DMC/DC/F.14/Comp.2869/2/2023/ 20th July, 2023

**O R D E R**

The Delhi Medical Council through its Disciplinary Committee examined a representation from Police Station, Malviya Nagar, New Delhi, seeking medical opinion in respect of death of Shri Rohit, allegedly due to medical negligence in the treatment administered to him at Aakash Hospital, 90/43, Malviya Nagar, New Delhi-110017, resulting in his death on 10.06.2019.

The Order of the Disciplinary Committee dated 15th June, 2023 is reproduced herein-below :-

The Disciplinary Committee of the Delhi Medical Council examined a representation from Police Station, Malviya Nagar, New Delhi, seeking medical opinion in respect of death of Shri Rohit (referred hereinafter as the patient), allegedly due to medical negligence in the treatment administered to him at Aakash Hospital, 90/43, Malviya Nagar, New Delhi-110017 (referred hereinafter as the said Hospital), resulting in his death on 10.06.2019.

The Disciplinary Committee perused the representation from Police, written submissions of Shri Sunil Kumar, written statement of Dr. Dharmendra Sharma, Medical Superintendent of Aakash Hospital enclosing therewith written statement of Dr. Mrinalini Sharma, Plastic Surgeon, Dr. Malavika Sharma, Anesthetist and copy of medical records of Aakash Hospital, Post mortem report No. 693/2019 dated 10.06.2019, subsequent opinion dated 19.02.2020 of All India Institute of Medical Sciences and other documents on record.

The following were heard in person:-

1) Shri Sunil Kumar Complainant

2) Shri Vineet Kashyap Son of the complainant

3) Dr. Mrinalini Sharma Plastic Surgeon, Aakash Hospital

4) Dr. Malavika Sharma Anaesthetist, Aakash Hospital

5) Dr. R.K. Mehra Medical Superintendent, Akaash

 Hospital

The Police in its representation has averred that an information was received at Police Station Malviya Nagar, New Delhi that one patient namely Rohit s/o unknown age 19 years was brought at Aakash Hospital Malviya Nagar for operation and he passed away during the treatment. The same information was lodged at Police Station Malviya Nagar Vide GD No. 64 A. On receipt of the same, they reached at Aakash Hospital, Malviya Nager New Delhi where the relatives of the deceased (the patient) met and their statements were recorded. They stated that the deceased had sustained burn injuries on 13th December 2018, for which, he was on conservative treatment and follow-up at Ram Manohar Lohiya Hospital, New Delhi. On 10th June, 2019, he was taken for the surgery for contracture release over the neck and chest. They further alleged that the deceased Shri Rohit passed away due to negligence of the doctors of Aakash Hospital. The post-mortem of the patient vide P.M. No.693/19 was conducted at AIIMS mortuary, New Delhi on 11th June, 2019. Viscera of the deceased was preserved and sent to RFSL, Chanakyapuri, New Delhi for chemical analysis. During the course of enquiry, notice U/S 91 CrPC was served to CMO Aakash Hospital to produce the relevant treatment documents. The medical records of Aakash Hospital and Ram Manohar Lohia Hospital as well as registration certificate of the doctors were collected and the same have been submitted to the Delhi Medical Council. Kindly put up the matter before the Committee of the doctors and opined as to whether there was any kind of negligenceon the part of the doctors of Aakash Hospital.

The complainant Shri Sunil Kumar stated that on 10th June, 2019, his son(the patient) Rohit was admitted in Aakash Hospital for the surgery, where Dr. Mrinalini Sharma and Dr. Malavika Sharma of Aakash Hospital treated his sonbut he died during the treatment, on the operation table, due to the negligent and irresponsible act of the doctors of the above said hospital. It clearly shows that the treatment given by the above said errant doctors to his son was very negligent and irresponsible.

In his written submission, Shri Sunil Kumar averred that his son was taken for the surgery at around 13.00 p.m. on 10th June, 2019, prior to that even the Consent Form was made to be signed by his son Vineet and it is pertinent to mention here that his son Vineet was a minor at the time and, there were other persons present other than his minor son who could have signed the said Consent Form. It may be noted that Dr. Mrinalini Sharma did not even have the decency to apprise his family herself that his son has died, she left in a clandestine manner and the body of his son was straightway given to the Police. He is not a stranger to the fact that sometimes the doctors do their best and sometimes the outcome is not favourable. However, the fact that Dr. Mrinalini Sharma, who just a few days prior was ferociously negotiating her fee with him, now would not even deign to look the mother whose child’s throat she has just slit in the eye. They could not understand as to what was happening, they had to see Dr. Mrinalini Sharma and seek answers, which they were able to do after a lot of efforts and during their interaction she told them that the surgery began at 14.00 p.m. and that his son suffered a heart attach within five minutes. Now, it is pertinent to mention there that if his son had died within five minutes, then, why were they not informed then and there? When he first saw the dead body of his son, in addition to the scars that he already had, he saw his throat which lay open. The post-mortem report has the following observations :-1) An incised wound placed traversely over the front of the neck on length 11 cm width varying between 1 cm to 2cm and subcutaneous issue deep, present 2 cm below the symphysis menti and 6 cm above the suprasternal notch, 2) An incised wound placed vertically over the midline of front of the neck of length 5 cm and width 1.52 cm upper end (illegible) meeting injury No.1 in the middle and lower end present 1 cm above the suprasternal notch. On layer-wise dissection of the neck,incised wound was found extending up to the muscle layer of the neck at a plane between the sternohyoid muscle and sternothyroid muscle in the midline. Around fifty grams of clotted blood was found in between the muscle layers adjacent to the incised wound trachea was intact. On opening trachea, mucosa was congested. He has been fighting his case against Dr. Mrinalini Sharma in the court of law, it has been four years and nothing fruitful has happened, but he will continue his fight because he does not want even a single soul to suffer what his family has suffered for each day for multiple years. It is his most humble request that a strict action be taken against Dr. Mrinalini Sharma.

Dr. Mrinalini Sharma Plastic Surgeon, Aakash Hospital in her written statement averred that the patient Shri Rohit, 19 years old male, visited her OPD on 04th May, 2019 as a case of post-burn contracture neck, right hand and left axilla with hypertrophic scarring over chest, right thigh and right hand. The patient had sustained thermal burns in December, 2018. The patient was treated at RML Hospital where split skin grafting for post-burn raw area neck and left axilla was performed in February, 2019. However, the patient suffered from graft loss and developed contracture subsequently. The patient had severe contracture over neck and restricted mouth opening within hypertrophic scarring over chest, right hand and right thigh with contracture left axilla. In view of multiple areas, she (Dr. Mrinalini Sharma) had counselled the patient and hisrelatives for astaged approachand planned for release of neck contracture with split skin grafting on 10th June, 2019. All pre-operative investigations were ordered and after ensuring that all reports were normal, the patient was posted for the surgery. In the preoperative period, pre-anaesthetic evaluation was done and anticipated difficulty in intubation was explained. The consents were taken from the patient and the relatives in view of restricted mouth opening and inadequate neck extension. All pre-anesthetic protocols were followed. Xylocaine sensitivity was performed and the vitals was noted. After premedication was given, the vitals were reconfirmed to be normal and Xylocaine infiltration (2% with adrenaline) was done into scar tissue in the neck (after aspiration to ensure that no blood vessels were punctured accidently). Minimal release of scar tissue was done by giving an incision in the neck till the subcutaneous tissue. Intubation was performed successfully after the manouvre. However, after intubation, the patient did not maintain O2 saturation and developed bradycardia. Despite adequate ventilation, the SPO2 was continuously dropping. Tracheostomy was attempted but had to be abandoned, as the patient went into asystole. The CPR was started according to ACLS protocols and was continued for forty minutes. However, despite all efforts, the patient could not be revived. The physician was called and the patient was declared dead in front of the patient relatives and staff. She (Dr. Mrinalini Sharma) likes to conclude her statement with the plea that she had followed all protocols as a plastic surgeon and discharged her duties to the best of her ability.

Dr. Malvika Sharma Anesthetist, Aakash Hospital stated that the patient Shri Rohit, 19 years old male, was admitted on 10th June, 2019 to this hospital under Dr. Mrinalini Sharma (Plastic Surgeon) as a case of post-burn contracture neck, right hand and left axilla and hypertrophic scarring over chest, right thigh and right hand. He was posted for post-burn contracture neck and right-hand release and split skin grafting under general anesthesia. The patient was clinically examined. Thorough pre-anesthetic check-up was done and all the investigations were reviewed and found to be within normal limits. The consent was taken from the patient and the relatives and they were explained about the difficult intubation in view of restricted mouth opening and inadequate neck extension. Pre-operatively, all monitors were attached and I.V. access was secured. All vitals were within normal limits. Pre-medication was given and the patient was ventilated using bag and mask ventilation. After ensuring that all vitals were within normal limits, the surgeon gave an incision through the neck contracture after Xylocaine Infiltration (Xylocaine sensitivity was tested on admission and found non-reactive). Intubation was carried out and was successful in the first attempt with no difficulty. Position of the tube was confirmed as per protocol by the chest auscultation. The chest was rising well, bilateral air entry was equal. However, post-intubation, the patient’s oxygen saturation started falling and he developed bradycardia. The SPO2 and pulse rate was continuously dropping and could not be maintained despite adequate ventilation. Tracheostomy was attempted but abandoned to start CPR, as the patient went into asystole. The CPR was started according to ACLS protocol and was continued for forty minutes. However, the patient could not be revived despite all efforts. The physician was called and the patient was declared dead in front of the hospital staff, relatives and physician. In conclusion all protocols were adhered to, during both pre-op and intra-op period. She (Dr. Malvika Sharma) had performed her duty as an anaesthetist to the best of her knowledge and ability and within all prescribed guidelines.

On enquiry by the Disciplinary Committee, Dr. Malavika Sharma stated that she used No.4 laryngoscope blade. Further, even though, they anticipated difficult intubation because of the burn contracture of the neck and chest, but after the surgeon has given the neck incision to partially release the contracture, she did not experience any difficult in intubation and according to her, the intubation was successful. As per her, the drop in SPO2 was due to bradycardia.

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

1. The patient Shri Rohit, 19 years old male was admitted in Akash Hospital on 10th June, 2019 as a case of post-burn contracture of neck, right hand and wrist and hypertropic skin in anterior right thigh and chest. He underwent pre-anaesthesia check-up. He was taken-up for contracture release of neck and split skin grafting under consent on 10th June, 2019 under general anaesthesia. Dr. Mrinalini Sharma was the operating surgeon and Dr. Malavika Sharma was the anaesthetist. The patient was taken to the OT at 2.30 p.m. Incision and release of contracture neck were planned prior to intubation to facilitate intubation. Release of contracture by incision was done after injecting 2% Xylocaine with adrenaline and the patient was intubated. Induction was done with injection Propofol and injection Vecuronium. Intubation was done with ETT 7 number cuffed. Position of the tube was confirmed by auscultation of the chest, the chest wall was noted to be rising well and bilateral air entry was equal. However, immediately after intubation, the patient’s saturation started falling and he developed bradycardia. The vitals were : pulse was 66/minute, blood-pressure was 100/60 mmHg, SPO2 was78%↓↓, ETCO2 was 34. The SPO2 and pulse rate continuously kept dropping and could not be maintained. Tracheostomy was attempted but it had to be abandoned, as the patient went into asystole. CPR was initiated but the patient could not be revived and was declared dead at 04.25 p.m. (10th June, 2019).

The cause of death as per subsequent opinion dated 19th February, 2020 in reference to post-mortem report No.693/2019 was that the exact cause of death cannot be given, however, death due to shock resulting from vagal stimulation during the alleged procedure cannot be rule out.

1. The contention of Dr. Malavika Sharma, Anaesthetist that the drop in SPO2 was due to bradycardia, is medically untenable, because the most probably reason for fall in SPO2 is improper intubation, rather than bradycardia. And both can occur in situation with improper intubation and ventilation.

Further, since trachestomy was attempted, it shows that the intubation was not proper, which was not taken cognizance off. by the anaesthetist. Ideally under such circumstances, tube should have been taken out and the patient should have been ventilated using bag mask, so that the saturation could have improved and then intubation may have been re-attempted with the assistance of more experience anaesthetist.

It is, thus, apparent that Dr. Malavika Sharma made an error in judgement in diagnosing of improper tracheal intubation and, thus, did not initiate timely remedial measures to salvage the situation of fall in SPO2 and heart rate, which unfortunately led to the demise of the patient.

Dr. Malavika Sharma, Anaesthetist, has contended thatthe probable cause for the patient suffering bradycardia was endotracheal intubation or vagal stimulation. It is noted that the subsequent opinion in reference to post-mortem report No.693/2019 has also opined that exact cause of death cannot be given. However, it has also alluded that death due to shock resulting from vagal stimulation cannot be ruled out.

It is noted that the post-mortem report could not define exact cause of death. We are of the considered opinion that the subsequent observation that ‘death due to shock resulting from vagal stimulation cannot be ruled out’, is misplaced, as post mortem cannot diagnose the vagal stimulation because that occurs in a living body.

1. It is noted that the Consent Form for the surgical procedure as well as the consent for anaesthesia bears the signature of Shri Rohit and witnessed by his brother. It is observed that since Shri Rohit was an adult, he could have consented to the surgery himself.
2. It is observed that old post-burn contracture neck is always difficult and challenging from the anaesthetist point of view. The gadgets for airway management like fibre optic bronchoscope and video laryngoscope should be readily available in the O.T., which were not there, so that any complication of the nature which has happened in this case and was foreseeable, could have been managed properly. Further, such anaesthetist procedure should ideally be conducted by a more experienced and skilled anaesthetistor at-least in their presence.

In light of the observations made hereinabove, it is the decision of the Disciplinary Committee that Dr. Malavika Sharma erred in judgement in the treatment of the patient Shri Rohit, she is, therefore, directed to undergo 15 hours of Continuing Medical Education (C.M.E.) on the subject related to ‘Airway Management’ and submit a compliance report to this effect to the Delhi Medical Council.

Matter stands disposed.

 Sd/: Sd/:

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

Chairman, Delhi Medical Association,

Disciplinary Committee Member,

 Disciplinary Committee

Sd/: Sd/:

(Dr. Vishnu Datt) (Dr. Shalabh Kumar)

Expert Member Expert Member

Disciplinary Committee Disciplinary Committee

The Order of the Disciplinary Committee dated 15thJune, 2023was taken up for confirmation before the Delhi Medical Council in its meeting held on 19th June, 2023 wherein “whilst confirming the Order of the Disciplinary Committee, the Council observed that the following observations, appearing at the following point of the Order of the Disciplinary Committee, is unwarranted, as the Disciplinary Committee in its Order has already noted that it was error in judgement; hence, be expunged.

2) Second Paragraph :-“**with the assistance of more experience anaesthetist.”**

2) ThirdParagraph **:-“and, thus, did not initiate timely remedial measures to salvage the situation of fall in SPO2 and heart rate, which unfortunately led to the demise of the patient.”**

2) Last Paragraph :-“**We are of the considered opinion that the subsequent observation that ‘death due to shock resulting from vagal stimulation cannot be ruled out’, is misplaced, as post mortem cannot diagnose the vagal stimulation because that occurs in a living body.**”

3) **“It is observed that since Shri Rohit was an adult, he could have consented to the surgery himself.”**

4) **“The gadgets for airway management like fibre optic bronchoscope and video laryngoscope should be readily available in the O.T., which were not there, so that any complication of the nature which has happened in this case and was foreseeable, could have been managed properly. Further, such anaesthetist procedure should ideally be conducted by a more experienced and skilled anaesthetist or at-least in their presence.”**

The Council further confirmed that Dr. Malavika Sharma shall undergo 15 hours of Continuing Medical Education (C.M.E.) on the subject related to ‘Airway Management’ within a period of three months from the date of the Order and submit a compliance report to this effect to the Delhi Medical Council.

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

By the Order & in the name of

 Delhi Medical Council

 (Dr. Girish Tyagi)

 Secretary

Copy to :-

1. Shri Sunil Kumar, 2592, 03rd Floor, Naya Bazar, Nayi Basti, Near Punjab & Sind Bank, Delhi-110006.
2. Dr. Mrinalini Sharma, Plastic Surgeon, Through Medical Superintendent, Akash Hospital, 90/43, Malviya Nagar, New Delhi-110017.
3. Dr. Malavika Sharma, Anaesthetist, Through Through Medical Superintendent, Akash Hospital, 90/43, Malviya Nagar, New Delhi-110017.
4. Medical Superintendent, Akash Hospital, 90/43, Malviya Nagar, New Delhi-110017.
5. Station House Officer, Police Station, Malviya Nagar, DD No.64A, Dated 10.06.2019, PS Malviya Nagar, New Delhi-110017-w.r.t. DD No.64A, Dated 10.06.19, PS Malviya Nagar, New Delhi-**for information**

 (Dr. Girish Tyagi)

 Secretary