BEFORE THE DISCIPLINARY COMMITTEE OF PAKISTAN MEDICAL COMMISSION

In the matter of

Complaint No. 165/2017-legal

Mr. Muhammad Ibrar Vs Dr. Asim and Dr. Saima Aslam

Mr. Ali Raza	Chairman
Mr. Aamir Ashraf Khawaja	Member
Dr. Asif Loya	Member

Present:

Maj Gen (R) Maqbool Ahmed	Expert (Surgery)
Mr. Muhammad Ibrar	Complainant
Dr. Saima Aslam	Respondent
Dr. Asim Ikram	Respondent

I. FACTUAL BACKGROUND

Reference from Punjab Health Care Commission

1. A reference was sent to the Disciplinary Committee of erstwhile PMDC on 21-04-2017 by Punjab health Care Commission (PHCC) in the matter of complaint by Mr. Muhammad Ibrar (hereinafter referred to as the "Complainant") against Dr. Asim Ikram and Dr. Saima Aslam (hereinafter referred to as the "Respondent No. 1" and "Respondent No. 2" respectively). Brief facts of the case are that on 23-10-2015 the Complainant took his daughter (Noor Fatima) to

Silver Jubilee Maternity and Children Hospital, Sahiwal, who was complaining of sudden mild chest infection. The Respondent No. 1 had asked him to bring the patient at 9:00 am whereas he took her to the aforementioned hospital at 9:15 am but the Respondent No. 1 was not there. When contacted telephonically he stated that if there's an emergency the patient be brought to his residence (located within the premises of hospital) and accordingly the Complainant took her to his residence. After charging the consultation and admission fee the Respondent stated that the child had blood deficiency therefore blood requires to be arranged. No admission receipt was provided by the Respondent No.1 against the admission fee. Blood however was arranged by the Complainant. The Respondent No.1 started blood transfusion after admission and left the place. The blood transfusion was completed after three hours. The child started to have difficulty in breathing. The Complainant noticed serious condition of the child, screamed for help but nobody paid attention and resultantly patient expired. In terms of Complaint the child was alright prior to blood transfusion.

2. The matter was taken up by PHCC on basis of complaint filed by the complainant. On 26-09-2016, the case was presented to an expert in the field of Pediatrics, who opined the following:

"The initial assessment by the Respondent appears to be correct and his steps of managing the patient and the situation were also appropriate. There does not appear to be any neglect in the advice. The medical record, however, does not show any proper monitoring of the patient and there are no progress notes of the patient, those must be prepared by the duty doctor. As far as the transfusion is concerned, transfusion reaction does not appear to be the cause of death, but the exact cause can only be ascertained after the autopsy report."

3. The PHCC board decided to refer the case of Dr. Saima Aslam to PMDC to take disciplinary action against her for her absence from duty and not informing consultant doctor.

Reply of Respondent No. 1

4. In response to hearing notice issued by the Disciplinary Committee, Dr. Asim Ikram submitted his reply vide letter dated 15-02-2021 as under:
   a. *In response to this notice, I want to say that I have resigned from the job of consultant child specialist in Silver Jubilee Maturity and children Hospital Sahiwal since 30th April, 2018, I have not received any charge sheet regarding the above said case.*

b. *Regarding the case No. C/194/2015, the opinion of experts regarding field of Pediatrics did not mention any mistake / negligence regarding my medical Advice to child.*

c. *Similarly, no neglect was mentioned and no disciplinary action was advised against me by the Board of Commissioner Punjab Healthcare Commission in their final verdict. So it is my humble request to honorable Pakistan Medical Commission to net proceed any disciplinary action against me.*

Reply of Respondent No. 2

5. Dr. Saima submitted her reply vide letter dated 14-06-2017 which is summarized as under:

   a. *It is informed that on Friday, 23rd October 2015 (09 Muharram Ul Haraam), my duty was in Peads Department (Children Ward) Silver Jubilee Maternity and Children Complex as Women Medical Officer from 3 to 4 pm. My only child had died and I had to go to his grave. Nobody informed me about seriousness of patient named Noor Fatima. The Outdoor of the hospital was closed on 09th and 10th Muharram and Nursery was also closed due to Sterilization. Only a few patients were present in the hospital. Medical Officers visit the wards for admitted patients but only for an hour. The situation was not in my knowledge due to communication problem. I have tried to inform on phone that if there is no serious patient during the evening visit, I will not come to hospital. But I could not establish communication with consultant on call and neither did the staff intimate me of any new admission. Sir, if any new patient is admitted and is so serious, I could be informed.*

   b. *Patient Noor Fatima was admitted in the ward at 10:00 am (Morning) and was suffering from painful breathing since two days. As per available record, Midwife Nasira had started blood transfusion from 01:00 which was completed at around 05:30pm.*

   c. *As per detailed decision of PHC, Blood Tx Reaction did not cause the death of children. According to mother of baby and on duty staff, breath of baby goes bad at 5:45 due to drinking a lot of water. Attendants of the patients called Dr. Asim Ikram who was in Faisalabad at that time. Before this, I did not receive any call from on duty staff. I had received call of ward Incharge at 06:00 and I reached hospital on 06:15 due to conveyance problem. The Patient was so serious as she could be expired at any time after admission, because as per patient record, she was patient of Anemia Cardiac Failure.*

d. *Sir, I was also feeling not well, and patient of Incisional endometriosis operation of which was performed on Christian Hospital Sahiwal date 29-03-2016 after 05 months of that incident. But I was clinically ill and could not perform duty so actively due to my painful condition. My C- Section was performed in September 2010 and I was patient of Incisional endometriosis since 05 years.*

II. PROCEEDINGS OF DISCILPLINARY COMMITTEE OF ERSTWHILE PMC

6. Matter was taken up by DC in its meeting held on 30-06-2019. The Complainant stated that the Respondent No. 2 not conducted proper evening rounds. The Complainant will be asked to appear with complete records including those of blood transfusion. Respondent No. 2 will be re-noticed for appearance before next DC meeting Lahore and 5000 expense will be paid by her to the Complainant as the travel cost.

7. Dr. Asim Ikram will be issued show cause notice for next DC meeting Lahore. The Complainant will be asked to appear with complete records including those of blood transfusion.

III. DISCIPLINARY COMMITTEE UNDER PAKISTAN MEDICAL COMMISSION ACT 2020

8. Pakistan Medical and Dental Council was dissolved on promulgation of Pakistan Medical Commission Act on 23rd September 2020 which repealed Pakistan Medical and Dental Council Ordinance, 1962. Section 32 of the Pakistan and Medical Commission Act, 2020 empowers the Disciplinary Committee consisting of Council Members to initiate disciplinary proceedings on the complaint of any person or on its own motion or on information received against any full license holder in case of professional negligence or misconduct. The Disciplinary Committee shall hear and decide each such complaint and impose the penalties commensurate with each category of offence.

Hearing on 20-03-2021

9. The Disciplinary Committee held the hearing of pending disciplinary proceedings including complaint of Mr. Muhammad Ibrar on 20-03-2021. Complainant and both Respondents were present.

10. The Complainant reiterates his allegations against the Respondents. The Disciplinary Committee inquired from Respondent No. 1, Dr. Asim about general condition of the patient, indication for admission and reason of his absence afterwards. He narrated that he was standing in the porch to leave for Faisalabad during Moharram Holidays when the Complainant called him. He was told to come to his residence. The Respondent reiterated that it was absolutely incorrect that he had demanded fee or he had received any money at his residence. The blood had been transfused due to anemic heart failure of the patient. He said that he had advised CBC and peripheral film test which the Complainant had got conducted from Al. Falah Lab. He further claimed that during infection blood could be transfused and in order to save the life of the patient he had recommended blood transfusion. Moreover, he had admitted the patient in the hospital on humanitarian grounds. He told that the hospital staff consists of qualified persons and that FCPS qualified doctors remain present in the ward. He said that all the qualified staff had remained present during the blood transfusion to the said patient.

11. Upon inquiring about facilities at the hospital he stated that oxygen and resuscitation facility was present at the hospital however there was no ICU.

12. The Respondent No. 1 was inquired specifically about general physical condition of the child and amount of blood transfusion advised by him to which he stated that she was of 2 years age, pale in appearance, irritable, sick and her Hb was 8gm/dL. Upon clinical examination her liver was enlarged and there were signs of anemic heart failure. Due counselling of family was done. She was advised 200 ml/kg of blood transfusion. In the instant case acute respiratory infection and Pneumonia were already diagnosed.

13. The Disciplinary Committee inquired from Dr. Asim as to why the patient was not referred to a better care facility with an ICU. He stated that he had explained the attendants the gravity of situation and had asked them to take the child to a tertiary care facility but they were adamant that patient be admitted since due to Moharram holidays it was difficult for them to arrange for transportation etc.

14. Upon specific question regarding X-ray and findings on chest auscultation, he stated that chest X-ray was not available and chest was not clear; patient however was short of breath.

15. The expert specifically inquired from Dr. Asim regarding his choice of dose for blood transfusion being 200 ml/ kg as the patient was in severe anemic heart failure and the same could result in fluid overload. The expert observed that the patient had signs of respiratory infection and no other possibility of SOB was excluded and definitive diagnosis was not given due consideration. No maintenance I/V fluid was given.

16. Upon inquiring possible reasons for the deterioration of the patient, Respondent Dr. Asim states that the child was already in distress and during transfusion the Complainant gave the child excessive water and perhaps the child could have aspirated that. This stance however was negated by the Complainant.

17. The Disciplinary Committee inquired from Respondent about findings during blood transfusion and saturation level of the patient to which he stated that he was on leave that day and had to leave to his native town and therefore saturation was being monitored by the on-call duty doctor present in the hospital. He got a call at 5:45 regarding the patient and was not in receipt of any information earlier since 1:00 pm, the time at which blood transfusion had started. According to Respondent Dr. Asim there appears no transfusion reaction.

18. The Committee inquired from Dr. Asim whether Dr. Imran the other physician at the hospital was aware of the situation of the patient throughout her admission. He stated that the staff on duty negligently had failed to apprise Dr. Imran about new admission.

19. The Committee inquired from Respondent No. 2 Dr. Saima (duty doctor) about condition of the child in her presence. She stated that she was called for duty only for few hours as it was Moharram day. Blood transfusion was already continued when she visited the child. The orders of Inj. Lassix (40mg) after two hours of transfusion on the advice of physician were already carried out by the staff. Afterwards there was call for baby again however when she came to see the baby, the baby had already expired. She states that it was after her duty hours she received the call and had already left for home. However, on humanitarian grounds she came back to see the baby.

20. The expert inquired from Dr. Saima about physical appearance of the child upon examination, to which she stated that the child was cyanosed but there were no signs of either edema or dehydration. The Complainant however negates the stance and states that the complexion of the child had turned pale and her body had started to swell.

21. The Disciplinary Committee perused an earlier response dated 14-06-2017available on record sent to erstwhile PMDC by Dr. Saima where she has stated that her duty was from 3 to 4 pm. Her only child had died and she had to go to his grave. Nobody informed her about seriousness of patient named Noor Fatima. She had informed on phone that if there was no serious patient during the evening visit, she will not come to hospital. Further evidence available on record shows her another stance that she was not feeling well as she was patient of Incisional endometriosis could not perform duty so actively due to her painful condition. Therefore, she could not attend her duty on the day this incident occurred. Now during the hearing she has stated that she visited hospital twice. The Committee observed that there is serious contradiction between her written and oral statements.

Expert Opinion by Maj Gen (Retd) Dr. Salman

22. Maj. Gen (Retd) Dr. Salman who was appointed as an expert to assist the Disciplinary Committee in the matter has opined that:

"The subject case was heard in the disciplinary committee meeting of the PMC on the notified dated and after hearing and cross questioning all medical staff and the complainant present there, the following conclusions have emerged:

The Pediatrician examined the child at his residence and noted that the baby to be very sick. She was having respiratory distress, nasal flaring, tachycardia with obvious pallor and a palpable live 5 to 6 cm below the right costal margin. He made a diagnosis of anemic heart failure/ respiratory infection and advised oxygen inhalation, antibiotic injections and blood transfusion 200 ml with injection Lasix to be given midway through the transfusion. Records indicate that the HB of the baby was 7.7 g/ dl which was not low enough to account for any heart failure due to anemia alone. Other possibilities which may have been the cause of the baby's serious illness include pneumonia, acute bronchiolitis or myocarditis. Therefore, the decision regarding blood transfusion needed to be taken after a detailed clinical, radiological and laboratory assessment which was possible in a relatively better healthcare facility than the one where the baby was managed.

As the baby was in respiratory distress, and even if it was considered necessary to transfuse blood for anemic heart failure, then a lower volume of blood i.e. around 5 to 10 ml/ kg body weight should have been advised to prevent worsening of heart failure due to circulatory overload.

The circumstantial evidence regarding the death of this baby indicates that the blood transfusion was carried out under partial supervision of the nurses with no doctor being in attendance. No doctor was available to resuscitate the baby at the last critical moments.

No post Mortem examination was carried out to ascertain the cause of death. Under these conditions, one can only speculate about the possible causes of death in this baby which on the basis of circumstantial evidence can by any of the following:

1. *The primary respiratory infection i.e. Pneumonia.*
2. *Possible myocarditis.*
3. *Volume overload due to blood transfusion.*
4. *The possibility of aspiration of any feed given to such a sick baby could have contributed to the downhill course of the baby by causing airway obstruction.*

In retrospect, one can say that better clinical assessment by the attending doctor, a lower and safer volume of transfusion and close monitoring by expert medical and nursing staff during the period of hospitalization could have been pivotal in avoiding such a calamity."

IV. FINDINGS/ CONCLUSION OF THE DISCIPLINARY COMMITTEE

23. The Committee has perused relevant record, submissions of the parties and the expert opinion in the matter. It has been alleged that patient was brought to residence of Respondent No. 1 located within the premises of hospital who advised blood transfusion. Blood was arranged by the Complainant and the Respondent No. 1 started blood transfusion after admission of patient at the hospital and left for Faisalabad due to Moharram holidays. The blood transfusion was completed after three hours. The child started to have difficulty in breathing. The Complainant noticed serious condition of the child and asked for help but no doctor was available and resultantly patient expired.

24. With regards to clinical assessment and diagnosis of anemic heart failure/respiratory infection by Respondent Dr. Asim, oxygen inhalation, antibiotic injections and blood transfusion 200 ml with injection Lasix to be given midway through the transfusion was advised by him. Records indicate that the HB of the baby was 7.7 g/dl and in view of expert opinion the same was not low enough to account for any heart failure due to anemia alone. The Committee observed that other possibilities which may have been the cause of the baby's serious illness include pneumonia, acute

bronchiolitis or myocarditis were not excluded by the Respondent. Therefore, the decision regarding blood transfusion needed to be taken after a detailed clinical, radiological and laboratory assessment which was possible in a relatively better healthcare facility than the one where the baby was managed.

25. Keeping in view the expert opinion, the Committee further observed that even if it was considered necessary to transfuse blood for anemic heart failure, then a lower volume of blood i.e. around 5 to 10 ml/kg body weight should have been advised to prevent worsening of heart failure due to circulatory overload.

26. During hearing it was an admitted fact that the blood transfusion was carried out under partial supervision of the nurses and midwives with no doctor being in attendance. Both consultants had disappeared and no doctor was available to resuscitate the baby at the last critical moments.

27. Moreover, no postmortem examination was carried out to ascertain the exact cause of death. Under these conditions, one can only speculate about the possible causes of death of patient which may include possibility of volume overload due to blood transfusion and the possibility of aspiration of any feed given to such a sick baby could have contributed to the downhill course of the baby by causing airway obstruction.

28. The Disciplinary Committee has observed that Respondent Dr. Saima had made contradictory statements and tried to twist the facts. In an earlier response dated 14-06-2017available on record sent to erstwhile PMDC by Dr. Saima, she had stated that her duty was from 3 to 4 pm. Her only child had died and she had to go to his grave. Nobody informed her about seriousness of patient named Noor Fatima. She had informed on phone that if there was no serious patient during the evening visit, she will not come to hospital. Further evidence available on record shows her another stance that she was not feeling well as she was patient of Incisional endometriosis could not perform duty so actively due to her painful condition. Therefore, she could not attend her duty on the day this incident occurred. During the hearing she stated that she visited hospital twice. Therefore, there was serious contradiction between her written and oral statements.

29. Keeping in view expert opinion, submissions of parties at length and complete facts/record of the case the Disciplinary Committee is of the considered view that Dr. Asim Ikram was negligent in performing his duty. On examination of patient he had noted that the baby had severe

respiratory distress, the patient should have been referred to a better tertiary care hospital with well-equipped intensive care. Instead, the patient was admitted in Silver Jubilee Maternity and Children Hospital which lacked these facilities, on his advice. He neither informed the other physician nor made adequate arrangement for supervision of patient during blood transfusion and left for Faisalabad. As per expert opinion that even if it was considered necessary to transfuse blood for anemic heart failure then a lower volume of blood i.e. around 5 to 10 ml/kg body weight should have been advised to prevent worsening of heart failure due to circulatory overload and that too under supervision of doctor. Reckless behavior of the doctor to treat and manage a patient contributed to her death. Therefore, the Disciplinary Committee is constrained to believe that the Respondent Dr. Asim is guilty of professional negligence, hence his license is suspended for one (01) year. Doctor Asim is directed to file a formal request for restoration of license after the completion of suspension period.

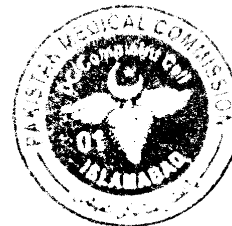
30. During the proceedings, the Respondent Dr. Saima has tried to conceal the true facts and made contradictory statements. For such conduct of the Respondent doctor, the Disciplinary Committee decides to impose a penalty of PKR 50,000 (Fifty Thousand Rupees) on Doctor Saima and directs her to be careful in future. Accordingly, the Respondent Doctor is directed to pay the fine amount in the designated bank of the Commission within fourteen (14) days from the issuance of this decision and forward a copy of the paid instrument to the office of the Secretary to the Disciplinary Committee, failing which license of the Respondent doctor shall be deemed as suspended and remain suspended until such time the fine is paid.

31. The subject proceedings stand disposed of in terms of above directions.

Mr. Aamir Ashraf Khawaja
Member

Dr. Asif Loya
Member

Muhammad Ali Raza
Chairman



31st May, 2021