SUMMARY

DR. PANKAJ SINGH SENGAR (CPSO# 81733)

1. Disposition

On June 15, 2018, the Inquiries, Complaints and Reports Committee (the Committee) ordered General Surgeon Dr. Sengar to complete a specified continuing education and remediation program (SCERP). The SCERP requires Dr. Sengar to:

- Practice under the guidance of a Clinical Supervisor acceptable to the College for three (3) months.
- Complete the Medical Record-Keeping Course, the Advanced Skills Training for Rural Surgeons: Laparoscopic Common Bile Duct Exploration and Closure of Complex Soft-Tissue Defects course, and the Cholecystectomy: From Lap Chole to Open Common Duct Exploration, all the Tools you Need course.
- Review the Canadian Medical Protective Association (CMPA) article on laparoscopic cholecystectomies, reflect on the current standards of practice, how they are applicable to his situation, what steps he has taken to improve his practice and record keeping, and the further steps he needs to take to ensure he complies with the College's policies *Medical Records, Disclosure of Harm,* and *Consent to Treatment.*

2. Introduction

The patient complained to the College that an abdominal surgery performed by Dr. Sengar resulted in emergency bile duct repair surgery, numerous hospitalizations, ongoing drainage tubes and care, abdominal pain, extreme weight loss, and some memory issues.

Dr. Sengar responded that everything seemed to be going smoothly during the surgery until the bile duct injury, which he recognized intraoperatively, and controlled by placing drainage tubes. He stated that he disclosed the injury to the patient, and arranged for further follow-up. He acknowledged that his notes were not adequate, said that it reflected the distress he felt during

the procedure, and indicated that he would take more appropriate notes in the future.

3. Committee Process

A Surgical Panel of the Committee, consisting of public and physician members, met to review the relevant records and documents related to the complaint. The Committee always has before it applicable legislation and regulations, along with policies that the College has developed, which reflect the College's professional expectations for physicians practising in Ontario. Current versions of these documents are available on the College's website at www.cpso.on.ca, under the heading "Policies & Publications."

As part of this investigation, the Committee obtained a letter of opinion from an independent opinion provider who reviewed Dr. Sengar's care of this patient, and submitted a written report to the Committee.

4. Committee's Analysis

The Committee agreed with the Independent Opinion provider that Dr. Sengar failed to meet the standard of care, displayed a lack of knowledge and judgment, and exposed the patient to harm. Specifically, Dr. Sengar's operative approach and notes did not indicate that he obtained a critical view of safety during the operation. The Committee also noted that Dr. Sengar recognized larger than anticipated ductal structures and that there were more than two, but did not explain any rationale for failing to adjust his procedural approach. As a result, Dr. Sengar cut the common bile duct and common hepatic duct, which caused an extremely significant injury for the patient.

The Committee recognized that Dr. Sengar has not (to their knowledge) caused previous biliary injuries, but is concerned that the results of this surgery indicate that he lacks knowledge of fundamental surgical issues. Therefore, the Committee's opinion was that Dr. Sengar required further education on intraoperative management of difficult laparoscopic cholecystectomies.

Dr. Sengar's notes were not adequate. He did not document any discussion between him and the patient regarding the risk of biliary injury, despite discussions of other risks being recorded. This is insufficient, as biliary injury is one of the most significant risks of abdominal surgery. His updates to the operative note still did not indicate that he followed correct procedure during the surgery, and the Committee noted that stress is not an acceptable reason for not maintaining a proper medical record.

Further, Dr. Sengar's response indicated to the Committee that he lacked insight into his errors. As a result, the Committee determined that Dr. Sengar required surgical supervision to ensure that his surgical practices are adequate, in addition to further education.