BEFORE THE DISCIPLINARY COMMITTEE OF PAKISTAN MEDICAL COMMISSION

In the matter of

Complaint No. PF.8.2124/2022-DC-PMC

Mr. Adeel Pervez Vs. Dr. Khaleeq-uz-Zaman

Prof. Dr. Naqib Ullah Achakzai	Chairman
Prof. Dr. Noshad Ahmad Shaikh	Member
Mr. Jawad Amin Khan	Member
Barrister Ch. Sultan Mansoor	Secretary
Expert of Neurosurgery	

Present:

Mr. Adeel Pervez	Complainant (online through zoom)
Dr. Khaleeq-uz-Zaman (421-N)	Respondent
Hearing dated	21.11.2022

I. FACTUAL BACKGROUND

1. Mr. Adeel Pervez (the "Complainant") filed a complaint on 20.04.2022 regarding professional negligence of Dr. Khaleeq-uz-Zaman (the "Respondent") in treatment of his aunt, Mrs. Gulshan Ara (the "Patient") at Ali Medical Hospital (the "Hospital"). Brief facts of the complaint are that:

The Complainant has alleged that the patient (since deceased) was brought to the Respondent for checkup and he diagnosed back pain and advised Lumber Surgery for the patient. It is alleged by the Complainant that the Respondent performed the surgery of the patient without completing the pre-operative testing e.g.

Echo Cardiogram of the patient. Due to this negligence of the Respondent, the patient endured cardiac complications during surgery and ultimately expired during the procedure.

II. SHOW CAUSE NOTICE TO RESPONDENT, DR. KHALEEQ UZ ZAMAN

2. In view of the allegations leveled in the complaint Show Cause Notice dated 24.10.2022 was issued to Respondent, Dr. Khaleeq uz Zaman mentioning the allegations in the following terms:

"...

***3. WHEREAS,** a Complaint has been filed by Mr. Adeel Pervez (the "Complainant") before the Disciplinary Committee of the Commission (the "Complaint") which is enclosed along with its annexures and shall be read as an integral part of this Notice; and*

***4. WHEREAS,** in terms of the Complaint, it has been alleged that you diagnosed back pain and advised lumber surgery for Mrs. Gulshan Ara (the "Patient") at Ali Medical Center (the "Hospital"), without completing the pre-operative testing i.e., Echo Cardiogram. During the surgery, the patient endured cardiac complications, suffered a heart attack and ultimately died; and*

***5. Now therefore,** you are hereby served such Notice, explaining as to why the penalty shall not be imposed on you under the Pakistan Medical Commission Act, 2020. You are directed to submit your response along with complete medical record within the period of thirty (30) days. You are further directed to submit a copy of your registration...."*

III. REPLY OF RESPONDENT, DR. KHALEEQ UZ ZAMAN

3. The Respondent, Dr. Khaleeq uz Zaman submitted his reply to the Show Cause Notice on 17.11.2022, wherein she contended that:

a) I saw Mrs. Gulshan Ara on 16.2.2022 with a history of backache and left sciatica. She did not report any comorbid at the time. Upon examination, she had a diminished pin-prick sensation at S 1 and her MRI showed L 4/5 Disc prolapse with migration inferiorly. I counselled the patient and attendants regarding the need for surgery and advised rest, analgesia and antacid. I further advised them that in case they decide to undergo surgery, they should get her admitted in AMC.

b) *As per medical notes record/ admission record: On 27.03.2022, Mrs. Gulshan Ara got admitted in AMC with the following admission orders and preoperative preparation as per established protocol for all the patients coming for surgery: -*

i. NPO for 6 hours before surgery

ii. Blood CP Blood Chemistry

iii. Blood Chemistry

iv. ECG

v. X Ray Chest PA view

vi. Anesthetist Dr. Nusrat Ali informed

vii. Urine RE

viii. Instructions to the staff to prepare for surgery

ix. Referral to Cardiologist Dr. Naveed Pirzada for GA fitness.

c) *The Cardiologist Dr. Naveed Pirzada saw the patient. He recorded her blood pressure as 160/100 and started Exforge HCT 10/110/12.5. He labelled her as Level II Risk and advised ECG and Echo. The admitting doctor, Dr. Ihsan carried out all the pre-operative orders and tried to consult Dr. Naveed Pirzada on 27.3.2022 by phone, and later another cardiologist Dr. Amer Niaz from 2102 hrs. to 2130 hrs. to perform the ECHO but could not establish communication because of the law & order situation in the city. At 2224 hrs. on the same date, Dr. Nusrat Ali, the Anesthetist was consulted who advised anxiolytic and antihypertensive before INPO. He also told Doctor Ihsan that the new ECG early in the morning is a must and that Echo is not necessary.*

d) *The Patient was put second on the list for surgery on the following day i.e. 28.3.2022. As the first case turned out to be positive for Hepatitis B, Mrs. Gulshan Ara was moved up the operating list to avoid her getting exposed to Hepatitis infection.*

e) *I was informed regarding scheduled surgeries to be performed by me on 28-03-2022. Accordingly, I reached AMC and Operation Theatre (OT) at around 08.45 hrs. Dr. Nusrat Ali (the Anesthetist) shifted Mrs Gulshan Ara in the OT and informed me that he examined Mrs. Gulshan Ara in the pre-operative room. As per record, he got the duly signed Consent of patient (family) for general anesthesia and did all the pre-operative assessment of the patient and various investigations, including the ECG done earlier that morning at 07.00 hrs.*

f) *As per record, ECHO was declared unnecessary by the Anesthetist concerned. (This fact was in knowledge of the family as mentioned in their complaint). However, fresh ECG was performed early in the morning, as per the instructions of the Anesthetist at 7 am on 28-03-2022. I was informed that the Anesthetist has fully reviewed the ECG to his full satisfaction and the general anesthesia Consent was given by the patient and her family in the pre-operative room whereafter the patient was allowed to be shifted to the OT, for surgery. (Annex-VII).*

g) *At this stage must mention that Ali Medical is an ISO certified facility and patients are never shifted to the OT unless it is ensured that all the Standard Operating Procedures (SOPs) are completed by all concerned, and the system is followed in true letter & spirit. When the patient Mrs. Gulshan Ara was shifted to the OT, all the SOPs had been complied with and the patient was ready for surgery.*

h) *Having been shifted to the OT, the patient was anesthetized at 09.00 hrs. by the Anesthetist. The patient was put in position, cleaned and draped by me. The surgery started at 09.15 hrs. The surgery was simple & straightforward. I almost finished the procedure, established the hemostasis and was about to close the wound. At that moment, the anesthetist informed me that the patient has gone into sudden cardiac arrest. CPR was started immediately as per the guidelines. The Cardiologist was immediately called to the OT who placed the temporary pacemaker. During this period, I managed to brief the attendants regarding the critical condition of the patient. The patient had reverted back, and I completed the closure and the patient was to be managed by the Cardiologist and other concerned afterwards. However, later the patient unfortunately again went into cardiac arrest and could not be reverted.*

i) *I performed surgery with the best of my ability and the same was successfully completed. There was no negligence, misconduct or violation of my obligations committed by me during the entire procedure performed by me in OT and the record is evident regarding the same.*

j) *The above events and record make it clear that the death of Mrs. Gulshan Ara was not due to surgical cause, and that the team tried its best to save her life. The Anesthetist and the Cardiologist were of the opinion that the cause of death was massive cardiac infarction which is a known complication of General Anesthesia.*

IV. HEARING

4. The matter was fixed for hearing before the Disciplinary Committee on 21.11.2022. Notices dated 17.11.2022 were issued to the Complainant and Respondent directing them to appear before the Disciplinary Committee on 21.11.2022.

5. The Complainant was present through online mode and reiterated contents of his complaint already submitted before the Disciplinary Committee. The Complainant stated upon query that earlier ECG of the patient was done and that the Cardiologist had pre-reviewed the patient.

6. The Respondent was present in person and submitted before the Disciplinary Committee that he had followed all the necessary medical protocols in treating the patient. He submitted that the procedure was explained to the patient/attendant and consent was taken accordingly, explaining the consent process in detail. The Respondent responding to the query of the Disciplinary Committee regarding the administration of anesthesia stated that anesthesia was administered by a qualified anesthetist.

V. EXPERT OPINION

7. A Professor of Neurosurgery was appointed as an Expert to assist the Disciplinary Committee in this matter. The Expert opined as under:

1. Surgeon is not responsible for cardiac arrest as spine surgery has no direct relationship.

2. ECG was normal, nothing significant related to heart was found in

3. Echo is not a predictor of cardiac arrest during surgery.

4. Sudden cardiac arrest is the single most common cause of death worldwide even in normal population is 1%.

No negligence on the part of neurosurgeon.

VI. FINDINGS AND CONCLUSION

8. The Disciplinary Committee has perused the relevant record, submissions of the parties and the expert opinion in the instant Complaint.

9. The Complainant has placed his reliance on the fact that the Echo-Cardiogram test of the patient was not done, prior to her operation. The expert has opined in this proceeding that Echo test is done only if the ECG of the patient has been found to be problematic, not the case of the patient. It has been further opined by the Expert that the Echo test does not predict the possibility of a heart-attack.

10. The record and evidences available before the Disciplinary Committee indicate that there was no complication related to the surgery performed by the Respondent and there is no negligence or evidence thereof, on the part of the Respondent, while performing the operation of the patient. As a matter of record ECG of the patient was performed in the morning before the surgery and the cardiologist had pre-evaluated the patient and cited no adverse observations. Furthermore, as noted by the Expert cardiac arrest is a most common cause of death in general anesthesia cases.

11. Therefore, the Disciplinary Committee is of the considered view that no case of negligence is made out against Respondent Dr. Khaleeq-uz-Zaman and he is exonerated of the allegations.

12. The instant Complaint is disposed of in the above terms.

Prof. Dr. Noshad Ahmad Shaikh	Mr. Jawad Amin Khan	Barrister Ch. Sultan Mansoor
Member	Member	Secretary

Prof. Dr. Naqib Ullah Achakzai

Chairman

21/11 ~~December~~, 2022