DMC/DC/F.14/Comp.2167/2/2022/ 19th October, 2022

**O R D E R**

The Delhi Medical Council through its Disciplinary Committee examined a complaint of Shri Jai Prakash Chauhan, S/o Lt. Chandra Singh, R/o T-58A Nangli Razapur, Sarai Kale Khan, New Delhi-110013, forwarded by the Directorate General of Health Service, Govt. of NCT of Delhi, alleging medical negligence on the part of the doctors of Jeewan Hospital, 150, Jeewan Nagar, Opp. Maharani Bagh, New Delhi-110014, in the treatment of the complainant’s nephew Shri Vipin Chauhan, resulting in his death 06.07.2017.

The Order of the Disciplinary Committee dated 29th July, 2022 is reproduced herein-below :-

The Disciplinary Committee of the Delhi Medical Council examined a complaint of Shri Jai Prakash Chauhan, S/o Lt. Chandra Singh, R/o T-58A Nangli Razapur, Sarai Kale Khan, New Delhi-110013 (referred hereinafter as the complainant), forwarded by the Directorate General of Health Service, Govt. of NCT of Delhi, alleging medical negligence on the part of the doctors of Jeewan Hospital, 150, Jeewan Nagar, Opp. Maharani Bagh, New Delhi-110014 (referred hereinafter as the said Hospital), in the treatment of the complainant’s nephew Shri Vipin Chauhan (referred hereinafter as the patient), resulting in his death 06.07.2017.

The Disciplinary Committee perused the complaint, written statement of Dr. Rajeev Om Prakash, joint written statement of Dr. Rajeev Om Prakash, Dr. Vipender Sabharwal, Director, Jeewan Hospital, copy of medical records of Jeewan Hospital, written submissions of Shri Jai Prakash Chauhan and other documents on record.

The following were heard in person :-

1) Shri Jai Prakash Chauhan Complainant

2) Dr. Rajeev Omprakash Surgeon, Jeewan Hospital

3) Dr. Ajeet Consultant Medicine, Jeewan Hospital

4) Dr. Vipender Sabharwal Medical Superintendent, Jeewan Hospital

The complainant Shri Jai Prakash Chauhan alleged that the patient Shri Vipin Chauhan who was suffering from stone in the gall bladder underwent cholecystectomy on 16.06.2017 at Jeewan Hospital which was performed by Dr. Rajeev Om Prakash. Post surgery, the patient experienced difficulty in breathing, even though, he had no such complaints prior to surgery. Subsequently on 24.06.2017, the patient was subjected to second surgery(ERCP with stent placement). Thereafter, even though, the patient’s condition was not good, he was discharged on 03rd July, 2017. On 05.07.2017, the patient suffered from acute breathlessness, hence, he had to be readmitted in Jeewan Hospital. No doctor saw him for a long time and only when his condition further deteriorated that he was shifted to ICU. On 06.07.2017, he was put on ventilator. The patient died on 06.07.2017 because of medical negligence of doctors of Jeewan Hospital. It is requested that strict action be taken in this case.

The complainant Shri Jai Prakash Chauhan in his written submissions averred that during the first week of June, 2017, the patient experienced some pain in his abdomen and, therefore, the patient was taken to SDM Charitable Medical Centre in Jangpura Extension, New Delhi to get an abdominal ultrasound done. The report of the ultrasound reflected that the patient was having cholelithiasis (stone). The patient was did not have any other problems or complication and was in an absolutely healthy state, as can be clearly seen from the ultrasound report dated 09th June, 2017 which is a part of the official record. The patient then approached the Jeewan Hospital for the proper treatment of the stones, as Jeewan Hospital had represented itself as one of the hospitals having the best in class facilities to deal with stones. The doctors and the hospital assured the patient and his family members including him (the complainant) that they have the expertise to properly treat the stones found in the patient. The doctors and hospital had advised the patient that in order to remove the stones, the patient would have to undergo an operation. The patient alongwith his family members agreed to undergo the said operation, as it involved very minimal risks and were assured by the doctors and the hospital that it was the best and correct line of the treatment and that the patient was in very safe hands in the hospital. It is not out of place here to mention that prior to the operation, the doctors and the hospital conducted their own medical test of the patient which showed that the patient was in otherwise good health excluding the mild pain due to the stones and there was no other problem with the patient. Subsequently, on 16th June, 2017, the patient was operated by the doctors of Jeewan Hospital’s. It is pertinent to note here that the doctors and the hospital went for laparoscopy operation (i.e. operation by way which involves minimum risk) but due to negligent acts during the surgery, as a result of deficiency of services and lack of due care on part of the doctors and the hospital, the operation was stopped midway and the doctors came out of the operation theatre in a state of trepidation and panic to inform him(the complainant) alongwith the family members of the patient about the situation. Thereafter, the doctors and the hospital advised him and family members to go for an open surgery and presented that as the only option available to the complainant. Thereafter, the doctors under undue pressure took the consent for an open surgery. The patient had, then, undergone an open surgery by the doctors. Further, the general consent for authorization signed by Shri Sachin Chauhan, brother of the patient is not an accepted legal document, as it was not an Informed Consent and also not signed by the patient. The risks columns had been left totally blank, which means that the surgery was performed without sharing the risks with the patient and making a note of the same. The second surgery was undertaken for the reasons that as the first surgery was done negligently by Dr. Rajeev Om Prakash, as it caused injury to the common bile duct of the patient. Such act of Dr. Rajeev Om Prakash was aggravated by the acts and omission on part of the doctors and the hospital. As per pre-operative ultrasound scan, there were no stones in the common bile duct and, therefore, there was no indication for exploring the, common bile duct. Dr. Rajeev Om Prakash has harmed the patient by exploring the common bile duct which caused damage to the bile duct which, led to bile leak in the peritoneal cavity, leading to biliary peritonitis and sepsis which eventually led to the patient's death. One cannot fathom as to why was the open surgery done in such haste without consulting a hepato-biliary surgery specialist doctor or took his assistance while conducting the said open surgery. The haste only suggests a cover-up by the doctors and hospital of their negligence in damaging the bile duct, because of which, bile leak occurred in the peritoneal cavity, which led to biliary peritonitis and sepsis, and which ultimately was the cause of death of the patient. Thus, the patient was operated and was denied of the benefit of second opinion, recommendation or assistance by a hepato-biliary specialist doctor, especially when Dr. Rajeev Om Prakash admits to the fact that he is only MBBS, MS in general surgery, thus, cumulatively making the doctors and hospital responsible, in the act of negligence, in not providing specialist care to the patient. The doctors and the hospital used hegar's dilators during the surgery which is a rigid stainless steel dilator, used by obstetrician and gynaecologist for dilating the cervix. This instrumentation by hegars dilator caused acute pancreatitis. No surgeon in his ordinary senses would ever use hegars dilators in the common bile duct. The patient was, therefore, denied of the treatment by a hepato-biliary surgical specialist, which is clear case of negligence on part of the doctors and the hospital and such negligence has occurred and perpetrated, due to the acts and omissions of the doctors and hospital, in not intervening at the right time, but rather continuing with the negligent acts of Dr. Rajeev Om Prakash. It is a known that laparoscopic operation involves minimal risk and invasion, yet damage to bile duct was done by Dr. Rajeev Om Prakash. The complications in surgery were blamed on the fat laden neck of the bile duct. However, there is no documentary evidence which has been provided by the doctors and the hospital to support the said submission. The ultrasound of the abdomen performed at SDM Charitable Centre mentioned no such condition of the patient. Dr. Rajeev Om Prakash during the said surgery, used hegar's dilator which is a solid stainless steel dilator used to dilate the cervix in obstetric practice and never used in hepato-biliary surgery and has also been found to be a leading cause of acute pancreatitis. It is strange as to why was the family of the patient was not informed about such complications like the damage to the bile duct. This clearly shows that the patient was subjected to suffer because of the two operations conducted by Dr. Rajeev Om Prakash which was the consequence of their own negligent act. The plan of care document, as prepared, clearly reflects that the surgery was to be conducted by way of laparoscopy which, however, failed and as an attempt to save themselves from the consequences of their negligent act and to clean their mess, they conducted an open surgery. It is pertinent to note that the only medical condition that the patient had prior to the surgery, was gall bladder stones, everything else was perfectly normal and the patient was maintaining otherwise good health. Post-operation, the doctors and the hospital assured the patient, complainant and his family members that the surgery was successful and that the patient would be released from the hospital within two days. The doctors and the hospital had also falsely assured that the patient was free from all problems and that he shall soon recover from the surgery and become absolutely healthy. The patient was, then, shifted to the private ward of the hospital. The patient subsequently got uneasy and developed breathing troubles within twenty four hours of the surgery and also started complaining about pain in certain parts of his body. When the family members raised their concerns before the doctors and hospital, they bluntly ignored all the concerns and were of the opinion that these things were very normal after the operation and assured that would recover soon. The doctors and the hospital assured that the patient would very soon become healthy and shall be discharged within two days. Dr. Rajeev Om Prakash promise and assured that the condition of the patient shall improve after the operation, however, on the contrary, the situation of the patient further deteriorated. When the attendees inquired about the condition of the patient from the doctors and the hospital, they kept on ignoring the concerns of the family members and further assured that soon the patient would become fully fit and shall be discharged from the hospital within the next two days. However, the doctors and the hospital failed to meet their assurances and promises. Due to continuous wilful negligence on part of the doctors and the hospital which can be understood by the fact that the condition of the patient deteriorated further despite assurances and representations from the doctors and the hospital that the patient was recovering normally and would be in perfect health soon. However, the patient was shifted to the Intensive Care Unit (ICU) on 19th June, 2017. The patient was, then, diagnosed with the acute respiratory distress syndrome with lower CBD obstruction (this obstruction was caused by the doctors and the hospital due to their negligent actions). Further, the patient suffered from biliary peritonitis and subsequently was diagnosed with sepsis. The patient developed all the aforementioned issues and problems within three days of the operation conducted by the doctors and the hospital. It is important to note that the doctors and the hospital never informed anything to the family members of the patient despite the fact that they repeatedly asked for the details regarding the health of the patient. The doctors and the hospital never informed the family members about the actual condition of the patient to his family members including the complainant and the brother of the patient who was present in the premises of the hospital on all days during the treatment of the patient and always ignored their request on some pretext or the other for reasons which are best known to themselves. Further, it is pertinent to mention that the doctors and the hospital and their staff did not provide any report of the tests conducted by them, despite several requests by the family members. It is also pertinent to note that the reports were finally provided to the family members of the patient only after the intervention of the Police i.e. five days (approx.) after the death of the patient. The Doctors Sheet dated 22nd June, 2017 shows that the patient was diagnosed with jaundice and it is of utmost importance for this Hon’ble Council to note that this was never disclosed to the family members of the patient. The family members of the patient including the complainant only came to know that the patient had developed jaundice only when they received the reports from the Station House Officer, Sunlight Colony. Jaundice was caused by the damage to common bile duct by negligent acts of the doctors and the hospital. The condition of the patient was rapidly deteriorating and the patient was unable to breathe properly. It is pertinent for this Hon’ble Council to note that the doctors and the hospital after wasting a considerable number of days which could have been the difference between life and death for the patient, called Dr. Harsh Kapoor, an expert from Moolchand Hospital, Delhi on 24th June, 2017 to conduct a second operation on the patient. A stent was affixed to connect the duodenum with the bile duct. As per post mortem report of the patient, however, it was confirmed that the stent which was placed was an infant feeding tube lying freely in the peritoneal cavity indicating thereby that the bile duct was completely damaged by Dr. Rajeev Om Prakash during the surgery. The patient and his family members on various occasions mentioned to the doctors and the hospital his problem in breathing and the doctors and the hospital had maintained their stand on the matter that it was merely a post-operative problem and would get fine over time. However, few days after the operation upon personal meeting, to his (the complainant) shock Dr. Harsh Kapoor informed, off the record, that there was a cut in the common bile duct of the patient, which was caused during the operation on 16th June, 2017 due to sheer negligence of the doctors, due to which, the patient has developed biliary peritonitis and sepsis and was in such painful condition. When the attendees confronted this information with the doctors and the hospital, they blatantly denied of any such happening and were of the opinion that the patient was already suffering from breathing respiratory complications. The gross negligence on the part of the doctors and the hospital is clearly evident from the fact that they were required to put a stent in the patient just after they conducted an operation for the removal of stones. The doctors and the hospital failed to provide a substantial reason for the second operation and it is pertinent for this Hon’ble Council to note that the patient had undergone a surgery of removal of stones and there was no reason for the doctors and the hospital to conduct a second operation for a reason which was not even remotely related to the first operation for the removal of stones. It was only to cover up the damage suffered by the patient because of their gross negligent act, due to which, a young human being lost his valuable life when he was absolutely good health prior to the operation conducted by Dr. Rajeev Om Prakash which is evident from the initial assessment sheet dated 16th June, 2017. There was no improvement in the condition of the patient from the breathing problem even after the operation conducted on 24th June, 2017. The patient was still suffering from severe pain, for which, the doctors and the hospital kept the patient in the ICU for the next six days. The doctors and the hospital did not clearly inform the complainant and family members of the patient about the patient’s conditions and always kept them in dark with respect to the condition of the patient. On 30.06.2017, the doctors deliberately shifted the patient from the ICU to the private ward without informing the complainant and the family members of the patient. They shifted the patient despite of the fact that there was no improvement in the condition of the patient. It is important here to note that as per the Doctor’s Sheet dated 29th June, 2017, the patient had developed sepsis, however, the doctors and the hospital still advised for shifting the patient from ICU to the private ward. The family members of the patient were never shown or provided with any test reports of the patient during the whole period of the treatment and they were never informed correctly and always misrepresented about the condition of the patient by the doctors and the hospital. Because of such negligent act of the hospital and the doctors and gross negligence on part of the Dr. Rajeev Om Prakash as well as of the Hospital staff, the health of the patient further deteriorated and, therefore, he (the complainant) alongwith the family members of the patient also confronted the management of the hospital namely Dr. Rajeev Om Prakash about whether they have all the required facilities, skills or the required equipment which can help the patient to recover well. The doctors and the hospital kept giving false assurances to him (the complainant) and the family members of the patient that the patient would soon completely recover. After seeing, no signs of recovery of the patient and realizing, the patient’s health was continuously deteriorating and also due to the continuous enquires of the family members of the patient alongwith the complainant about the health of the complainant, the doctors and the hospital mischievously started preparing false reports of the patient and also started deliberately adding or making changes in already prepared reports to discharge the patient and to avoid any further unwanted consequences. This act of the doctors and the hospital is clearly evident from the bare perusal of the Nurse Progress Reports, follow-up chart, ICU reports and blood reports prepared by the laboratory. On bare perusal of these aforesaid documents, it is crystal clear that there are numerous discrepancies in these reports which were deliberately made with the mala fide intention of the doctors and the hospital to fool the complainant alongwith the family members of the patient about his real condition. It is of utmost importance to note that the patient had developed sepsis on 29th June, 2017 and on 30th June, 2017; the reports of the tests undertaken by the hospital showed no problem with the patient and on the bare reading of the document any prudent medical professional would be of the opinion that no disease/infections exists in the body of the patient, which was not possible because the doctor’s sheet of 29th June, 2017 shows that the patient had already developed sepsis. On 03rd July, 2017, the doctors and the hospital decided to discharge the patient by faking the medical report and ignoring the real condition of the patient. The doctors and the hospital deliberately stated that the patient was in a stable condition and was continuously improving; however, the patient’s condition was never improving and only deteriorating day by day. He (the complainant) and the family members of the patient also requested the doctors and the hospital not to discharge the patient in such a grave condition, as the patient was in severe pain and was tremendously unwell. The doctors and the hospital again abruptly termed it is as mere act done in fear and, therefore, not serious in nature. The patient was not stable to be discharged on 03rd July, 2017 as post mortem report on 06th July, 2017 has categorically noted coils of intestine matted together with yellowish orange coloured foul smelling pus and slough. The post mortem report has further cited “Pus was present throughout the liver parenchyma”, which means the patient was suffering with infection due to negligence of the doctors and the hospital and, therefore, was not stable enough to be discharged on 03rd July, 2017 nor on 05th July, 2017 when the patient was readmitted to the hospital in a critical condition. The doctors and the hospital failed to provide all the documents including the medical reports along with the Discharge Summary of the patient, the payment receipts at the time of Discharge of the patient and when the attendees of the patient inquired about the aforesaid documents, the doctors and the hospital said that these documents were unavailable at that moment. This clearly shows that the patient was discharged in haste to avoid any consequence and to escape the liability which arose due to their grossly negligent acts. Due to non-availability of the required documents like discharge summary, test reports, medical reports, etc., the family members of the patient could not take the patient to any other hospital for further treatment, as all other hospitals were asking for these details before proceeding with the treatment. Even when the family members of the patient further requested the doctors and the hospital to provide these documents, the hospital again ignored the request of the family members and said that the documents were still unavailable and the patient was in a perfectly stable condition, which prima-facie was a misrepresentation and an offense punishable under the criminal laws, as the patient expired on 06th July, 2017. On 05th July, 2017, the condition of the patient got serious and, thus, the patient was then rushed to the doctors and the hospital for a check-up. The hospital and the hospital initially refused to admit the patient and stated that the patient was in a fine condition and there was no need to admit the patient. However, on continuous request by the family members of the patient, the doctors and the hospital agreed to admit the patient. An extremely important point to note here is that immediately the doctors shifted the patient to the ICU. This clearly shows that the condition of the patient was never stable; despite that the doctors and the hospital had discharged the patient to safe guard themselves from the consequences and the doctors and the hospital was trying to avoid the re-admission of patient with a mala-fide intention. In the early morning (around 5:00 a.m.) of 06th July, 2018, less than twenty four hours from the re-admission of the patient in the hospital, the doctors and the hospital decided to put the patient on ventilator which is again a reflection of blunt lies and foul play on part of the doctors and the hospital who were of the opinion that the condition of the patient was perfectly normal. In between the above duration, no qualified doctor was available in the hospital and the senior doctor was only called around 4:00-4:30 a.m. The doctor who was attending at around 05.00 a.m. informed Sh. Sachin Chauhan, brother of the patient, who was present there at that time, that if any relative wants to meet the patient, then, he/she must do it immediately, as it was just a matter of time and the patient would not be able to survive any longer. At this instance, the attendees were shocked to their spine as not even 24 hours earlier were they informed that the patient was completely fit and fine and there was no reason for the patient to be admitted into the hospital. A foul play on part of the doctors and the hospital can be ascertained from the fact that the doctors and the hospital kept the family members of the patient in dark about the condition of the patient and did not allow them to meet the patient till they had called the police to the hospital premise. It was only when the Station House Officer of the Sun Light Colony Police Station came to the premises of the hospital, then, only the doctors and the hospital informed the family members of the patient that the patient was no more. All the chain of events raised an enormous amount of doubt in the mind of the family members of the patient. The family members of the complainant also complained to the aforesaid SHO about the foul play done by the hospital and the hospital but to no avail. The family members of the patient were never given any medical reports; any documents related to the patient not even the payment receipts of the bills paid during the period of treatment of the patient. It was only after continuous follow up from the family members of the patient, and the intervention of the DCP and the SHO, certain documents were made available to the family members of the patient and also threatened the him (complainant) alongwith the family members of the patient for not pursuing any case in furtherance to this and warned the family members of the patient that otherwise there would be dire consequences. The SHO did not even give permission to the family members of the patient to conduct a peaceful protest against the foul play of the doctors and the hospital. He (complainant) was not given the post-mortem report at one instance. Even for the post-mortem report, he (the complainant) had to request the SHO number of times. The hospital gave different medical reports to the Insurance Company and different medical reports to the SHO who gave it to the attendees of the patient. The ultrasound reports and the x-ray report were never provided to the attendees; however, these reports were given to the Insurer Company. This was done solely with malice and nothing else. The post-mortem report which was prepared by the Department of Forensic Medicine and Toxicology, AIIMS, New Delhi, did not disclose the cause of the death properly and merely written that the reason of the death was shock due to septicaemia and secondary haemorrhage which is also questionable and further proves the negligence on the part of the hospital and the doctors. The complainant alongwith the family members of the patient ran from pillar to post and knocked all the doors either by way of applications or complaints to the all available authorities who could have helped the complainant and family members of the patient in getting proper and deserved justice, but each time their requests fell onto deaf ears. The doctors and the hospital rely on the final opinion dated 26th October, 2017 of AIIMS board which ultimately holds as :- “the*•* surgical operation was correctly performed as per the norms of surgical practice. The subsequent complication which occurred in the patient is not uncommon in surgical practice and has been reported in literature. The patient was adequately treated for the complications from which he (the patient) recovered and was discharged in a stable condition”. From the above, it becomes clear that, indeed there were complications. The report notes few complications in the “Treatment Summary of the Case” and which are given as : 19.06.2017:- “Mild breathlessness and biliary collection reported to have sepsis and high infection parameters. Yet the patient was discharged, in complete denial of the proper medical aid to the patient. This clearly shows the reckless and negligent behaviour of the doctors and the hospital, which ultimately lead to the death of the patient due to sepsis in the body”. The patient was diagnosed with infection and sepsis in his body, post-surgeries which is clear indication that the surgery was done negligently and not as per the standard procedure, as during the surgery the doctors and the hospital had damaged the bile duct, causing the bile fluid to seep into the various parts of the body, resulting in sepsis and infection, because of which, the patient succumbed to death. There was poor management or ignoring the infection/sepsis inside the body, and forcing the discharge of the patient even when the infection in the body was still present, however, the report is completely silent about the said aspect. Further, the AIIMS report is clearly a cover-up and manufactured document with the view to wash away the negligence of the doctors and the hospital, despite the fact it notes that there was 22.06.2017:- Jaundice with deranged KFT, Sepsis with raised TLC, (Emphasis Supplied); 23.06.2017:- Sepsis Chest Pathology with Respiratory Failure, Deranged LFT (Emphasis Supplied); 24.06.2017:- CBD Injury during cholecystectomy and stricture formation (Emphasis Supplied); 26.06.2017:- TLC around 35,000/Cu MM (Very High and indicates infection in the body); 29.06.2017:- Jaundice, Pancreatitis, Sepsis with UTI Para hepatic fluid seen in Ultrasound No entries recorded in the report after 29.06.2017 until 03.07.2017 and 03.07.2017:- the patient discharged (however, the report is completely silent on the aspect of sepsis or infection in the body at the time of discharge. No entries with regards to the state of infection in the body post 29.06.2017 which clearly indicates the intention of the authors of the report to cover up the cause of infection or sepsis in the body). The report also does not record that the patient had fever at the time of discharge, which is clear indication of infection and sepsis in the body, especially when in the past few days the patient had injury to the bile duct, which caused sepsis to the patient and which ultimately lead to death of the patient.

It is relevant to mention here that the medical board does not record any findings on the cause of sepsis and rather just holds the death was due to sepsis. The cause of sepsis was due to the damage to the bile duct and also due the wrong insertion of tube for drainage of the bile fluids. The report is a very cryptic document, as it notes that there was sepsis in the body of the patient for a long time; however, it conveniently does not record the state of sepsis at the time of discharge of the patient and yet holds that sepsis was the cause of death. If the report holds that the cause of death was sepsis, then, how could the report ignore the state of sepsis inside the body, between the dates 29th June, 2017 and 05th July, 2017, when the patient was cleared for discharge? At the time of discharge, the patient had fever, which is a clear indication that there was infection in the body, caused by the seepage of bile fluid inside the body. Thus, the report is clear made up document to cover up the negligence of the doctors and the hospital. It is, therefore, submitted that this report from AIIMS, New Delhi may be ignored by this Hon’ble Council. The report of the AIMS is scurrilous and pre-meditated aimed at giving a clean chit to the doctors and the hospital when it notes that a valid informed and explained consent was taken by the doctors prior to therapeutic procedure when there is nothing on record to show the same. It appears that the board easily concurred with the position of convenience of the doctors and the hospital when such negligence had occurred and perpetrated, due to the acts and omissions of the doctors and the hospital in not intervening at the right time, but rather continuing with the negligent act of the doctors and the hospital without giving any serious thought in the matter and without pointing out serious lapses in the course of treatment. The AIIMS board never concluded that the cause of death was cardiac arrest whereas the doctors and the hospital blatantly lied and fabricated the reason for cause of death as cardiac arrest. It was a nefarious attempt to cover up the original cause of death which was botched up gall bladder surgery, with injury to the bile duct, injuries to food pipe and placement of stent from liver to duodenum, all of which led deterioration of patient’s condition from 16th June, 2017 to 06th July, 2017, entire period of which, he spent under the supervision of Dr. Rajeev Om Prakash at Jeewan Hospital. There is a direct nexus between his negligent acts on 16th June, 2017 and the patient’s untimely death on 06th July, 2017. In response to the Autopsy, Medical Board have wrongly stated that there was no septicaemia at the time of discharge, LFT Liver function test, B.U.N. test blood urea, and serum creatinine were within normal range and there were no signs of peritonitis. All these assertions are false and fabricated, as the AIIMS post mortem report dated 06th July, 2017, on the day of death, mentioned clearly that cause of death was septicaemia. The only nexus between septicaemia and haemorrhage over the preceding twenty days since 16th June, 2017 was cholecystecctomy, injury to bile duct, placement of stent and finally his death on 06th July, 2017. He, therefore, states that in view of the forgoing facts and circumstances, present complaint may be allowed in his favour.

Dr. Rajeev Omprakash, Surgeon, Jeewan Hospital in his written statement averred that on the day of admission 16.06.2017 for cholecystectomy, pre-anesthesia check up was done. Consent for operation was taken explaining all aspects of surgery and its complications. Laparoscopic cholecystectomy was converted to open cholecystectomy due to distorted fat laden neck and body of gall bladder. The relatives were informed for conversion and consent simultaneously. Cholecystectomy was done after adhesionolysis, around gall bladder and its neck. Tortous lower end of common bile duct was found while operating and it was explored needing choledochostmy. Stricture at lower end was detected (not reported in ultrasound report). 6 F Hegar dilator was used for dialatation successfully. The procedures were done under all valid norms. 6 Fr feeding tube was inserted in CBD, for further constant dilatation, as T tube insertion was not possible, due to small size of CBD, in anticipation of ERCP at later date. A tube drain was kept in near G.B Fossa, surgery was completed. The patient was shifted to Ward haemodynamically stable. On 18.06.2017, feeding tube was taken out from CBD in evening. Relatives were informed about nessecity of MRCP & ERCP. On 19.06.2017 (evening) patient developed breathing difficulty, shifted to ICU for supervised special care. On 19.06.2017, ultrasound abdomen showed approximately 200 ml of ascites in pelvis (irrigation fluid in dependent area). There was no drainage from tube. Medical treatment was sought and started by the physicians and ICU doctors together. On 20.06.2017 and 21.06.2017, the medical treatment continued and the patient showed steady improvement. Gastroenterologist (Dr. Harsh Kapoor) and the physician (Dr. Ajit Talukdar) opinion were taken for MRCP, they advised optimising his general condition before MRCP and then ERCP. On 21.06.2017, MRCP revealed supra duodenal stricture. Detailed reports of which already submitted to the Delhi Medical Council. On 23.06.2017, the decision of ERCP and pre-anaesthesia check up was done. Consent was taken for ERCP to be done in OT on 24.06.2017 with high risk consent. ERCP was done successfully. Biliary stent was inserted. Clear bile came out as seen in ERCP/endoscope. The relatives were informed of the successful procedure. The patient was shifted out of OT in good and stable condition. Between 25.06.2017 and 28.06.2017, the patient’s general condition improved gradually. On 29.06.2017, regular breathing exercises (inspirational) were done till 30.07.2017. The patient cooperated well. Liquid diet was started. The patient was under cover of antibiotics, IV fluids. On 29.06.2017, the patient was shifted to Ward from ICU. Blood culture taken earlier was sterile (29.06.2017) and decreasing TLC counts. Abdomen drain tube tip gram staining done. It showed gram negative bacilli. The patient showed gradual improvement and was still under combined supervision of physicians and surgeons treatment. Details already submitted to the Delhi Medical Council. On 30.06.2017, the discharge was postponed for another 48 hours, inspite of relatives’ requests, to optimise his medical condition and outcome of treatment. The patient was managed on established medical protocol after cholecystectomy and ERCP procedure. On 3.07.2017, the patient was discharged on 1) Tablet Cefuroxime 500mg/hourly. 2) Udiliv 300 mg /12 hourly. 3) Tablet Paracetamol 500mg 1 S.O.S. 4) Pantocid 40mg/24 hourly. 5) Enterogemina Oral Vial/12 hourly. On 01.07.2017, LFT done earlier was within normal limits. On 2.07.2017, B.U.N was within normal limits. Dressing done-no discharge, no cough, afebrile, abdomen soft/non tender, was passing stool and flatus adequately, vitals stable. Advised repeat ERCP after 2-3 weeks. Was advised abdominal drain removal on 05.07.2017 morning. The patient named Shri Vipin Chauhan did not attend surgical OPD for drain removal, dressing and further medical treatment for reason best not known to him. Opinion 1) any patient is prone to post operative complications, inspite of best efforts to prevent it. Because of some dormant foci in the body may get activated with surgery leading to unforeseen result beyond control of clinicians. It is difficult to detect these foci and apprehend them before surgery/after it. 2) the patient did not have any respiratory complication (chest problem) during the first 48 hours of surgery and he was already on IV antibiotics etc . 3) negligence: no. cause of collection in abdomen after two weeks-could be reactionary changes in abdomen cavity or reactionary pancreatitis for instance. 4) Duodeno pancreatitis reflux of duodenal and bile fluid combined with vascular insufficiency; common channel theory proposed by halstead, postulation. Text book of surgery Davis Christopher & Sabiston, 11th Edition. Page 1295.

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

1. The patient Shri Vipin Chauhan, 33 years old male with a diagnosis of Gall Bladder stone (cholelithiasis) planned for laparoscopy cholecystectomy but due to difficult surgery converted to open cholecystectomy, under consent on 16.06.2017 in Jeevan Hospital. The surgery was performed by Dr. Rajeev Omprakash. After surgery, there was deterioration in his condition and he was shifted to ICU. On 24.06.2017, the patient underwent ERCP and papillotomy with stent placement. He was discharged on 03.07.2017. The patient condition again deteriorated and, thus, had to be readmitted in the said Hospital on 05.07.2017. He expired at 12:50 p.m. on 06.07.2017. The cause of death as per post mortem report no.918-17 of All India Institute of Medical Sciences was shock due to septicaemia and secondary hemorrhage.
2. It is observed that the pre-operatives ultrasound dated 09th June, 2017 of SDM Charitable Medical Centre was only suggestive of two large (12.5 and 13.5 mm) calculi in the fundus of Gall-Bladder and showed normal CBD (Common Bile Duct) without stone. As per the written statement of Dr. Rajeev Om Prakash during surgery some anomaly of CBD was noted and surgeon decided for CBD exploration; whilst carrying out the procedure of cholecystectomy. This resulted in the injury to the CBD. Further, although, injury to the CBD was detected, the appropriate measures of endoscopic placement of biliary stent were not done in a timely manner.
3. In light of the medical condtion documented in the medical records of the said Hospital on 03rd July, 2017, as per which, the patient was in stable condition, hence, he could have been considered for discharge.
4. In view of the course of events, following the cholecystectomy procedure done on 16th June, 2017, it is apparent that the patient died of sepsis shock and biliary leak, leading to peritonitis.

In light of the observations made herein-above, it is the decision of the Disciplinary Committee that Dr. Rajeev Om Prakash delayed decision for ERCP stenting due to unstable condition of the patient. The CBD exploration and the management of the suspected bile duct injury was not as per established professional guidelines/protocols. The Disciplinary Committee, therefore, recommends that a warning be issued to Dr. Rajeev Om Prakash (Delhi Medical Council Registration No.3672) with a direction that he should undergo 12 hours of Continuing Medical Education (C.M.E.) on the subject related to ‘Hepato-Biliary Surgery’ and submit a compliance report to this effect to the Delhi Medical Council.

Complaint stands disposed.

Sd/: Sd/:

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

Chairman, Delhi Medical Association

Disciplinary Committee Member, Disciplinary Committee

Sd/: Sd/:

(Dr. P. Kar) (Dr. Anil Agarwal)

Expert Member, Expert Member,

Disciplinary Committee Disciplinary Committee

The Order of the Disciplinary Committee dated 29th July, 2022 was confirmed by the Delhi Medical Council in its meeting held on 10th August, 2022.

The Council further confirmed the punishment of warning awarded by the Disciplinary Committee to Dr. Rajeev Om Prakash (Delhi Medical Council Registration No.3672) with a direction that he should undergo 12 hours of Continuing Medical Education (C.M.E.) on the subject related to ‘Hepato-Biliary Surgery’” 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.

By the Order & in the name of

Delhi Medical Council

(Dr. Girish Tyagi)

Secretary

Copy to :-

1. Shri Jai Prakash Chauhan, S/o Lt. Chandra Singh, R/o T-58A Nangli Razapur, Sarai Kale Khan, New Delhi-110013.
2. Dr. Rajeev Omprakash, Through Medical Superintendent, Jeewan Hospital & Nursing Home Pvt. Ltd., Gate No.1, 150, Jeewan Nagar, Opp. Maharani Bagh, New Delhi-110014.
3. Medical Superintendent, Jeewan Hospital & Nursing Home Pvt. Ltd., Gate No.1, 150, Jeewan Nagar, Opp. Maharani Bagh, New Delhi-110014.
4. Medical Superintendent, Nursing Home Cell, Directorate General of Health Services, Govt. of NCT of Delhi, Nursing Home Cell, F-17, Karkardooma, Delhi-110032-w.r.t. letter No.F.23/892/Comp.SED/DGHS/HQ/NH/2016-17/216015-18 dated 26.07.2017-**for information**.
5. Station House Officer, Police Station Sunlight Colony, New Delhi-110014-w.r.t. DD No.34B, Dated 06.07.2017, U/S : 174 Cr. P.C. PS Sunlight Colony, New Delhi-**for information.**
6. Registrar, Rajasthan Medical Council, Sardar Patel Marg, Near 22 Godam Circle, C-Scheme, Jaipur-302001, Rajsthan **(Dr. Rajeev Om Prakash** **is also registered with the Rajasthan Medical Council under Registration No. 6761 dated 09.12.1977)-for information & necessary action.**
7. National Medical Commission, Pocket-14, Sector-8 Dwarka, Phase-1, New Delhi-110077-**for information & necessary action**.

(Dr. Girish Tyagi)

Secretary