DMC/DC/F.14/Comp.2471/2/2019/ 30th October, 2019 **O R D E R**

The Delhi Medical Council through its Disciplinary Committee examined a complaint of Shri Ram Baboo, s/o Late Shri Sita Ram, r/o- B-1075, Sangam Vihar, New Delhi-110080, forwarded by the Medical Council of India, alleging medical negligence on the part of Dr. Harish Kapila of Max Super Specialty Hospital, Mandir Marg, Press Enclave Road, Saket, New Delhi-110017, in the treatment administered to complainant‘s wife Smt. Shobha at Max Super Specialty Hospital, resulting in her death on 20.04.2017 at Batra Hospital and Medical Research Centre where she subsequently received treatment.

The Order of the Disciplinary Committee dated 26th August, 2019 is reproduced herein-below :-

The Disciplinary Committee of the Delhi Medical Council examined a complaint of Shri Ram Baboo, s/o Late Shri Sita Ram, r/o- B-1075, Sangam Vihar, New Delhi-110080 (referred hereinafter as the complainant), forwarded by the Medical Council of India, alleging medical negligence on the part of Dr. Harish Kapila of Max Super Specialty Hospital, Mandir Marg, Press Enclave Road, Saket, New Delhi-110017, in the treatment administered to complainant‘s wife Smt. Shobha (referred hereinafter as the patient) at Max Super Specialty Hospital (referred hereinafter as the said Hospital), resulting in her death on 20.04.2017 at Batra Hospital and Medical Research Centre where she subsequently received treatment.

The Disciplinary Committee perused the complaint, written statement of Dr. Sahar Qureshi, Medical Superintendent of Max Hospital, written statement of Dr. Harish Kapila, copy of medical records of Max Hospital and other documents on record.

The following were head in person :-

1) Shri Ram Baboo Complainant

2) Dr. Harish Kapila Sr. Consultant Surgeon, Max Super Specialty Hospital

3) Dr. Sahar Quareshi Medical Superintendent, Max Super Specialty Hospital

4) Moaileen AGM, Max Super Specialty Hospital

The complainant Shri Ram Baboo alleged that on 7th December, 2016 at 8.03 a.m., he had brought his ailing wife (the patient) namely Smt. Shobha, to Max Hospital, Saket, as she was suffering from pain and swelling in her stomach/abdomen. Accordingly, his wife was admitted in the said hospital vide Registration No.SKDD 315495, IP No. 13272. Dr. Harish Kapila being a Senior Consultant in department of GI, MAS & Bariatric Surgery in Max Hospital aware with the facts that Dr. Harish Kapila after having diagnosed the patient and found that the patient suffered from incisional (ventral hernia); advised the patient to undergo surgery of laparoscopic ventral (incisional) hemioplasty + laparoscopic adhesiolysis. Dr. Harish Kapila asked him (the complainant) to give his consent for the operation, accordingly, he gave his consent and agreed to get the operation done on the patient, solely on the basis of the advice, given by Dr. Harish Kapila. Dr. Harish Kapila after having obtained his (the complainant) consent, carried out the aforesaid operation upon the patient and during the course of operation, Dr. Harish Kapila observed the facts that a 2 cm. defect umbilical and paramubilicial are dense bowel. Dr. Harish Kapila by way o£ operation, removed the portion of infected area of abdominal wall and fitted a composite mesh. Dr. Harish Kapila on 10.12.2016 at 10.07 a.m. discharged the patient, after receiving a total sum of Rs.75,739.80 vide Bill No. SCIC17277 dated 10.12.2016. After discharge from the hospital, the patient felt sever pain in abdomen, as such he on 13.12.2016 at 4·90 a.m. brought the patient in the Max Hospital and she was readmitted in ICU, while during the course of analysis by Dr. Harish Kapila, it was observed that there was severe inflammation of anterior abdominal wall and signs of peritonitis present. In ICU, Dr. Harish Kapila did preoperative investigation and NCCT abdomen, which showed ascites and inter bowel free fluid and on exploration, there was a severe inflation anterior abdominal wall and necrosis of subcutaneous intraperitoneal pus collection and evitalized ometum etc. Dr. Harish Kapila after peritoneal lavage/operation, drain at sub hepatic and pelvis, discharged the patient from Max Hospital vide LAMA Summary dated 29.12.2016 that too after receiving a sum of Rs. 2,28,116.00 from him vide Bill No. SCIC18264 dated 29.12.2016. During the course of the operation in fixing composite mesh which resulted in severe pain and food waste logged at the edges of the said mesh Thereafter, he (the complainant) immediately on the very same date of discharge of the patient from the Max Hospital, took the patient to Sir Ganga Ram Hospital and she was admitted vide Registration No.1997825 in Ward No. 4 CD, Bed No. 1456-A Cat-3, due to the reason of severe, diffuse pain abdomen due to burst abdomen and faecal fistula, where Dr. Rathindra Sarangi diagnosed the patient and found enterocutaneious fistula (High output) proximal ileum burst abdomen, sepsis, hypoalbuminemia and found mesh infection and health condition of the patient deteriorating. During the course of admission of the patient in Sir Ganga Ram Hospital, on 09.01.2017, the patient underwent operation-exploratory laparotomy + adhesiolysis + ileostomy under G.A; there were dense adhesions between the bowel and parietal wall and inter bowel adhesions. Two perforations-first in proximal ileum and second in distal ileum were identified and repaired primarily, fecal collection was noted in subcutaneous plane above sheath. Removac (suction) drain was placed in subcutaneous plane. Thereafter on 20.1.2017, exploratory laparotomy with adhesilysis with ileostomy was done under G.A.- previous midline laparotomy incision was opened. Dense adhesions between the bowel loops and parietal wall alongwith bowel adhesion were separated. Leak was noted from previous enterotomy sites. Performation of promixal ileum was repaired using 3-0 vicryl suture and distal enterotomy was brought out as ileostomy thorugh left lower abdomen. The previous ileostomy on the right lower abdomen was left untouched. On, 9th February, 2017, the patient was discharged from the Sir Ganga Ram Hospital that too after receiving a sum of Rs.9,64,737.00/- vide bill No.2016-2017/Ca/I/0551126. The above said facts clearly shows that Dr. Harish Kapila had committed negligence in performing the operation upon the patient in fixing the composite mesh, which resulted in inflammation and, severe pain in the patient and forced the complainant to admit the patient in the Sir Ganga Ram Hospital. It is submitted that despite the effort of the doctor concerned of Sir Ganga Ram Hospital, the infection caused in fixing the composite mesh by Dr. Harish Kapila, not able cured which further resulted in to severe pain in the abdomen of the patient. On 24.02.2017, he (the complainant) took the patient to Batra Hospital & Medical Research Centre, New Delhi where she was admitted under Dr. Sham Sunder who diagnosed and found mesh infection and. burst abdomen and enterofacial fistula/high output jejunostomy/wound infection/acute kidney injury etc. During the course of medical treatment in Batra Hospital & Medical Research Centre, the patient was dialysed. However, during the course of medical treatment under Dr. Vijay, the patient died on 20.4.2017 at 9.00 p.m. He (the complainant) incurred total sum of Rs. 6,09, 083/- on account of charges against the medical treatment provided by Batra Hospital. In view of the above and circumstances, it is crystal clear that the patient died due to the medical negligence committed by Dr. Harish Kapila in Max Hospital in fixing the composite mesh and the same further was damaged due to the water food items/urea etc. logged between the gap of the mesh. In view of the above, it is clear that Dr. Harish Kapila and Max Hospital committed the negligence, because of which, his wife died. Hence, Dr. Harish Kapila and Max Hospital are liable to be prosecuted and punished in accordance with the law.

Dr. Harish Kapila, Sr. Consultant Surgeon, Max Super Specialty Hospital in his written statement averred that the patient Smt. Shobha, a 46 year old female, first came to surgery OPD of the Hospital on 1st December, 2016 with complaints of pain and swelling over the previous operated site (2009 at outside hospital) with mass like protrusion and with a past history of abdominal koch’s sunder treatment with ATI and history of PIVD. The patient underwent thorough investigation; on clinical examination, it was noted that as swelling in umbilical region, non-reducible. Accordingly, it was diagnosed as obstructed incisional hernia non reducible. Thus, advised for lap. incisional hernia repair. Pre- anesthesia check (PAC) was conducted as per protocol for the surgery. Subsequently, review PAC was done on 3rd December, 2016 and cleared for the surgery. Accordingly, the patient was planned for the surgery on 7th December, 2016 and advised to get admitted in the hospital on 7th December, 2016. Despite plan for surgery on 7th December, 2016 and was thoroughly worked up for the same, the patient came to the emergency room of the hospital on 7th December, 2016 morning at 8.03 am with the same complaint that was shown to him on 1st December, 2016 in his OPD. The patient was assessed by the emergency doctor on duty and observing that the patient had already consulted him in his OPD and has been advised for admission to the hospital on 7th December, 2016 for the surgery: accordingly thoroughly worked up for surgery on the same day, the patient was referred to surgery team. The patient was seen by him and his team at 8.20 am and seeing that the patient has been cleared in the PAC for the surgery, shifted for surgery. The patient was taken up for surgery at 2.17 pm and the surgery finished at 4:10 pm. The surgery was done under general anaesthesia after duly obtaining Informed consent for laparoscopic incisional hernioplasty (surgery) from the patient; wherein the detailed benefits and risks involved in such surgery are mentioned. The surgical findings on operation were : Two 2 cm defects in umbilical and para umbilical, dense bowel and omental adhesions, omentum as content and tubercles on parietal peritoneum. The surgical procedure done were : - Lap. adhesiolysis done, hernia reduced, haemostasis done, composite mesh (10.8 cm x 15.9 cm) placed and anchored with sutures and tackers, intra-op bleeding ooze from omentum was cauterised and abdominal toileting done and skin closed. The surgery was uneventful. The patient was shifted to ward after surgery and stayed for three days in the hospital. The postoperative stay was uneventful. On postoperative day one (08.12.2018), the patient was mobilized and clear liquid was allowed. In post-operative day 2 (09.12.2016), the patient complained of pain at surgical site. On examination, it was noted that the patient was having a pulse rate of 80/min and her abdomen was soft. So, the patient was advised oral analgesics (tablet Ultraset). On 10.12.2016, the patient was observed to have no complaint and fit to be discharged in the morning. Accordingly, discharged on 10.12.2016 at 10.07 a.m. At the time of discharge, the patient’s vitals were stable, mild tenderness in lower abdomen. Discharged with advise on antibiotics and to attend OPD after one week. The patient came to the emergency room of the hospital on 13.12.2016 at 4.52 am with complaints of abdominal distension, loose stools and .generalised weakness. On evaluation, it was noted that the patient had a history of not passing stool for one day, for which, the treatment (syrup, tablet) was taken. Thereafter, the patient had six to seven episodes of loose stools, but without fever and cough. The patient was immediately seen by the attending consultant of surgical team at the ER. On evaluation, the patient was observed to be afebrile with pulse rate 116/min, BP- 100/70, SP02 72% off oxygen. Accordingly, the patient was advised for CBC, KFT, UT, urine R/E, x -ray abdomen, blood culture and urine culture, ultrasound whole abdomen and admission to the hospital. The ultrasound whole abdomen showed mild tree fluid in peritoneal cavity. The patient was examined in the ward by him at 9:00 am on 13th December, 2016 and after reviewing the blood and ultrasound reports. The patient was advised exploratory laparotomy after CT abdomen and put on injection Imipenem 1 gm IV and injection Metrogyl 100 ml I.V. Cardiology and nephrology opinion were taken for optimisation. CT abdomen showed presence of mesh in midline in peri umbilical region, free air noted in the peritoneal cavity, mild ascites noted in the pelvis which appears to track from the midline. Note is made of a collection in the inter bowel space in the left lumbar region, interior to stomach. Presence of air was seen in the overlying of superficial abdominal wall. Keeping in view of the CT findings and clinical parameters, it was clinically diagnosed as perforation peritonitis and advised for exploratory laporotomy and proceed(CO second surgery). The patient was taken up for the second surgery on 13th December, 2016 at 9:00 pm after obtaining informed consent. It is to be highlighted that the risk involved in the second surgery is categorically mentioned as infection, bleeding and bowel injury. Intra operatively, it was diagnosed as omental necrosis, subcutaneous fat necrosis and pyo peritoneum and faecal matter in left lumbar region. Therefore, infected mesh was removed, partial omentectomy and subcutaneous necrosectomy done. Entire bowel was inspected for any perforation, as there was faecal matter in left lumbar region but no perforation was found. Peritoneal toileting was done, pus-sent for culture and sensitivity and omentum for HPE. Wound closed with loop prolene. Tube drains were placed in right sub hepatic region and on left side in pelvis. A romovac drain was placed subcutaneously. The surgery was closed at 11.25 pm and the patient sent to ICU on elective ventilation with minimal requirement of inotropes. The patient’s condition improved post operatively. Inotropes were stopped from 15th December, 2016. On 16th December, 2016, she was allowed orally and extubation was planned on. However, she could not be weaned off ventilator due to glotic oedema. In view of which, tracheostomy was done on 19th December, 2016. On 21st December, 2016, the patient developed enterocutaneous fistula with wound dehiscence. The patient was managed on TPN (total parenteral nutrition) with oral liquids and local wound management. Free drainage of contents was provided to prevent any intra abdominal collection by opening the wound. She was given to two units of whole blood and high protein diet. On 22nd December, 2016, bio chemical parameters were as follows: Hb - 9.5, TLC - 11,900, platelets - 4.31 lakhs, Na-133, K - 4.1, urea -21A creatinine - .5, APE of omntum, non specific inflammation abdominal pus -pseudomonas +klebsiella. The patient was being managed conservatively. However, on 29th December, 2016, the patient went Leave Against Medical Admission (LAMA) refusing any further treatment. At the time of LAMA, the patient’s pulse was 110/min, BP – 110/90, SP02 98 to 99%, enterocutaneous fistula, wound infection and wound dehiscence. Her biochemical parameters were as follows: HB-9.5, TLC-13.3, platelets - 4.91 lakhs, urea-19.3, creatinine - 0.5. Thus, the patient was diagnosed and treated well, as needed, within the ambit of the medical standards for such patient.

Dr. Sahar Quareshi, Medical Superintendent, Max Super Specialty Hospital reiterated the stand taken by Dr. Harish Kapila.

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

1. It is observed that Dr. Harish Kapila, Sr. Consultant Surgeon, Max Super Specialty Hospital saw the patient Smt. Shobha, a 46 year old female, in surgery OPD of the Hospital on 1st December, 2016 with complaints of pain and swelling over the previous operated site (2009 at outside hospital) with mass like protrusion and with a past history of abdominal tuberculosis under treatment with ATT. The patient was diagnosed as obstructed incisional hernia and advised for laparoscopic incisional hernia repair. Following PAC, the patient was planned for surgery on 7th December, 2016 and was taken up for surgery at 2.17 pm on the scheduled day. The intra-operative findings were :-

(i) Two 2 cm defects in umbilical and para umbilical regions,

(ii) Dense bowel and omental adhesions,
(iii) Omentum as content of hernial sac and

(iv) Tubercles on parietal peritoneum.

Laparoscopic adhesiolysiswas done followed by composite mesh(10.8 cm x 15.9 cm) placement. The postoperative period was uneventful and the patient was discharged on 10.12.2016.
The patient came to the emergency room of the hospital on 13.12.2016 at 4.52 am with complaints of abdominal distension, loose stools and .generalised weakness. The ultrasound whole abdomen showed mild tree fluid in peritoneal cavity. The patient was advised exploratory laparotomy after CT abdomen, which showed free air in the peritoneal cavity and mild ascites along with collection in the inter bowel space in the left lumbar region, and anterior to stomach and air was seen in the superficial abdominal wall. The patient was clinically diagnosed as perforation peritonitis and taken up for exploratory laparotomy on 13th December, 2016 at 9:00 pm. Intra operatively, it was diagnosed as omental necrosis, subcutaneous fat necrosis and pyoperitoneum and faecal matter in left lumbar region. Therefore, infected mesh was removed, partial omentectomy and subcutaneous necrosectomy done. Entire bowel was inspected for any perforation but no perforation was found. Peritoneal toileting was done and abdomen closed with drains. Though the patient’s condition improved initially post operatively, she could not be weaned off ventilator due to glottic oedema. In view of which, tracheostomy was done on 19th December, 2016. On 21st December, 2016, the patient developed enterocutaneous fistula with wound dehiscence. The patient was managed on TPN (total parenteral nutrition) with oral liquids and local wound management. On 29th December, 2016, the patient went LAMA.

1. It is observed that the history, intra-operative findings and post-operative course of the patient and the management bring out the following salient observations:-

a) The patient had a positive history of tuberculosis. There was no clear evidence of the patient having received full course of antitubercular treatment.

No attempt was made by the operating surgeon to find out if the patient was suffering from active tuberculosis or the after effects of the same.

b) The intraoperative findings (omental adhesions and tubercles on parietal peritoneum) clearly indicate presence of active abdominal tuberculosis, which is a known contraindication for hernia repair by meshplasty.

The operating surgeon ignored the aforesaid intraoperative findings and went ahead with meshplasty

c) The postoperative course of events leading to entero-cutaneous fistula clearly point to the possibility of abdominal tuberculosis being the cause of the complications.

In view of the above, the Disciplinary Committee is of the opinion that the operative surgeon (Dr. Harish Kapila) did not exercise application of standard surgical knowledge in diagnosing, investigating and treating the patient and, therefore, the Disciplinary Committee recommends that name of Dr. Harish Kapila (Delhi Medical Council Registration No.3414) be removed from the State Medical Register of the Delhi Medical Council for a period of 30 days.

Complaint stands disposed.

Sd/: Sd/:

(Dr. Subodh Kumar) (Dr. Ashwini Dalmiya)

Chairman, Delhi Medical Association,

Disciplinary Committee Member,

 Disciplinary Committee

Sd/:

(Dr. U.C. Biswal)

Expert Member

Disciplinary Committee

The Order of the Disciplinary Committee dated 26th August, 2019 is confirmed by the Delhi Medical Council in its meeting held on 30th September, 2019.

The Council also confirmed the punishment of removal of name of Dr. Harish Kapila (Delhi Medical Council Registration No.3414) for a period of 30 days awarded by the Disciplinary Committee.

The Council further directed that Dr. Harish Gupta should undergo 6 hours C.M.E. (Continuing Medical Education) on the subject ‘Indication and Contraindication of Meshplasty’ within a period of six months and submit a compliance report to this effect to the Delhi Medical Council.

The Council further observed that the Order directing the removal of name from the State Medical Register of Delhi Medical Council shall come into effect after 30 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 Ram Baboo, s/o Late Shri Sita Ram, r/o- B-1075, Sangam Vihar, New Delhi-110080.
2. Dr. Harish Kapila, B-156, East of Kailash, New Delhi-110065.
3. Medical Superintendent, Max Super Specialty Hospital, Mandir Marg, Press Enclave Road, Saket, New Delhi-110017.
4. Section Officer, Medical Council of India, Pocket-14, Phase-1, Sector-8, Dwarka, New Delhi-110077—w.r.t. letter No.MCI-211(2)(Gen.)/2018-Ethics./110868 dated 23.05.18-**for information.**
5. Secretary, Medical Council of India, Pocket-14, Phase-1, Sector-8, Dwarka, New Delhi-110077 **(Dr. Harish Kapila is also registered with the Medical Council of India under registration No.1588 dated 22.2.80**) -**for information & necessary action.**

 (Dr. Girish Tyagi)

 Secretary