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Case Report

Alleged Medical Negligence in Tubectomy Associated Death: A Case Report

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ABSTRACT

A 27-year-old, mother of four children, from rural background visited a government district hospital for permanent birth control under a government programme. She was advised to get admitted for the Laparoscopic Tubal Obliteration which was planned for next day. Accordingly, she got admitted in the morning and was operated in the afternoon and by evening she was discharged in a recovered condition with an advice to come for stitch removal after one week. Unfortunately, she expired on postoperative 7th day at home. A police complaint of wrong treatment was lodged. The autopsy revealed massive intestinal haemorrhage from colonic diverticulum leading to hemorrhagic shock as the cause of death as. After the local inquiry, the complaint was also registered at national human rights commission. Forensic investigation framework along with correlation of cause of death with treatment has been discussed in the light of professional standards.

Keywords: Diverticulosis, Intestinal haemorrhage, Medical negligence, Tubal ligation

INTRODUCTION

Sterilization services and quality of care being provided is one of the main concerns of the Reproductive and Child Health Program of the Government of India for addressing the large unmet need in terminal methods [1,2]. To achieve this goal, a revised 'Standards on Female [1] and Male sterilization [2] has been prepared based on the latest national and international guidelines available. The basic qualification required for female sterilization is either of these; trained MBBS, DGO, MD (Obs and Gynae), MS (Specialist in another Surgical field). The doctors can perform Mini-Lap and/or laparoscopic sterilization only after such training. Ordinarily the eligible client should be of sound mind, ever-married of the age group of 22-49 years, should be having at least one child who is of the age above one year. The client should fulfil the criteria of eligibility for surgery. In the unlikely event of any complication / failure/ death there is a redressal mechanism available in the form of indemnity coverage.

Compensation is provided, as per the existing provisions of the Government of India "Family Planning Indemnity Scheme", to the patient/ her dependent if any complication arises due to the procedure of sterilization, including death of the patient. The compensation being provided serves

as full and final settlement and she/ her dependent will not be entitled to claim any other compensation including cost for upbringing of the child, if any, born on account of failure of sterilization, over and above the one offered, from any court of law in this regard [1,2].

Up to 2 lac rupees is provided in cases of death attributable to sterilization (inclusive of death during the process of sterilization operation) in hospital or within 7 days from the date of discharge from the hospital. Up to Rs. 50,000 is given as compensation, if such deaths happen within 8 - 30 days from the date of discharge from the hospital. Up to Rs. 2 Lac per claim has been fixed for indemnity per Doctor/Health Facilities but not more than 4 in a year. Beneficiary to the claims should file documents within 90 days from the occurrence of the event of Complications /Failures/Deaths. Claims would be settled within15 working days in case of death [1,2]. We are presenting a case of alleged medical negligence that expired within a week of laparoscopic tubectomy after the discharge.

CASE REPORT

The complainant (husband) stated that a wrong tubectomy surgery was conducted on her wife at a District Hospital. A few hours after the operation, the victim was discharged. Subsequently on the sixth day, the victim died due to severe intra-abdominal bleeding at home.

The deceased was 27 years old with no history of past/ present illness/allergic/chronic illness. Her haemoglobin was 6.7gm% with blood group A-positive. Her viral markers (HIV/VDRL/HBS) status was non-reactive. Systemic examination findings were non-significant. She was operated (Laparoscopic Tubal Obliteration: LTO) on the subsequent day, after taking informed consent, under local anaesthesia along with short general anaesthesia with sedation (Injection Pentazocine, injection Midazolam 2mg). The antibiotic coverage included Inj Lactamine. Adequate analgesia, oxygen saturation and hydration were maintained. Vitals charting was done and it remained uneventful. The operation and post-operative period were uneventful. Same day, she was discharged in a stable condition in the evening with an advice to review after 1 week for stitch removal. After observation and uneventful peri-operative and post-operative period, she was advised to get discharged. In response, the patient expressed her concern that she cannot live at home and she has small children at home, however she was counselled to get discharge after giving information about dealing with any eventuality if they arise during her stay at home. If nothing goes wrong, she can come after 7 days for removal of sutures. Subsequently on sixth day, the victim died due to severe intra-abdominal bleeding at home. On autopsy, body was pale. Single suture knot was found placed below umbilicus. Ecchymosis was seen in periumbilical region in an area of 12x6cm. Blood clots were seen involving small and large intestine with diverticulum. All the internal organs were pale in appearance. The cause of death was mentioned as intestinal haemorrhage from colonic diverticulum leading to hemorrhagic shock. Manner of death was natural.

As the death was related to the birth control programme of the state government, the facts were inquired in detail by a panel of expert doctors including the Chief Medical Officer. A three doctor's team was sent to the home of the deceased. During the enquiry, following facts came out. The patient expired in the morning at home at about 7.00 to 8.00am, for which a police case was lodged. The patient had 4 live children, the smallest being 1 year of age. This patient was discharged and sent back through an ambulance at home. It also came out that the lady used to remain ailing most of the time. This fact was never reported to the doctors before the tubectomy operation.

The cause of death was given as haemorrhagic shock with chronic diverticulitis in addition, not related to tubectomy. In this matter through Family Planning Indemnity Scheme, 2 lacs INR were given as compensation to the family of the deceased. A recommendation "to follow standard operative procedure for sterilization" was also made.

DISCUSSION

Severe anaemia at the time of undergoing surgery increases the chances of development of post-surgical complications. As per NRHM (National Rural Health Mission) guidelines 2006 for female sterilization, if Hb <7gm%; the underlying disease should be identified. The procedure (comes under category D) should be delayed until the condition is evaluated and or corrected. Alternative temporary method of contraception should be provided [1,2].

In this case the level of haemoglobin was less than 7gm%, which should have alerted the operating team to delay the procedure and underlying disease-causing anaemia should have been evaluated/identified.

In the present case the cause of death was "intestinal haemorrhage from colonic diverticulum leading to hemorrhagic shock and death". The patient should have been investigated for this underlying disease i.e. diverticulitis which is usually identifiable on radiological investigations and commonly studied using CT scan [3]. But at the same time asymptomatic diverticulosis is often an incidental finding in patients undergoing imaging for other indications [4].Colonic diverticular bleeding ceases spontaneously in 70% to 90% of cases [5,6]. However, approximately 4% of patients with colonic diverticulosis suffer from severe diverticular bleeding [7].

In this case, the operation tubectomy should have been delayed. Continuing with the elective surgery was in contradiction of NRHM guidelines. However, in view of the cause of death i.e. bleeding from diverticular disease after a gap of about one week from date of operation; the possibility of spontaneous independent bleed cannot be ruled out and is not specifically in direct consequence to operative procedure.

CONCLUSION

The team which provides permanent contraceptive procedures should be well aware of specific contra-indications of the operative procedures and should strictly adhere to the standard operative procedures. Regular training programmes for contraception should be provided under NRHM.

For a comprehensive investigation of such cases, the following questions should be considered relevant during forensic investigation:

1. Whether valid consent was taken?
2. Whether the operating team was trained and qualified?
3. Whether the patient was suffering from any known illness?
4. Whether such history was taken during consultation before surgical intervention?
5. Whether the patient was operated for its absolute/ relative indication/contra-indication?
6. Whether there was any damage in direct consequence to contravention of prescribed guidelines?
7. Whether there is any correlation between postoperative consequences and the cause of death?
8. Whether the patient was discharged in stable and recovered condition with proper post-operative advice?
9. Whether the clinical record is corroborating with statements of the operating team, autopsy report and other facts of previous inquiry?
10. If there was any liability, whether compensation was given to the family?

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