BEFORE THE DISCIPLINARY COMMITTEE OF PAKISTAN MEDICAL COMMISSION

In the matter of

Complaint 12.comp. 218/2018-Legal

Mr. Aftab Ahmad Khan vs Dr. Asifa Alia

Mr. Ali Raza	Chairman
Mr. Aamir Ashraf Khawaja	Member
Dr. Asif Loya	Member
Present:	
Brig. (Retd) Dr. Ambreen Anwar	Expert (Obstetrics & Gynecology)
Brig. (Retd) Dr. Irfan Shukar	Expert (Surgery)
Mr. Aftab Ahmad Khan	Complainant
Dr. Asifa Alia (35021-P)	Respondent
Hearing dated	20-03-2021

I. FACTUAL BACKGROUND

Reference from Punjab Health Care Commission

1. A reference was sent to the Disciplinary Committee of erstwhile PMDC on 14-05--2018 by Punjab health Care Commission (PHCC) in the matter of complaint by Mr. Aftab Ahmad (hereinafter referred to as "Complainant") against Dr. Asifa Alia (hereinafter referred to as the "Respondent"). The complaint was lodged at PHCC on 26-07-2016. Brief facts are that the complainant's daughter 34 years old G3P1+1 was a regular patient of Dr. Asifa at Wajahat Hospital for antenatal checkups. She has had previous three abdominal surgeries i.e myomectomy, followed by laparotomy for small gut strangulation (both at Hameed Latif Hospital in October 2010) and LSCS on 1-11-2013 at Surgimed Hospital Lahore. The patient was admitted

on 3-06-2016 by Dr Asifa for elective C section due to IUGR, absent liquor, breech presentation and previous scars. Operation was conducted same day which was uneventful. On third day post operation patient complained of chest pain. X ray was done and on fourth post-operative day patient was discharged. On 7-06-2016 patient revisited Dr Asifa with complaint of abdominal distension when ultrasound abdomen/pelvic and x ray abdomen erect was advised. On receipt of reports patient was sent to Faizi Hospital where laparotomy was done by Dr Ghulam Hussain who found jejunal perforation and referred patient to Surgimed Hospital for further specialized care. Where disrupted anastomosis was found and consequently jejunal resection and double-barreled ileostomy was done on 20-06-2016 and the patient was discharged on 2-07-2016.

2. PHCC took cognizance thereupon and proceeded with the case. Expert in the field of surgery made the following observations:

"Patient Rabi Khalid had 3 abdominal surgeries i.e. Myomectomy, laparatomy (as a consequence of myomectomy) and a C/ Section. She remained under care of Dr. Asifa Tariq from 6th November, 2015 to 02nd June, 2016 as an OPD as an OPD patient. On 3-6-2016 LSCS was done by Dr. Asifa who states that if it was straight forward. She did not leave any drain. The patient C/o chest pain on 5-6-2016 for which a physician was consulted. She had some abdominal distension and failure to pass flatus. An X-ray chest ordered by the physician was not seen by the physician or the Gynecologist. It showed gas under the Rt. done diaphragm. The free air could be because of the C/Section.

She was discharged on 6-6-2016. The patient reported back on 7-6-2016 with abdominal distension and failure to pass flatus and feces. Dr. Asifa Tariq saw her and advised USG abdomen and X-ray abdomen. This too showed free gas. She had other features of peritonitis, so she was referred to a surgeon by Dr. Asifa. The patient was taken to Dr. Ghulam Hussain Faizi on 7-6-2016. He did a laparotomy and found a jejuna perforation, 50 cm distal to DJ flexure, and spillage of gut contents in the peritoneum. He anastomosed the perforation & left in drains. On 15-6-2016, the surgeon noticed gut contents in the drain. He referred the patient for further specialized care. The patient was taken to Surgimed Hospital, Lahore where she was re-operated on 19th June. A disrupted anstomosis was found. Jejunal resection and double-barreled ileostomy was done. In view of the previous surgeries, adhesions can occur which can lead to perforation during successive surgeries but the gynecologist did not show any such findings.

The jejuna perforation can occur iatrogenically during surgery or spontaneously postoperatively. If a drain had been left in it could have been detected. Had the first x-ray chest been seen by the physician

or the gynecologist, it could have raised a suspicion and an USG or a CT scan could have revealed the telltale collection of abdominal fluid and the condition detected earlier. Dr. Ghulam Hussain closed the perforation, but it leaked. This is a known complication and can occur in the face of gross peritonitis."

3. The PHCC Board had also presented the matter to an expert in the field of Gynae and Obstetrics. The expert had made the following observations:

   "By the record provided, patient was high risk surgical case for Caesarian Section due to previous Myomectomy, Laparotomy and Caesarian Section. According to Dr. Asifa's statement, there were no adhesions (intra-operative) in current surgery. In post-operative period, due to abdominal distension and pain, patient had laparotomy by Dr. Ghulam Hussain and jejuna perforation was diagnosed. Keeping the high-risk surgery in mind, this patient should have had closer and vigilant monitoring in post-operative period to detect complications in early post-operative period."

4. Based on above expert findings and complete facts of the case the PHCC Board gave its findings regarding Dr. Asifa Alia that PM&DC be approached to warn Dr. Asifa Tariq for not recognizing the complication earlier and not seeing the X-ray herself at the time of discharging the patient.

Reply of Respondent

5. The Respondent doctor in her reply has submitted that:
   a. I am directed to submit my comments and complete record pertaining to the patient with PHC complaint number 155/2016. The summary of all surgical events encountered by me is hereby attached (already been presented to health care commission).
   b. The case was missed because on first post-operation day the patient complaint of back ache and chest pain were more marked then abdominal symptoms for which X-ray chest PA view was advised by physician.
   c. The report of chest X-ray was wrongly communicated to me by the medical officer on duty and it was admitted by him during hearing at health care commission as well that he did not see the X-ray. That's why gas under the diaphragm was missed.
   d. When the patient came back on fourth post- operative day with acute abdomen, she needed ICU care and immediate laparotomy, the facility of ICU care was not available in Wajahat Hospital. Patient's husband was thoroughly explained to shift the patient to ICU care setting and two options were given to him by me. He decided to take patient to hospital of his own

choice as that surgeon was known to him. Unfortunately, the counseling of husband was not written in patient's file it was only verbal and now he denies all that communication with me in front of health care commission.

e. According to expert opinion penal it was suggested that in such a high-risk patient I should place intra peritoneal drain. I admit it as this can diverts my diagnosis towards early detection of perforation and decrease the morbidity of patient.

II. PROCEEDINGS OF DISCIPLINARY COMMITTEE OF ERSTWHILE PMDC

6. The matter was taken up by the Disciplinary committee on 28-06-2019 at Lahore and was adjourned since both the parties failed to appear.

III. DISCIPLINARY COMMITTEE UNDER PAKISTAN MEDICAL COMMISSION ACT 2020

7. Pakistan Medical and Dental Council was dissolved on promulgation of Pakistan Medical Commission Act on 23 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

8. The Disciplinary Committee held the hearing of pending disciplinary proceedings including complaint of Mr. Aftab Ahmed Khan on 20-03-2021. On the date of hearing both parties; Complainant and Respondent were present.

9. Complainant reiterated his allegations against Dr. Asifa Alia. He states that his daughter was a regular patient of Dr. Asifa Alia and went to her for regular antenatal checkups. She had admitted the patient for C-Section on 03-06-2016 and after C-Section her condition got deteriorated. She got her chest x-ray done on 05-06-2016 and discharged her on 06-06-2016. The patient however

did not get better. She advised an ultrasound and x-ray abdomen, after which she advised them to see a surgeon. The patient was then taken to Dr. Ghulam Hussain Faizi who informed the patient was critical and referred to tertiary care facility in Lahore. On their insistence patient was retained till 19-06-2016 and surgical procedure was also done but eventually patient had to be taken to Surgimed Lahore, where patient was re-opened due to complications that occurred due negligence of Dr. Asifa Alia. He further states that her daughter cannot become mother due to negligence of the doctor.

10. During hearing the respondent doctor was asked specific question regarding intra-operative findings, she submits that the C-Section was uneventful. However, postoperatively there was abdominal distention and acute abdomen. Therefore, x-ray abdomen and ultrasound were advised.

11. On enquiry regarding follow up on investigations advised she stated that since X-ray facility is not available 24/7 therefore the patient had come for follow up only with ultrasound report. The radiologist however was contacted telephonically by the Respondent who explained that there is fluid in abdomen. Without any delay and keeping in view that laparotomy would be required and that the patient may require better care/ ICU at other hospital. Her husband was explained the entire situation and a qualified surgeon was also contacted for surgery; her husband however wanted to take her to Dr. Faizi. Later for follow up, she also contacted her relative who told that she had been operated upon.

12. Regarding ordering specific investigations, she states that she took advice from physician on call who asked to get investigations including X-ray done that unfortunately no one followed. On ultrasound though, it was incidental that there is gas under diaphragm.

13. The Respondent doctor states that she used to do her private practice at Wajahat Hospital owned by Dr. Wajahat (Pediatrician) and Dr. Saejeela (dermatologist). She discontinued her practice at Wajahat Hospital after this incident realizing that she needs to work in a better tertiary care hospital. She is now working as Associate Professor in Rai Medical College, Sargodha and working as a private consultant at Sadiq Hospital.

14. During hearing the Disciplinary Committee asked specific question regarding consent. The consent for surgery was taken by staff on duty instead of Dr. Asifa herself, who was responsible

for seeking consent of the patient herself as operating surgeon and for keeping proper documentation including follow up notes, a protocol she did not observe.

15. Upon inquiring from the Complainant that why complaint has not been filed by the daughter (patient) herself, the Complainant stated that settlement in terms of money was made by the doctor with his son in law. He did not agree to any settlement and opted to file the complaint. Dr. Asifa responding to the same question stated that she tried to approach patients' father and she had been negotiating but he refused the settlement. The settlement however has been done by the patient herself and affidavit to this effect has been given by her to her husband to grant her apology.

Expert Opinion by Brig. (Retd) Dr. Ambreen Sarwar:

16. Brig. (Retd) Dr. Ambreen Sarwar who was appointed as an expert to assist the Disciplinary Committee in the matter has opined that:

- *'Facts: 34 year, G3P1+ 1, Booked patient of* R, *High Risk patient, Previous 3 abdominal surgeries (i) Myomectomy (Oct 2010) (ii) Followed by laparotomy for small gut strangulation (at Hameed Latif Hospital) (iii) LSCS Nov 2013 (Surgimed Hospital Lahore). CS performed by* R *3/6/2016 at Private Hospital Sargodha for IUGR and previous surgeries at term. There were no significant adhesions and surgery was uncomplicated and uneventful. 3rd post op day a chest Xray was carried out on complaint of chest pain, which settled by itself and patient was discharged on 4th POD. On 6th POD 7/6/2016 patient contacted the* R *and was asked to come to Wajahat Hospital straightaway where Dr Asifa examined her at 0200 pm on her arrival. She suspected peritonitis and sent patient for USS and Xray in a nearby facility. She had already made the decision of exploratory laparotomy and had done liaison with a tertiary care facility, contacted Surgical specialist. there and arranged a bed in ICU. Despite USS findings being inconsequential she decided to proceed with surgery. However, patients husband intervened and decided to take patient to Faizi hospital (someone known to him) who found jejunal perforation and sent her to Surgimed Lahore where temporary ileostomy was performed. Patient made an uneventful recovery and well now.*
- *Evidence: Case selection was inappropriate at her 6-year experience. In-appropriately performed in a facility lacking colorectal surgeon and ICU. No written high-risk consent or evidence to support that thorough counselling was done regarding gut injury risk (esp in view of previous gut strangulation). Standby surgeon made alert but no evidence in case notes. Early recognition missed on 3rd day post op CXR with gas under diaphragm- but explained to C, it could be due to air entry during operation. -* R *responded well when issue arose, arranged everything. Kept follow-up through a known person to both parties.*

- *Expert Opinion: No negligence. But R needs to improve her soft skills as documentation and communication."*

IV. FINDINGS/ CONCLUSION OF DISCIPLINARY COMMITTEE

17. The Committee has perused the relevant record, submissions of the parties and the expert opinion in the matter. It is observed that Mrs. Rabia Khalid (patient) was 34 years old, G3P+1, booked patient and reported regularly at Wajahat Latif Hospital. She has had three previous abdominal surgeries. She was admitted on 03-06-2016 for elective C Section due to IUGR, absent liquor, breech presentation and previous 2 scars. Third post-operative day the patient complained of pain in chest, after which physician was contacted by the Respondent who advised X-ray Chest and on 06-06-2016 patient was discharged. However, on 07-06-2016 at 2:00 pm the Respondent was contacted telephonically by the attendants and was informed that patient had abdominal distention for which she advised X-ray, ultrasound abdomen/pelvis. After seeing the ultrasound report she advised that the patient be taken to a surgeon in a hospital with better facilities. Moreover, she contacted a surgeon too for the same. The attendants however took her to Faizi Hospital where laparotomy was done by Dr Ghulam Hussain who found jejunal perforation and referred patient to Surgimed Hospital for further specialized care.

18. Based on the expert opinion, the Committee has observed that the patient was at high risk and predisposed to complications due to previous surgical history. It was unfortunate that the Chest X ray advised by the physician was not followed up by the duty doctor. Dr. Alia Asifa should have followed it up herself.

19. Surgery was performed in a facility which lacked colorectal surgeon and ICU. Dr. Asifa, was responsible for seeking consent of the patient herself as operating surgeon. No written high-risk consent found on record. In fact during the hearing, Respondent doctor admitted that consent for surgery was taken by staff on duty. The Committee also observed that the Respondent doctor did not follow the protocol of proper documentation including follow up notes of the patient.

20. There is no evidence to support that thorough counselling was done regarding gut injury risk especially in view of previous gut strangulation. Respondent doctor states that standby surgeon made alert but no evidence in this regard is available on the records. Chest x ray to find out gas under diaphragm which was essential on third post-operative day has been missed by the

Respondent doctor. These are the important protocols which the Respondent doctor was required to follow.

21. The Committee after considering the submissions of the parties and expert opinion is of the considered view that the treatment provided by the Respondent doctor was right and she appropriately referred the patient to a better care facility right in time which saved the patient, therefore there appears no professional negligence during the surgery. However, she has not followed the protocols of seeking consent of the patient herself, post -operative care of the patient and keeping proper documentation including follow up notes. Therefore, a penalty of PKR 50,000 (Fifty Thousand Rupees) is imposed on Respondent and she is directed to be careful in future and follow protocols in terms of her management of the patient in accordance with the provisions of the code of ethic and professional practice.

22. The Respondent Doctor is directed to pay the fine amount (PKR 50,000) 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 suspended and shall remain suspended until such time the fine is paid.

23. 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