, echocardiography, Troponin T and other blood investigations. Gastro opinion was sought. The ECG did not show any fresh change and Echo did not reveal any fresh wall motion abnormality. The Troponin T was 0.089 ng/ml (normal up-to 0.060) and kidney function were deranged. Repeated Echo did not show any fresh wall motion abnormality, accordingly, the patient was managed conservatively. A coronary angiogram was planned on 17th August, 2018, however, the patient died on 17th August, 2018.
3. It is observed that the patient required early CABG after the first procedure which could not be done. The patient had poor prognosis in the absence of revascularization. The patient was seen by the cardiologist team during the second admission and managed, however, before the definitive procedure could be done-CAG/CABG, she died on 17th August, 2018.

In light of the observations made herein-above, it is the decision of the Disciplinary Committee that no medical negligence can be attributed on the part of Dr. Anil Dhall of Venketeshwar Hospital, in the treatment administered to the complainant’s wife Smt. Sunanda Julka.

Complaint stands disposed.

 Sd/- Sd/- Sd/-

(Dr. Maneesh Singhal) (Shri Bharat Gupta) (Dr. Vimal Mehta)

Chairman, Legal Expert, Expert Member,

Disciplinary Committee Member, Disciplinary Committee

 Disciplinary Committee

The Order of the Disciplinary Committee dated 11th 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 Sudesh Julka, r/o- WZ-253/A, Street No. 08, Sadh Nagar, Palam Colony, New Delhi-110045.
2. Dr. Anil Dhall, Through Medical Superintendent, Venketeshwar Hospital, Sector-18A, Dwarka, New Delhi-110075.
3. Medical Superintendent, Venketeshwar Hospital, Sector-18A, Dwarka, New Delhi-110075.

 (Dr. Girish Tyagi)

 Secretary