DMC/DC/F.14/Comp.2369/2/2023/ 14th July, 2023

**O R D E R**

The Delhi Medical Council through its Disciplinary Committee examined a complaint of Shri Sahil Malik r/o F-218, Gali No. 27, Old Mustfabad, Delhi-110094, alleging medical negligence on the part of doctors of GTB Hospital, Dilshad Garden, Delhi-110095, in the treatment of the complainant’s wife Smt. Sahana Malik.

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

The Disciplinary Committee of the Delhi Medical Council examined a complaint of Shri Sahil Malik r/o F-218, Gali No. 27, Old Mustfabad, Delhi-110094 (referred hereinafter as the complainant), alleging medical negligence on the part of doctors of GTB Hospital, Dilshad Garden, Delhi-110095, in the treatment of the complainant’s wife Smt. Sahana Malik(referred hereinafter as the patient).

The Disciplinary Committee perused the complaint, written statement of Dr. Ravinder Singh, DMS & Public Grievance Officer, G.T.B Hospital enclosing therewith written statement of Dr.LalendraUpreti, Department of Radiology, Dr.Daizy Garg, Department of Radiology, joint written statement of Dr.Shalini Rajaram, Dr.Bindiya Gupta, Dr.Anshuja Singla, written statement of Dr. GopeshMehotra, written statement of Dr. Rashmi Shriya, Dr.Aakanksha Singhal, Dr. Anuradha Tyagi, Dr.Varkha, Dr.Megha Jindal, Dr. Vinita Rathi and Dr. Rajat Malhotra, copy of medical records of G.T.B Hospital and other documents on record.

The following were heard in person : -

1. Shri Sahil Malik Complainant
2. Smt. Shahana Wife of the Complainant (the Patient)

3) Dr.LalendraUpreti Ex HOD, Radiology, GTB Hospital

4) Dr.Daizy Garg PG Trainee, Department of Radiology, GTB Hospital

5) Dr.Bindiya Gupta Associate Professor, Obst. & Gynae. GTB Hospital

1. Dr.Anshuja Singla Associate Professor, Obst. & Gynae. GTB Hospital
2. Dr.Gopesh Mehrotra Professor, UCMS & GTB Hospital
3. Dr. Anuradha Tyagi Senior Resident, Obst. & Gynae., GTB Hospital
4. Dr.Meghana Jindal Consultant Obst. & Gynae, GTB Hospital
5. Dr. Rashmi Shriya Consultant ORTUS Health, GTB Hospital
6. Dr. Rachna Agarwal Consultant, GTB Hospital
7. Dr.Shuchi Bhatt Professor CAS, GTB Hospital
8. Dr.Aakansha Singhal M.O., GTB Hospital
9. Dr.AmitaSuneja HOD, Obst. & Gynae., GTB Hospital
10. Dr.Varkha Senior Resident, Obst. & Gynae., GTB Hospital
11. Dr. Rajat Malhotra Ex-Senior Resident, GTB Hospital
12. Dr. Vinita Rathi Director, Professor, Department of Radio Diagnosis, UCMS & GTB Hospital
13. Dr. Rajat Jhamb AMS (IV), GTB Hospital

The Disciplinary Committee noted that the complainant Shri Shail Malik did appear before the Disciplinary but his wife Smt. Shahna (the patient) appeared before the Disciplinary Committee.

The Disciplinary Committee further noted that Dr. Shalini Rajaram did not appear before the Disciplinary Committee but sent a representation wherein she stated that due to her health illness, she is unable to attend the hearings.

It is noted as per the complaint that the complainant’s (Shri Sahil Malik) wife Smt. Sahana Malik(the patient) who was pregnant underwent obstetric ultrasound on 11th July, 2017 at Ruprela X-ray and Advanced Diagnostic Centre, Raipur. The USG report gave finding suggestive of neural tube defect. The doctor of AIIMS Raipur advised abortion. Since his wife was in consultation during her ante-natal period at GTB Hospital, Delhi, on the advice of the doctor’s GTB Hospital, she again underwent USG on 18th July, 2017 which was reported as normal and they advised to continue the pregnancy. After two months on advice of the doctor of GTB Hospital, another USG was done on 12th September, 2017. This USG scan-level-II done at sevenmonths pregnancy reported fetus anomaly (spine showing kyphotic deformity, lumbosaccral region showing separation and widening of posterior elements echoes of spine with meningocoele formation of size 43 x 26 mm). The fetus could not be aborted this late in the pregnancy. Thus, on 03rd December, 2017, a baby girl with incurable deformities was born, and as such, the family is suffering because of negligence of the doctors of GTB Hospital. It is requested that strict action be taken in this matter.

Smt. Sahana (the patient) wife of the complainant reiterated the assertions made in the complaint.

She further stated that on 18th July, 2017, when she had reported for level-II scan, she requested the doctors to have a look at the ultrasound reported dated 11th July, 2017 of Ruprela X-ray and Advanced Diagnostic Centre, Raipur but the doctor refused to see the report and insisted that they will only take cognizance of ultrasound being done at GTB Hospital.

Dr.Daizy Garg, (PG trainee), Department of Radiology, G.T.B. Hospital in her written statement averred that she has reviewed the medical records of the patient Smt. Sahana Malik and during her conversation with the complainant on 22nd December, 2017, she was informed that the complainant was getting his wife’s (the patient) antenatal check-up from the All India Institute of Raipur, where the fetus was diagnosed with the anomaly on 11th July, 2017 based on the anomaly scan done in a private centre in Raipur and was suggested to get admitted to get the baby aborted on urgent basis, as the fetus was already 19 week 04 days after getting the paediatric surgeon opinion. But the patient by her own came to G.T.B. Hospital. The patient came to radiology department of GTB Hospital to get the antenatal level 2 scan on 18th July, 2017 with period of gestation of 20 weeks 5 days with LMP of 25/02/2017, as documented on the OPD paper. The patient or the complainant did not disclose any of the information about the previous scan on that day 18/07/2017. Nor it was mentioned in the requisition from about any previous suspected anomaly. They had twenty level II scans routinely booked on that day 18/07/2017 and due to booking of other ultrasound scans in the same machine on the same day, all of the level 2 scans had to be performed within three hours. Each level 2 scan had to be performed in ten minutes on an average. A comprehensive level two anomaly scan is the detailed scan which requires minimum of 30-35 minutes in expert hands. Despite being a post-graduate trainee, due to heavy patient load and limited ultrasound machines, they are performing screening level 2 scans under the limited time. She could not exactly recall the details of the patient and the ultrasound. But it is not always possible to rule out all the anomalies on ultrasound due to fetal position and mother habitus. The sensitivity of scan varies due to various factors like specific persistent difficult fetal possible position, liquor, gestational age, maternal habitus, ultrasound machine quality, experience of the radiologist done etc., and detection rate never approaches 100 %. The detection rate for open spina-bifida detect is 88% and 12% could be missed even in expert hands. She was a trainee doing her post-graduation in radiology and on the day of event, she was in the beginning of second year of training, and have not yet got her radiology degree. She does scans under the constant verbal supervision of the seniors posted with her that time. She is also under the supervision of the consultant on duty in ultrasound. She reported whatever part of fetus and the part of spine; she was able to see as per the fetus position and maternal factors at per ability under the super vision of her senior posted with her. As they are severely constrained by limited resources and heavy patient load, they depend on the clinical information provided in the requisition form to minimize their error rates despite working with constrained resources in this case. The patient was previously diagnosed with congenital anomaly in AIIMS Raipur and this important piece of information was withheld in the level 2 requisition form and by the patient. Further, if there is any discrepancy of the ultrasound report done in their hospital and elsewhere outside, it is usually sent for the review scan by the clinicians and then the case is reviewed by the radiology consultant in charge of ultrasound. In this case, though there was discrepancy between their report and the report made by the private centre in Raipur, the case was not sent to them for a review. They were never made aware of this discrepancy. Lastly, the patient had come to their department with gestational age of 20 w 5 days on the day of ultrasound scan as per the documented LMP. This date was already beyond the permissible date of medical abortion as per the MTP Act.

On enquiry by the Disciplinary Committee, Dr.Daizy Garg stated that she performed the ante-natal level-II scan on the patient on 18th July, 2017 under the supervision of the Senior Resident Radiology on duty. She could not recall the name of the Senior Resident. Further, the ultrasound report is not in her handwriting, as she had dictated the same to the post-graduate first year doctor. The report, however, bare her signature. The Form ‘F’ relating to the said ultrasound was also filled by her, as at that time, post-graduate radiology student were authorized to do the same.

Dr.Daizy Garg further stated that as far as she could recall, she was posted on 18th July, 2017 in the radiology department under Senior Resident Dr. Rajat Malhotra and the Consultants were Dr.Gopesh Mehrotra and Dr. Vinita Rathi. Further, she admitted that who having filled and signed the Form ‘F’ herself.

Dr.Gopesh Mehrotra, Professor Radiology, GTB Hospital in his written statement averred that the complaint mentions that Smt. Shahna Malik was to undergo a level-II ultrasound in GTB Hospital on 18th July 2017, for which, she was brought to Delhi from Raipur in July, 2017 (“HamaraIlaaj March Maheene se GTB Hospital meinchalrahathajismeinunhone 18th July, 2017 ko hospital keander ka ultrasound karaane ko kaha thaa, isliye main apnipatni ko Raipur se Dilli GTBaspatalmeinlekaraaya aur ultrasound karaya jismein GTB kedwarabataayagaya ki sab theek haiaapilaajjaaarirakhen”). Whereas, on perusal of booking registers revealed that she was not booked for an appointment on 18th July, 2017. Dr. Daizy Garg had performed the ultrasound on her own on 18th July, 2017 of Smt. Shahna Malik. That much is clear from her comments. Whereas, Dr. Rachna and not Dr. Daizy Garg was on ultrasound duty, a fact which Dr. Lalendra Upreti attempted to obfuscate by way of his comments, in his above-mentioned response to his (Dr.Gopesh Mehrotra) vide letter No.8005/8006. The same also stands corroborated by the Departmental Duty Roster NO.378-I dated 27th June, 2017, signed and circulated by Dr. Lalendra Upreti himself. Surely, this fact was very much known to Dr. Lalendra Upreti. Further, on that particular day i.e. 18th July, 2017, Dr. Daizy Garg was not to be under his supervision but that of another consultant, Dr. Vineeta Rathi. This stands corroborated by the by the Department Duty Roster No.412 dated 15th July, 2017, signed by Dr. Lalendra Upreti, himself. This fact too, was very much known to Dr. Lalendra Upreti. From the above, this is clear that Dr. Daizy Garg was neither posted in the USG on 18th July, 2017, nor was to be under his supervision as per the Departmental Duty Roster. Whereas, in case, Dr. Vineeta was to be unavailable for any reason, the onus of supervision would belong to Dr. Lalendra Upretiy as per standing instructions vide Circular No.735 circulated by Dr. Lalendra Upreti on 24th October, 2016. This fact too, was very much known to Dr. Lalendra Upreti. Despite being aware of all things mentioned above, Dr. Lalendra Upreti has chosen to implicate him (Dr.Gopesh Mehrota). His (Dr. Lalendra Upreti) communication dated 26th December, 2017 were intent on making malevolently, negating his response (8005/8006), by way of misrepresentation in wilful suppression of facts and material evidence. Whereas, in the light of foregoing; no liability lies with him.

Dr. Gopesh Mehrotra, Professor Radiology, GTB Hospital vehemently denied that on 18th July, 2017, Dr.Daizy Garg was posted under him.

Dr.LalendraUpreti, HOD Radiology, G.T.B. Hospital in his written statement averred that the complainant Shri Sahil Malik in his representation has admitted the fact of child being abnormal was already known to him(the complainant) on 11th July, 2017 and the complainant was already advised that the pregnancy should be terminated. This information regarding outcome of the case was already known to the patient/complainant before 18th July, 2017, the day ultrasound was done in the GTB Hospital. If the complainant had acted on this advice, the present circumstances could have been avoided. Dr.Daizy Garg has submitted that the fact of previous ultrasound done on 11th July, 2017 at Raipur was not disclosed to her by the patient. When the complainant was asked regarding this issue, the complainant informed that he (the complainant) had not gone with the patient, however, he (the complainant) was aware that this fact was not disclosed by the patient to the doctor conducting the ultrasound. It is a welldocumented fact that the findings of ultrasound depend upon various factors like fetal position, thickness of maternal body parts, and amount of the fluid inside the fetus. All anomalies cannot be picked on ultrasound due to these and many other factors. While the actual circumstances are not clear, if the previous report of the child being abnormal and advice given by the AIIMS Raipur on not keeping the child had been brought to the knowledge of the radiologist performing the ultrasound, she would have taken its cognizance and if fetal parts were not well visualized, she would have rescheduled the examination or taken the opinion of the consultant In-charge prior to preparing the final report of no obvious gross congenital anomaly in the fetus. It is most humbly submitted that the patient also has a duty to make a complete disclosure to the care giver in order to facilitate proper diagnosis and management plan. Dr.Daizy Garg has also submitted that lot of level II ultrasound were booked on that day, nearly 20. The department has only two ultrasound machines which cater to the patients being referred from OPD, wards and emergency. It may be noted that during that period, it was a stated government policy that no investigation is to be referred to the outside facility. It is further informed that level II ultrasound has to be scheduled within a narrow window period of 16-18 weeks of pregnancy, so that appropriate management decision, especially regarding termination of pregnancy are taken in a timely manner. The department receives a lot of requests for level II ultrasound which have to be given appointment between above gestational period only. Thus, it was common place to have many levels II scan on a day, during that period. Level II ultrasound is a time intensive investigation taking anytime between 30 minutes to one hour. This was a practical issue; they were facing at that point in time. Presently with the notification of the DAK mechanism by the GNCT of Delhi, the Delhi patients can be referred to the outside facility. So, presently they have restricted the number of level II examinations in order to have more time available to conduct the study. Dr. Gopesh Mehrota, consultant in-charge of ultrasound has completely failed to discharge his responsibility as the supervisor of the day. His (Dr. Gopesh Mehrota) submission that the ultrasound was not booked on that day is most unfortunate. The fact of this ultrasound being done under his (Dr. Gopesh Mehrota) supervision is on record and a copy was endorsed to him as well. Regarding his (Dr. Gopesh Mehrota) contention that his (Dr. Gopesh Mehrota) consent was not taken for changing the duty, it may be noted that all duty arrangement are done by him (Dr. Lalendra Upreti) based on available man power on that particular day. This has been the practice in the past many years. It is not clear why he (Dr. Gopesh Mehrota) has suddenly become averse to this practice while he (Dr. Gopesh Mehrota) never objected when other consultant Dr. Shuchi Bhatt was in-charge of the resident posting. Moreover, this submission is also irrelevant; as he (Dr. Gopesh Mehrota) was responsible for the supervision of ultrasound irrespective, of which, Resident did the ultrasound. His (Dr. Gopesh Mehrota) submission that he can comment only on non-MLC cases that too when he has dedicated equipment for the consultant with film recording facility exposes his (Dr. Gopesh Mehrota) mindset of not taking any responsibility for supervision of the cases being done under his (Dr. Gopesh Mehrota) watch. It is clear a well-known fact that all concerned with the patient care have to do their best under existing circumstances. However, Dr. Gopesh Mehrota is insisting upon the best possible environment even before doing anything. This is unbecoming of a senior level officer like him (Dr. Gopesh Mehrota). He (Dr. Lalendra Upreti) and worthy MD, GTB Hospital have sent multiple communications to the Principal UCMS regarding his (Dr. Gopesh Mehrota) refusal to take responsibility to supervise the patient care in his (Dr. Gopesh Mehrota) work area. It is incumbent upon any Consultant to frequently visit his work area and enquire from the Residents regarding any case requiring review. He cannot just sit in his room expecting that he will go to his work area only when called and will work only when best and exclusive equipments are provided to him.

Dr. Vinita Rathi, Director, Professor, Department of Radio Diagnosis, UCMS & GTB Hospital in her written statement averred that it is noted that the complaint was filed in the Delhi Medical Council by the complainant on 19th February, 2018. Fiver years later, it has been brought to the notice of the Delhi Medical Council probably by Dr. Gopesh Mehotra, Ex-Professor in her department, that she was the consultant on duty under whom Dr. Daizy Garg was posted at the time of this incidence. The matter relates to an ultrasound done six years ago i.e. on 18th July, 2017 which was a Tuesday. As per her memory of the Routine Weekly Roster for Consultants, Department of Radiology at G.T.B. Hospital, Tuesday was not her allotted day to supervise ultrasound in the department. Hence, she could not have signed any ultrasound report of the wife of the complainant. Dr. Gopesh Mehrotra should be asked to furnish documentary proof of his statement, as mentioned in the Delhi Medical Council’s letter, and the documents submitted, should be endorsed by the HOD Radiology and her (Dr. Vinita Rathi) employer i.e. GTB Hospital administration.

Dr. Rajat Malhotra in his written statement averred that ultrasound scan of the wife of the complainant was not examined by him and he has not reported nor reviewed this scan as well. This ultrasound and report were not in his knowledge.

Dr. Anuradha Tyagi, Senior Resident, Obst. & Gynae., GTB Hospital in her written statement averred that she had seen the patient Smt. Sahana Malik in antenatal OPD at GTB Hospital during her Senior Residency on 19th June, 2017 at 16 + 2 weeks and advised the investigations including a level-II USG at 18 weeks and review after three weeks for consultant. Her (the patient) antenatal follow-up were continued at GTB Hospital.

Dr.Aakansha Singhal, M.O. , GTB Hospital in her written statement averred that she had seen the patient Smt. Sahana Malik in antenatal OPD at GTB Hospital during her Senior Residency on 20th July, 2017 in ANC OPD at Guru Teg Bahadur Hospital. She did the patient ANC check-up and wrote the USG report (18.07.2017) that the patient bought on ANC Card and advised medicine with review visit after four weeks.

Dr. Rashmi Shriya, Consultant ORTUS Health, GTB Hospital in her written statement averred she had seen the patient Smt. Sahana Malik on 11th September, 2017 once in antennal OPD at Guru Teg Bahadur Hospital during her Senior Residency. Then, the patient was at 28 weeks 2 days of her pregnancy according to her LMP. She asked is everything fine, asked the reason is she having any complaints at present, then, said verbally that USG was done in AIIMS Raipur, which has shown some problem in spine of the baby but was not having that USG report with her (so did document ? neural tube effect as was unaware of exact anomaly). She(Dr. Rashmi Shriya) reviewed level-II scan report done at GTB Hospital which was reported as No Gross Congenital Malformation, so advised her to get a repeat USG done as early as possible and get the previous report which was done at AIIMS Raipur. She did inform the Unit Consultant as well.

Dr. Meghana Jindal, Consultant Obst. & Gynae, GTB Hospital in her written statement averred that she had seen the patient Smt. Sahana Mali in antenatal OPD at Guru Teg Bahadur Hospital during her Senior Residency. Then, the patient was 28 weeks 6 days on 12th September, 2017 into her pregnancy according her (the patient) last menstrual period. The patient got an ultrasound report done (done from the outside) showing craniospinal deformity in the fetus. For which, she had advised her to take paediatric opinion regarding the possible implications and outcome of pregnancy. The patient’s antenatal follow-up continued at Guru Teg Bahadur Hospital.

Dr.Varkha, Senior Resident, Obst. & Gynae., GTB Hospital in her written statement averred that she had seen the said the patient Smt. Sahana Malik in antenatal OPD at Guru Teg Bahadur Hospital during her Senior Residency. Then, the patient was 24 weeks 1 day into her pregnancy according to her last menstrual period on 17th August, 2017. The patient had an ultrasound report showing no gross congenital abnormality in the fetus. She advised iron, folic acid calcium and further antenatal follow up at Guru Teg Bahadur Hospital.

Dr. Shalini Rajaram, Dir Prof & Officiating HOD, Obst. & Gynae., Dr.Bindiya Gupta, Assistant Professor, Obst. & Gynae. and Dr.Anshuja Singla, Assistant Professor, Obst. &Gynae,in their joint written statement averred that the first visit of the patient Smt. Sahana Malik was on 22nd May, 2017 at 12 weeks + 6 days POG in emergency with abdominal pain. The patient was examined and given treatment. The patient came for a routine antenatal check-up in the OPD on 19th June, 2017 at 16 +2 weeks and was advised for investigations including a level II USG. The ultrasound was done in the radiology department on 18th July, 2017 and was reported as normal. The anomaly scan done outside (Raipur) on 11th July, 2017 was not disclosed by the patient to the treating doctor. The subsequent ANC visits were on 20th July, 2017 and 10th August, 2017. On 11th September, 2017 at 28 weeks + 2 days, the patient verbally told the doctors that there was an anomaly of the spine on a previous ultrasound. However, the document was not shown to the treating doctor and the patient was advised a repeat ultrasound. At the next visit at 28 + 6 weeks, the patient go an outside USG report showing craniospinal deformity. The patient was advised paediatric opinion, which was subsequently taken. Thereafter, the patient came for her regular antenatal follow-ups and had breech vaginal delivery on 03rd December, 2017 at 06.55 p.m. In the partum period, re-suturing was done for a gaped episotomy on 24th December, 2017. Rest of the post-partum period was uneventful. The neonate was managed by the paediatrics department.

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

1. It is noted that the patient Smt. Sahana Malik, a 23 years old female who was primigravida and under antenatal consultation with GTB Hospital, underwent obstetric ultrasound (anomaly) scan at 19 weeks 3 days pregnancy at Raipur (her husband was employed at Raipur). The USG (ultrasound) scan No.7588 dated 11th July, 2017 of Ruprela X-ray and Advanced Diagnostic Centre gave finding of ‘lemon shaped skull, banana shaped cerebellum, with obscured cisterna magna and 4th ventricle. Open spinal bifida defect with menigocele at lumbosacral junction suggestive of neural tube defect (Arnold chiari malformation type 2)’. Apparently, the doctors of AIIMS Raipur, as per the complaint, advised abortion. The patient, however, consulted the doctors at GTB Hospital and on their advice the patient underwent at 19 week 06 days,ultrasound at GTB Hospital on 18th July, 2017. This USG/Ante-natal Level-II scan was reported as normal by Dr.Daizy Garg. The patient was advised to continue with pregnancy. Thereafter, the patient underwent another USG scan on 12th September, 2017 at 26 weeks 4 days pregnancy on the advice of the doctors of GTB Hospital. This USG Anomaly Scan-Level II (No.45) dated 12th September, 2017 done at Unique Diagnostics; GTB Enclave reported that ‘spine shows kyphotic deformity, the lumbosaccral region shows separation and widening of posterior elements echoes of spine with menigocoele formation of size 43 x 26 mm’. The patient subsequently delivered a baby girl who suffered from deformities(meningomylocele and leg deformity), on 03rd December, 2017 through LSCS.
2. It is noted that as per the hospital protocol, no ultrasound can be conducted or reported/issued independently by a post-graduate radiology student. Similarly, the post-graduate student is not authorized to file the Form ‘F’. The post-graduate are expected to perform ultrasound scans under the supervision of the Senior Residents, and the Consultants, who only are authorized to issue the final reports. Inspite of the hospitals protocol, in the present case, it is apparent that the ultrasound dated 18th July, 2017 was conducted by the second year post-graduate student namely Dr.Daizy Garg and the same was reported by her. This is serious breech of the hospital protocol. Level-II scans being highly specialized investigation require the expertise of either the Senior Resident or the Consultants whilstconducting and reporting on them, as they have sufficient training and experience, in this regard.
3. It is noted that the ultrasound scan dated 11th July, 2017 at Raipur Chhattisgarh done at 19 weeks pregnancy, was suggestive of neural tube defect (Arnold Chiari Malformation type), which under the prevailing medical condition made the pregnancy unviable. It is however, noted that Dr.Daizy Garg did not report any of the anomaly in her report of Level-II scan done at 19 weeks 6 days.
4. Although, the fact remains that not all congenital anomalies can be detected on ultrasound and many neural tube defects can be missed on Level 2 scan even by expert operators. This does not negate the fact that modern day ultrasound equipment have sufficient resolution to detect such open neural tube defects. However, such diagnosis needs skilled operators with sufficient training and expertise.

The fact that the same anomalies were picked up in other ultrasound done before the scan under question further strengthens the fact that this anomaly would have been picked up by an expert operator.

1. In any department clinical privileges are defined by concerned departmental hospital committees. As a standard practice, Level II scans are to be carried out by a radiologist with sufficient expertise and training. In this case Dr Daizy being an early 2nd year PG trainee was not entitled to work in isolation for level 2 scans. Dr. Rajat Malhotra in his written statement stated that he had neither examined nor reported or reviewed the USG scan in question.

The circumstances in a heavy footfall hospitals, like GTB hospital with huge patient load and lack of trained manpower to conduct various specialised scans is highlighted by the various concerned authorities in their submission.

The Hospital authorities erred in allowing a P.G. student Dr.Daizy Garg to conduct, issue USG reports without any senior’s supervision and since as per the averments of the HOD(Radiology), Dr.Gopesh Mehrotra, Consultant Radiology, was consultant in-charge of ultrasound/supervisor of the day in question, he was responsible for the conduct of the P.G. student. The claim of Dr. Gopesh Mehrotra that on the particular day (18-07-2017), Dr. Daizy Garg was posted under another consultant Dr. Vinita Rathi, was found to be incorrect, as Dr. Vinita Rathi has asserted that it was not her allotted day to supervise the ultrasound in the department. The Head of Department (HOD) is also accountable for not providing adequate equipment, manpower and adequate time / SOPs for ultrasound scans.

In light of the above, the Disciplinary Committee recommends that a warning be issued to Dr. Daizy Garg (Delhi Medical Council Registration No.DMC/R/12161) with a direction that she should undergo 15 hours of Continuing Medical Education (C.M.E.) on the subject related to ‘Obstetrics Ultrasound (TIFA/Level II Scan/Anomaly Scan)’ and submit a compliance report to this effect to the Delhi Medical Council and also to exercise due diligence, in future. Further, a warning be also issued to Dr. Gopesh Mehrotra (Delhi Medical Council Registration No.7019) and Dr. Lalendra Upreti (Delhi Medical Council Registration No.4008) with a direction that they should formulate Standard Operating Procedure (SOPs) instead of protocol and ensure their adherence by all the concerned doctors in their department in letter and spirit, for future.

Complaints stands disposed.

Sd/: Sd/: Sd/:

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

Chairman, Delhi Medical Association, Expert Member,

Disciplinary Committee Member, Disciplinary Committee

Disciplinary Committee

Sd/:

(Dr. Ashok Kumar)

Expert Member,

Disciplinary Committee

The Order of the Disciplinary Committee dated 15th June, 2023 was confirmed by the Delhi Medical Council in its meeting held on19th June, 2023.

The Council further confirmed the punishment of warning awarded by the Disciplinary Committee to Dr. Daizy Garg (Delhi Medical Council Registration No.DMC/R/12161) with a direction that she should undergo 15 hours of Continuing Medical Education (C.M.E.) on the subject related to ‘Obstetrics Ultrasound (TIFA/Level II Scan/Anomaly Scan)’ 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. The Council also confirmed the punishment of warning awarded by the Disciplinary Committee Dr. Gopesh Mehrotra(Delhi Medical Council Registration No.7019) and Dr. Lalendra Upreti (Delhi Medical Council Registration No.4008)

The Council further observed that the Order directing the issuance of warning shall come into effect after 60 days from the date of the Order.

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 Sahil Malik r/o F-218, Gali No. 27, Old Mustfabad, Delhi-110094.
2. Dr. Rajat Malhotra A-468, Defence Colony, 3rd Floor, New Delhi- 110024.
3. Dr. Lalendra Upreti, Department of Radiology, Through Medical Superintendent, GTB Hospital, Dilshad Garden, Delhi-110095.
4. Dr. Daizy Garg, 232 B Pocket F, GTB Enclave, Dilshad Garden, near GTB Hospital, New Delhi-110095.
5. Dr. Shalini Rajaram, Through Medical Superintendent, GTB Hospital, Dilshad Garden, Delhi-110095.
6. Dr. Bindiya Gupta, Through Medical Superintendent, GTB Hospital, Dilshad Garden, Delhi-110095.
7. Dr. Anshuja Singla, Through Medical Superintendent, GTB Hospital, Dilshad Garden, Delhi-110095.
8. Dr. Vinita Rathi, Through Medical Superintendent, GTB Hospital, Dilshad Garden, Delhi-110095.
9. Medical Superintendent, GTB Hospital, Dilshad Garden, Delhi-110095.
10. Dr. Gopesh Mehrotra, 122-A, Pocket-A, Mayur Vihar, Phase-II, Delhi- 110091.
11. National Medical Commission, Pocket-14, Phase-1, Sector-8, Dwarka, New Delhi-110077-**for information & necessary action** and ***also Dr. Lalendra Upreti is also registered with the erstwhile Medical Council of India under Registration No.6792 dated 07-01-1988-for information & necessary action.***
12. Registrar, Uttar Pradesh Medical Council, 5, Sarvapally Mall Avenue Road, Lucknow-226001, Uttar Pradesh (**Dr. Gopesh Mehrotra is also registered with Uttar Pradesh Medical Council under registration No-** **26024 dated 31-12-1981**)-**for information & necessary action**.

(Dr. Girish Tyagi)

Secretary