BEFORE THE DISCIPLINARY COMMITTEE OF PAKISTAN MEDICAL COMMISSION

In the matter of

File No. P.F-8-1920/2021/DC/PMC

1. **Information referred by Kaul Associates, Lahore regarding Dr. Muhammad Sheraz Saleem Chaudhary, Dr. Fatima Tu Zehra and Dr. Mujtaba Sajid.**

2. **Umer Farooq Vs Dr. Muhammad Bilal and Dr. Tipu Sultan**

Committee:

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

Present:

Prof. Dr. Riaz Ahmed	Expert (Orthopedic)
Dr. Fauzia Anis Khan	Expert (Anesthesiology) via zoom
Kaul Associates	Informant
Mr. Umer Farooq	Complainant
Dr. Muhammad Sheraz Saleem Chaudhary	Respondent
Dr. Fatima Tu Zehra	Respondent
Dr. Mujtaba Sajid	Respondent
Dr. Muhammad Bilal	Respondent
Dr. Tipu Sultan	Respondent

I. FACTUAL BACKGROUND

Information received from Kaul Associates, Lahore

1. Pakistan Medical Commission received information through email dated 30th March, 2021 from Kaul Associates, Lahore regarding request for a formal inquiry against Dr. Muhammad Sheraz Saleem Chaudhary, Dr. Fatima Tu Zehra & Dr. Mujtaba Sajid. Kaul Associates who were engaged in providing services in respect of anesthesia, pre/post-operative care and critical care. It was stated

that in the instant case the anesthesia was supervised by (i) Dr. Muhammad Sheraz Saleem Chaudhary as the consultant along with (ii) Dr. Mujtaba Sajid (PGT) and (iii) Dr. Fatima Tu Zehra (PGT). The Kaul Associates in terms of their initial inquiry done, stated there existed a probability of failure of duty of care to the patient by the anesthesia team.

2. The facts of the case are that Hafsa Umer, a girl aged 4 ½ years, had fallen from the bed and sustained an injury on the left elbow/arm, and was brought to Hameed Latif Hospital, Lahore past midnight on 20-03-2021. After an initial diagnosis of a fracture/dislocation she was scheduled for surgery on 20th March, 2021 at around 6:00 am with a plan of closed reduction, if failed, to be followed by open reduction. Patient was shifted to the operation theatre (OT) well oriented in time place and person, in the lap of the nurse at 6:54am. Dr. Sheraz (Anesthetist), assisted by Dr. Mujtaba Sajid, administered anesthesia to the patient. Dr Sheraz came out of OT at 07.02 am after administering anesthesia and leaving the patient in Dr. Mujtaba Sajid's care. Dr. Bilal, the orthopedic surgeon proceeded with the surgery. Dr. Fatima arrived in the OT at 07:16am to start her shift and relieve Dr. Mujtaba Sajid who was on night shift. After induction approximately around 7:20am, B.P of the patient dropped to 82/43 and heart rate dropped to 80/min and remained on the lowering trend for next around 20minutes. Dr Sheraz had remained outside the OT since his departure at 07:02am. At 7:40 am Dr. Fatima noticed straight line on pulse oximeter and a decrease in heart rate. She gave atropine to treat bradycardia and called Dr. Sheraz, who came into the OT noticed severe bradycardia with absent pulse; he asked her give adrenaline and started cardiac massage. Spontaneous circulation returned within 45 seconds. Dr Sheraz asked the surgeon to proceed with surgery after return of spontaneous circulation. She started breathing spontaneously but failed to wake up after termination of anesthesia. After about 30minutes of termination of anesthesia, generalized seizure activity with up rolling of the eyeballs was observed. Patient was intubated, mechanically ventilated and shifted to Post Anesthesia Care Unit after consultation with Neurologist and Pediatrician. EEG done on the following day showed generalized seizure activity. CT scan showed global ischemic injury to both cerebral hemisphere. On the morning of 22nd March, 2021 the patient's pupils become unresponsive to neurological examination carried out 12hours apart, which confirmed brain stem death. She was disconnected from the ventilator on the morning of 23rd March, 2021.

II. SHOW CAUSE NOTICES TO ANESTHESIA TEAM

3. The Disciplinary Committee of Pakistan Medical Commission on the basis of *prima facie* professional negligence of the Anesthesia team made out from the information received from the Kaul Associates, issued show cause notices on 31st March, 2021 to; Dr. Muhammad Sheraz Saleem

Chaudhary, Dr. Fatima Tu Zehra & Dr. Mujtaba Sajid with a copy of the show cause notices to Kaul Associates and family of the deceased.

4. On 31st March, 2021 a letter was also issued to the administrator of Hameed Latif Hospital, Lahore to provide all relevant record (including investigations, notes/ findings, reports, x-rays, video footage, and any other evidence relevant to the subject matter. A reminder was also sent in this regard. Finally, the record was provided by Hameed Latif Hospital vide letter dated 7th April 2021 received in this office on 13th April 2021

5. On 8th April, 2021 a letter was received from Mr. Umer Farooq, father of deceased (addressed to Hameed Latif Hospital and copied to PMC) with subject "inquiry regarding negligence and failure in case of Hafsa Umer". It was stated in the letter that action has been taken against the anesthesia team, however probabilities of negligence by Dr. Bilal, the paeds departments, the team who falsely reported EEG and the other staff of the hospital cannot be ignored. The Disciplinary Committee in response issued a letter to Mr. Umer Farooq on 20th April, 2021 requesting that if he intends to lodge a formal complaint against Dr. Bilal under section 32 of PMC Act before the Disciplinary Committee he may file the same.

6. On 20th April, 2021 a reminder was issued to Dr. Fatima, Dr. Mujtaba, and Dr. Sheraz Saleem for their pending replies to the show cause notices issued by the Disciplinary Committee. Replies of the show cause notices were received from Dr. Mujtaba Sajid & Dr. Fatima Tu Zehra on 27th April, 2021 whereas Dr. Sheraz Saleem submitted his reply on 29th April, 2021.

Reply to Show Cause Notice by Dr. Mujtaba Sajid (3rd Year Anesthesia PGR)

7. In response to the show cause notice dated 31st March, 2021, reply was received from Dr. Mujtab Sajid (3rd year Anesthesia PGR) on 27th April, 2021. He submitted that:

i. On the morning of 20th March, 2021 around 06:50am in the anesthesia office, Dr. Sheraz asked me about shifting status of the patient, baby Hafsa to the OR. I asked the sister in-charge and she informed me that the surgeon had arrived. I also took a look at the patient and checked if she had an IV line placed or not, which she did. In the meantime, I asked the patient about her name, introduced myself to her and asked her how she got the injury to which she after telling her name told that she had fallen from a jumping castle while playing. Her pre-induction vitals were as follows, pulse: 131/min, B.P 97/66, SP02:97% at room air. Her vitals at 07:00am were as follows; Pulse 133/min, B.P 132/53, SP02 99% with 2 liters flow, FiO2 0.6% isoflurane at 2%.

ii. Dr. Fatima entered the OR around 07:10am for her morning duty. I gave her a detailed over regarding the patient's history, surgical teams plan, drugs administered and ventilator settings. My shift had come to an end so I left at around 07:15am on the following vitals; Pulse:75, B.P: 89/41, SPO2: 99%, ETCO2:38. On my way out, I saw Dr. Sheraz was sitting in the surgeon's

office where I informed him about giving the patient over to Dr. Fatima and also about vitals of the patient to which Dr. Sheraz said he would have a look at it, and I left for home.

Reply to Show Cause Notice by Dr. Fatima Tu Zehra (2rd Year Anesthesia PGR)

8. In response to the show cause notice issued on 31st March, 2021, reply was received from Dr.Fatima Tu Zehra (2rd year Anesthesia PGR) on 27th April, 2021. She stated that:

i. Patient Hafsa Umer a 5 years old patient was scheduled for K-wiring of left arm on 20th March, 2021, and was undergoing the procedure when I arrived for my morning duty at 07:05am. I took detailed hand over of the case from him (Dr. Mujtaba) and he left around 07:20am. The patient had following vitals at that point, Heart rate 70bpm, BP: 76/41mmhg, SPO2 99% and ETCO2 38mmHg at 07:30am.

ii. I administered atracurium 2mg after observing irregularities in capnograph to keep her paralyzed and reduced Isoflurane to 2%, as per standard medical practice. At 07:35am her blood pressure was 84/49 mmHg, heart rate 74bpm, spo2: 99% and ETCO2 34mmHg.

iii. At 07:40am, I noticed the dis-appearance of pulse oximeter waveform, initially suspecting the dislodgement of finger probe, I readjusted the probe and changed the finger for it. While I was doing so, I noticed the drop in heart rate up to 47bpm, accompanied by decrease in ETCO2. I checked her pulse, which was present. I administered 0.2 mg of Atropine, increased FiO2 to 100%, switched off isoflourane and simultaneously made call for help. She didn't respond to initial bolus so I gave another bolus of 0.2mg atropine.

iv. Dr. Sheraz arrived, I briefly updated about the status of patient and management steps I had taken till that point. He advised me to give a third atropine 0.2mg bolus, as her heart rate still had declining trend, assured 100% oxygen delivery and switching off of isoflourane. Dr. Sheraz checked her pulse, which was absent now so he informed the surgeon and started the chest compressions and advised me to give adrenaline 10mcg bolus, followed by a second bolus of 100mcg. Return of spontaneous circulation was achieved in 45 seconds. Her vitals post ROSC were; heart rate 140bpm, BP: 79/30mmHg, Spo2 100% and ETCO2 34mmHg. Dr. Sheraz advised me to turn on the isoflurane to 1% dial concentration.

v. The surgeon completed the surgery by 8:25am after which Dr. Sheraz advised me to switch off the isoflurane and increase the fresh gas flow. Upon return of spontaneous breathing of the patient, Dr. Sheraz advised me to give neostigmine 1mg to the patient.

vi. Dr. Asiya Taqi arrived in the operation theater at 08:30am and Dr. Sheraz informed her about the patient. At 08:50am, after the mutual discussion between them, the diagnosis of delayed recovery was made. Patient later on was intubated by Dr. Arshad Taqi and BSL monitoring was done frequently to manage BSL swings as advised by consultant. As patient was having generalized tonic colonic fits, the patient was given the leading dose of henytoin upon advice of pediatric team. At the end of my shift, detailed hand over was given to Dr. Umair, who was appointed in PACU that day. Patient's vitals were; heart rate 133bpmm, BP: 100/40mmgh and Spo2 was 99% and irritable on stimulation.

Reply of Respondent Dr. Muhammad Sheraz Saleem Ch (FCPS Anesthesia)

9. In response to the show cause notice issued on 31st March, 2021, reply was received from Dr. Muhammad Sheraz Saleem Chaudhary (FCPS Anesthesia) on 29th April, 2021. He stated that:

i. The baby was brought to operation theatre few minutes before 07:00am hours and Dr. Mujtaba Sajid who is a PGR Anesthesia working under my supervision, started the induction. The patient was handed over to the surgeons and they decided to do open reduction and fixation with k-wire after assessing the fracture by C-ARM and non-feasibility of closed reduction.

ii. At around 07:05am hours, after stabilizing the baby, I moved to doctor's office close to the operation theatre. Around 07:15am hours, the morning duty PGR Dr. Fatima Tu Zehra took handover from the night duty PGR Dr. Mujtaba Sajid.

iii. At around 07:40am, I was notified that the baby is having bradycardia for which I came to theatre in less than 10 seconds. Based on the information provided by Dr. Fatima that till 07:35am, the baby had acceptable readings but then she noticed sudden bradycardia of HR 47/min and un-recordable BP at around 07:40am, I witnessed the heart rate to be around 45/min. The surgeon was notified to stop the surgery. I started chest compressions, 100% oxygen, injection adrenaline 100 mcg IV then stat return of spontaneous circulation with in 45seconds. The baby was observed for next 10 minutes maintaining hemodynamic, adequate ventilation and oxygenation and the surgery was resumed and was finished in next 20 to 25 minutes.

iv. The event was notified to senior morning consultant Dr. Asiya Taqi. Baby started opening the eyes gradually but the eye balls were noticeably rolled up and the baby was still not obeying command. Blood sugar was checked and was found to be 337mg/dl and ABGs were carried out showing mixed metabolic and respiratory acidosis. The baby was hemodynamically stable, maintaining adequate ventilation and was found struggling with LMA and after a mutual discussion with Dr. Asiya, based on the clinical condition, the LMA was removed and the baby was put in lateral recovery condition with supplemental oxygen through a breathing circuit to avoid laryngospasm.

v. Dr. Arshad Taqi arrived at the situation and after assessing the baby, discussed with the family about all the possible reversible things to be corrected and took family onboard for elective intubation and ventilation and correct reversible causes and investigated further with the help of pediatrician and neurologist. I handed over the patient to Dr. Arshad Taqi with all the events documented in the file and anesthetic chart at around 09:30am.

III. HEARING NOTICE DATED 07th MAY2021

10. Replies from all three respondent doctors were received and hearing was scheduled in the matter. In this regard hearing notices were issued to all three doctors namely Dr. Fatima, Dr. Mujtaba and Dr. Sheraz Saleem for hearing to be conducted on 07.05.2021 at 02:30 pm at Pakistan Medical Commission Secretariat, Islamabad. The Administrator, Hameed Latif Hospital Lahore was called to attend hearing through letter dated 05-05-2021, Lahore. Mr. Umer Farooq, father of deceased was also informed about the hearing through letter and email dated 05th May, 2021. An expert was also appointed to assist the Disciplinary Committee and a letter was issued on 03rd May, 2021 for invitation of expert to hearing.

11. A letter dated 05-05-2021 was received from Mr. Umer Farooq wherein he requested to postpone the said hearing scheduled for 07.05.2021. Considering his request the Disciplinary Committee decided to postpone the hearing.

IV. SHOW CAUSE NOTICES TO DR. MUHAMMAD BILAL (ORTHOPEDIC SURGEON) AND DR. TIPU SULTAN (PEDIATRIC NEUROLOGIST)

12. Mr. Umer Farooq sent another letter dated 04-05-2021 alongwith hospital mortality committee report and raised specific allegations of professional negligence by Dr. Tipu Sultan and Dr. M. Bilal in addition to three anesthesia doctors who were already issued show cause notices. Considering the gravity of allegations leveled by Mr. Umar Farooq against Dr. Tipu Sultan and Dr. M. Bilal and findings of the hospital mortality committee, both doctors were issued show cause notices on 06-05-2021 and copies were provided to Mr. Umar Farooq.

13. Mr. Umer Farooq was provided copies of show cause notices through letter dated 6th May 2021 and he was further requested to provide comments on the replies of show causes notices earlier issued to anesthesia team.

Reply to Show Cause Notice by Dr. Muhammad Bilal (Orthopedic Surgeon)

14. In response to the show cause notice issued on 06th May, 2021, reply was received from Dr. Muhammad Bilal (Orthopedic Surgeon) on 22nd May, 2021. He stated that:

i. In operating room, Dr. Sheraz gave General Anesthesia. We were allowed to start procedure at approximately at 07:10am. At 07:40am anesthesia team alerted us about bradycardia and patient's surgical work was stopped immediately. Dr. Sheraz commenced chest compression and cardio pulmonary resuscitation, which was continued for 45seconds. Return of spontaneous circulation was achieved and patient was further monitored for another 10 minutes. We were allowed by Dr. Sheraz to resume surgical activity at 07:50am.

ii. Pre-operatively at 06:15am where examination was performed, consent discuss and surgical procedure explained. Immediately after surgery at 08:10am, Post-operative x-rays were shown to mother and rehabilitation plan discussed.

iii. I also attended two briefing session with the parents led by Dr. Sheraz first at 08:45am and then by Dr. Taqi at 09:30am on 20th March, 2021. In the afternoon 01:30pm, surgical procedure was explained to another member of family.

Reply of Respondent Prof. Dr. Tipu Sultan (Pediatric Neurologist)

15. In response to the show cause notice issued on 06th May, 2021, reply was received from Prof. Dr. Tipu Sultan (Pediatric Neurologist) on 25th May, 2021. He stated that:

i. The patient was on ventilator and we had been asked by her prime care team of physician to examine her condition and evaluate. She was examined by Dr. Shumaila Rafiq, patient has GCS of 6/15, EEG revealed electric activity of voltage more than 25 microvolt which is not consistent with isoelectric activity required for brain death with epileptic foci.

ii. On 22nd March, 2021 her EEG was explained to anesthesia team by one of our team member who is duly qualified Pediatric Neurologist (Dr. Shaila Ali). Whereas, in response to the query, "how EEG report was prepared under my name, while I was not there physically". It is worth mentioning that during the pandemic of Covid-19 globally, telemedicine is the medium of clinical practice. Therefore, it is submitted one of the team member was there physically on both occasions. Decision of brain death is not possible neither at single clinical examination nor through EEG alone & should not be in haste. Whereas, if primary clinicians are of the view that this investigation is not supporting their clinical judgment, it is important to mention that the clinical impression is always superior.

16. Mr. Umar Farooq was issued a letter on 26th May 2021 along with copies of the replies received from Dr. M. Bilal and Dr. Tipu Sultan with the request to file rejoinder with in fourteen (14) days as the show cause notices were issued to aforementioned doctors on his complaint against them. However, Mr. Umer Farooq failed to file rejoinder.

17. On 14th July 2021 a letter was received from Mr. Umer Farooq wherein he showed satisfaction to the extent of Dr. Tipu Sultan. However, asked the Disciplinary Committee to issue show cause notices to other doctors as well as technicians and other staff of the hospital. Mr. Umer Farooq was explained through letter dated 26th July, 2021 that the Disciplinary Committee is mandated to take disciplinary action against "full license holder" which only includes doctors and does not include nursing, technical staff and a hospital. That five doctors have been issued show cause notices after review of available record by the Disciplinary Committee. There were no specific information or allegation and evidence to proceed against any other doctor.

V. HEARING NOTICE DATED 28th JULY 2021

18. On 28th July, 2021 hearing notices were issued to all the parties to the proceedings for the hearing scheduled on 06th August, 2021 at 02:30 pm at Pakistan Medical Commission Secretariat, Islamabad. Administrator Hameed Latif Hospital Lahore was also called to attend the hearing along with record.

19. A letter dated 03-08-2021 was received from Mr. Umer Farooq wherein it was stated that proceedings before the Punjab Health Care Commission are getting mature, therefore, proceedings before the Disciplinary Committee be adjourned *sine die.*

20. In response, Mr. Umer Farooq was issued a letter on 04-08-2021 to state that the earlier hearing in the matter was fixed on 07-05-2021 which was postponed on his request. Now again he has placed

a request for 'sine die adjournment' in the subject matter, which shows that he does not wish the matter to proceed. Further, no rejoinder/comments despite reminders by the Disciplinary Committee have been filed in the matter. Further it was clarified that the proceedings of the Disciplinary Committee are not subservient to the proceedings before the Punjab Health Care Commission. Pakistan Medical Commission is the regulator of medical practitioners. Under the PMC Act 2020, the Commission has been mandated to grant license to medical practitioners and take disciplinary action against them, therefore there is no question of conflict with the proceedings and decisions of Punjab Health Care Commission. Therefore, the request that matter be adjourned sine die cannot be accepted.

21. Mr. Umer Farooq sent a letter on 05-08-2021 wherein report of a lab was attached that Mr. Umer Farooq has been tested covid- 19 positive, upon which Mr. Umer Farooq was granted an opportunity to join the hearing proceedings online on 06-08-2021.

Writ Petition Before Lahore High Court

22. On 06th August 2021, an email was received from Mr. Umer Farooq with attachment of WP No. 49176/2021 before the Lahore High Court, Lahore titled as Umer Farooq vs Disciplinary Committee, PMC. In writ petition it was prayed that (a) cancellation of hearing notice dated 28th July, 2021 for hearing before the Disciplinary Committee (b) issuance of notices to other doctors (c) adjournment of proceedings before the Disciplinary Committee until the Punjab health care commission conclude the matter. The Lahore Court heard the matter and passed the following order on 06-08-2021:

> *"In view of what have been stated above, this petition along with its annexure is converted to a representation which shall be deemed pending before respondent No. 1 (Disciplinary Committee Pakistan Medical Commission) who is directed to give a right of hearing to the petitioner as well as all other concerned persons and considered all the legal and factual issues raised therein and decide the matter strictly in accordance with law. Learned counsel appearing on behalf of the Respondent shall convey this order to the quarter concerned. With the above observations, the petition is disposed of.".*

VI. HEARING ON 06th AUGUST 2021

23. The Disciplinary Committee held the hearing in the matter on 06th August, 2021. On the date of hearing all parties were present. Complainant along with its legal representative attended the hearing through online zoom facility.

24. Mr. Sheikh. Muhammad Ali, legal representative of the Complainant, Mr. Umer Farooq made preliminary legal objections which will be addressed in this decision accordingly.

25. Dr. Fauzia Aniz, expert appointed in the matter to assist the Disciplinary Committee asked questions to respondent doctors. Some of the pertinent questions are reproduced.

A. Questions to Dr. Sheraz Saleem

(i) What is the on-call system of your hospital and if you have to be in hospital or not?
Ans: Yes, we have to be in the hospital.

(ii) How long do it takes to reach from surgeon office to OT?
Ans: Around 20 seconds.

(iii) What was the heart rate when you reached OT?
Ans: 47 b/min.

(iv) When you did ACLS (Advance Circulatory Life Support)?
Ans: Last year.

(v) Dr Fatima is a student of which year?
Ans: 3rd year resident

(vi) What about blood mass/fluid?
Ans: 2 I/V Line in place, 24 gauge & 22 gauge.

(vii) Did the patient have any congenital heart disease?
Ans: No (hypoxia comes in mind)

B. Questions to Dr. Fatima tu Zahra

(i) What is your temperature checking monitoring system for the patient?
Ans: Through Axillary probe.

(ii) What was the quantity of blood loss?
Ans: Minimal blood loss.

(iii) Do you have a cardiac arrest team in your hospital?
Ans: No

(vi) How did you record while during the event happened?
Ans: I did not record during the event happened rather recorded later from the monitors.

C. Questions to Dr. Mujtaba Sajid

(i) What about IV infusion?
Ans: IV infusion was started during induction and not before.

(ii) As you were on night duty, did you sleep in the night?
Ans: Yes, I did.

(iii) Have you done pre-op?
Ans: Yes, I talked to the patient.

(iv) While giving over to Dr Fatima, was open surgery started?
Ans: Not by then.

(v) Do you have MAC (Monitored Anesthesia Care) Monitoring System?
Ans: Yes

D. Chairman (Disciplinary Committee) to Dr. Sheraz Saleem

(i) What was the role of Dr. Athar in this case?
Ans: not sure/not involved.

(ii) What conversation did you had with Dr. Asiya Taq ?
Ans: When patient got stabilized, then I called Dr. Asiya that the case is stabled, I handed over the patient to Dr. Asiya between 08:00am to 08:10am.

(iii) What was the role of Dr. Taqi?
Ans: We just called him for help. He accessed the patient and spoke to the family after the patient being handed over to Dr. Asiya

E. Prof. Dr. Riaz Ahmed to Dr. Muhammad Bilal

(i) During open reduction, was the tourniquet applied or not?
Ans: No

(ii) What is your position/ studies?
Ans: I did my MBBS in 2005, FCPS-2014, and FRCS in 2017.

(iii) What is your routine of handling of such procedure?
Ans: We usually proceed for such cases in the morning and do immediately only if there is neurological involvement.

F. Chairman, Disciplinary Committee to Dr. M. Bilal

(i) What is your version about this case?
Ans: I received a call at 12:00 in night, it was a confirmed case of fracture, counseling of the patient family was done and they agreed to admit the patient, I visited at 06:00am, talked to the family who allowed to proceed. Patient was shifted to the OT and procedure was started by 07:10am. After five minutes we decided for open reduction, tourniquet was not applied because of swelling, during the procedure we were informed about bradycardia by the anesthesia team, we waited for almost 10minutes and then the surgery was restarted. At 07:55am, we had the final images, and case was closed. At 08:10am I met the family, told them the details and I told them that they can go home in the evening.

(ii) After the consent by the medical officer in night, is there any other consent?
Ans: I took second consent myself

G. Chairman, Disciplinary Committee to Dr. Tipu Sutlan

(i) The EEG report was issued but you were not present?
Ans: I was not physically present, but my Assistant Professor was there and he consulted me in the said case, after I saw the report only then I approved it.

H. Chairman, Disciplinary Committee to Dr. Fatima

(i) What are your comments about the handwriting on notes as it has been alleged that handwriting before and after 7:10 am is the same?
Ans; I started writing it on 07:20am and Dr. Mujtaba wrote it before me.

(ii) Since how long you and Dr. Mujtaba have been working together?
Ans: Since one year.

26. The Committee directed Mr. Alexander M. Bashir, legal representative of the Hameed Latif to provide the CCTV footage of the event and handing over of the patient to Dr. Asiya and Dr. Taqi and also provide list/chart of the doctors who examined the patient along with exact timing. Mr. Alexander undertook to present the record as directed within 48 hours.

27. Further, keeping in view the observations made during the hearing and the fact that Dr. Asiya Taqi and Dr. Arshad Taqi were post op brought into the case as senior consultants, the Disciplinary Committee decided to obtain the statements of Dr. Arshad Taqi and Dr Asiya Taqi as their version of the case history and events would assist in verifying the record and other statements already provided. In this regard letters were sent to both doctors on 10-08-2021. Both doctors submitted their statements.

Statement of Dr. Arshad Taqi

28. Dr. Arshad Taqi in his statement stated that:

a) On the morning of the 20 March, 2021, approximately around 9:15 am, I received a call from Dr. Asiya Taqi, who informed me that a four (4) year old child had cardiac arrest during anesthesia, with reported return of spontaneous circulation in 45 seconds but failing to regain consciousness at the end of surgical procedure. She asked me if I could come to the hospital to provide support. I immediately responded in affirmation and rushed to the Hospital. From the information I gathered over the phone, the child had abnormal eye movement likely to be seizure activity, raised blood sugar and severe metabolic and respiratory acidosis on arterial blood gases. The team was planning to intubate and ventilate her.

b) I reached the hospital after 9:30 am and went straight to preoperative holding area to meet the parents first and make sure they were apprised of the situation. They were understandably perturbed, the father insisted that he wanted to see the child himself. I asked concerned staff to facilitate his changing in OR scrubs and guide him to the OR after changing into OR scrubs myself I went to the OR to assess the situation around 9:45 am. Dr. Asiya was preparing to administer Propofol for induction and intubation, I asked her to hold this for a few minutes to let the father see the child's response himself. The father was led to the OR where he tried to communicate

with the child, who was not responsive. I then requested him to allow me to intubate the child to which he agreed.

c) After intubating the child, I assessed the situation, confirmed the trends on the monitor, reviewed the charts, debriefed the night roster anesthesia team and relieved Dr. Sheraz (the night roster consultant). By this time there was an agreement in the team that neurological and metabolic derangement was secondary to cardiac arrest. The plan was initiated to reverse the metabolic derangements and initiate other brain protection strategies. This included control of blood sugar, optimizing carbon dioxide levels, fluid resuscitation to correct metabolic acidosis, control of seizures and management of hypothermia.

d) Pediatric consultation was called, which arrived, they assessed the situation and agreed with the plan. The child, meanwhile, started having generalized seizures, loading dose of Phenytoin and boluses of midazolam were given. Treatment plan was initiated. Pediatrics and anesthesia teams agreed that the child should be electively ventilated for 24 hours to give a chance for neurological recovery. It was decided that, after stabilizing, child will be shifted to a dedicated room in post anesthesia care unit (PACU) where facilities for ventilation are available and family member can stay with the child.

e) While anesthesia team was managing the child, I assumed the task of coordinating her care with other specialties and counselling the family; I continued this role during the child's stay in the hospital.

f) I reassessed the patient on arrival in PACU and oversaw the handover to PACU staff at 3:30 pm. Pediatric neurology was consulted for advice on neuroprotection. Ophthalmology was asked to perform a fundoscopy, which revealed early papilledema. Dexamethasone, Leraice and Mannitol were added on their advice. They advised CT brain after 24 hours of ventilation. EEG was done that showed epileptiform activity.

g) I was constantly in touch with anesthesia personnel on duty in the PACU to ensure that the care was coordinated according to the plan. Pediatrics was on board and visited the child regularly for their advice. Ventilation and sedation were continued and adjusted according to the needs. General nursing measures were also undertaken.

h) Family requested consultation with the neurologist Dr. Qasim Bashir on the night of 20th March, 2021. He was contacted and he agreed to visit the child in the morning. I visited the child at 11:45 am on the morning of 21st March, 2021. The child was sedated and ventilated with intact brainstem reflexes. The family was informed about the progress. Dr. Qasim Bashir visited the child, advised CT brain without contrast and weaning after CT brain review. The patient was also seen by the pediatrician at 2:45 pm and advised an extubation after CT scan.

i) CT brain was done with the child still manually ventilated. On return from the scan she was hemodynamically stable, pupils reacting to light and there was withdrawal on painful stimulus. Scan images were shared with Dr. Qasim Bashir and me. This revealed a diffuse, severe brain injury. It was agreed that she will not be weaned from ventilator and aggressive neuroprotective measures will be initiated. Dr. Qasim Bashir advised Syrup Phenobarbital and to continue Midazolam. Midazolam infusion was started as the child beginning to fight the ventilator.

j) On the morning of 22nd March, 2021, I was informed that her pupils became fixed, dilated and non-reactive to light at 6:30 am. Neurologist was informed, advised a bolus of Mannitol. I visited the child at 08:00 am and counselled the family about poor outcome. Dr. Qasim Bashir was informed, he examined the child and declared that brainstem reflexes were absent. He advised repeat EEG that showed occasional multifocal spikes.

k) The family and a number of others gathered in the hospital, they had received the news of absent brainstem reflexes and wanted to know what the next step was. I counselled them about the protocol for declaring brain death. It was agreed that a second neurology consult will be sought from another consultant. Dr. Adnan Gill, was requested to examine the child for this purpose.

l) Dr. Gill examined the patient and declared that brainstem reflexes were not elicited. I met the family along-with Dr. Gill at around 10:00 pm and discussed the outcome. The family agreed that continuing ventilation was futile. The family wished that this should be scheduled in the morning to give them the time to prepare for her burial. It was agreed that they will come in the morning at 7:00 am, when the ventilator will be disconnected. Accordingly the child was disconnected from the ventilator and death was declared.

Statement of Dr. Asiya Taqi

29. Dr. Asiya Taqi in her statement stated as under:

a. I have been working as a consultant in Anesthesia with Kaul Associates since 2003. According to the duty roster for HLH, I was assigned the morning shift on 20" March, 2021, in my capacity as a consultant. While on my way to the HLH, I received a call from Dr. Sheeraz Saleem (consultant on the night shift) to update me on a child's condition who had developed bradycardia and to whom they had to do chest compressions for 45 seconds. Dr. Sheeraz told me that after spontaneous circulation had returned with stable hemodynamics, he had asked the surgeon to complete the procedure.

b. On reaching HLH, I went straight to the Operating Room (OR) and did a rapid assessment of the situation. The child had resumed spontaneous breathing, reversal of muscle relaxant was given at 8:35. Dr. Sheeraz was preparing to give Naloxone to reverse the effect of Nalbuphine, which was administered. The child was hemodynamically stable, breathing was smooth and regular, however, I noticed that her eyes were up-rolling, which was not the normal response and was a cause for concern. I suggested that the blood sugar of the child be checked immediately. Needful was done and the blood sugar turned out to be 337 mg/dl. It was past 9:00 am by that time. I asked for arterial blood gases to further assess her metabolic status.

c. Meanwhile, considering this was more than a case of routine delayed recovery, I decided to call Dr. Arshad Taqi, a senior anesthetist consultant, for his opinion. He did not have any pre-assigned clinical duty that morning, however, I briefed him about the condition of the child and he rushed to HLH to provide support to the team looking after the child. Meanwhile the result of arterial blood gas arrived, which showed severe metabolic and respiratory acidosis. I planned to intubate and mechanically ventilate to correct the metabolic abnormality. I also asked to set up insulin infusion to manage the child's blood sugar. Dr Arshad Taqi arrived as we were preparing to intubate the patient. The induction was held for a while as Dr. Arshad Taqi told us that the child's father wanted to have a look at her conscious status. Hence the father was brought to the OR. I briefed Dr. Arshad Taqi about what I had learned about the condition of the child so far. He agreed with my plan to intubate and ventilate the child to prevent any neurological injury. The child was intubated by Dr Taqi after her father had a brief look at her and verbally consented to the procedure. Ventilator was set to wash out carbon dioxide and insulin infusion was started to achieve target blood sugar levels. Urinary Ketones were checked to rule out the remote possibility of hypoglycemia and acidosis, which came out negative.

d. After discussion with Dr. Taqi and initial debrief from anesthesia team, it was agreed that delayed recovery and metabolic picture was a consequence of neurological injury sustained during cardiac arrest, and further management would focus on neuroprotection strategies. Immediate pediatric consultation was requested and after discussion with pediatric team, following targets were agreed:
   - Continue sedation and mechanical ventilation for next 24 hours to limit and reverse neurological injury;
   - Maintain carbon dioxide levels at lower limits of normal;
   - Maintain normoglycemia;
   - Prevent hyperthermia;
   - Control the fits with antiepileptics;
   - Sedation with Midazolam infusion and boluses if required;
   - Avoid muscle relaxants that may mask convulsions;

e. Once the night roster team was debriefed and plan to ventilate for next 24 hours was agreed, Dr. Sheraz was relieved from duty by Dr. Taqi. It was decided that the child will be moved to Post Anesthesia Care Unit (PACU) on a ventilated bed in a cabin where family can have access. I was coordinating the care with Dr Fatima, the resident looking after the child in the OR to ensure that agreed management strategies were translated into management plan. Meanwhile, Dr Arshad Taqi was counselling the family and coordinating the care plan in PACU.

f. Blood sugar returned to 170 mg/dl at 11:00 am and insulin infusion was stopped. Blood gas sent at 10:49 returned with an improvement in acidosis, further adjustment in ventilation were done and a fluid bolus was given.

g. The child started having generalized tonic clonic seizures, Midazolam boluses were given and a loading dose of Phenytoin was given on the advice of pediatrician. She required a bolus of 25% Dextrose when a low value was obtained during hourly monitoring.

h. The child was moved to PACU, intubated for ventilation according to the plan in accordance with the management goals already mentioned. I dictated detailed care plan that Dr Fatima documented and continued to implement in PACU.

i. Subsequent management of the child was handled by teams looking after the PACU and I did not have any role in subsequent management of the case.

Expert Opinion of Dr. Fauzia Anis Khan

30. Dr. Fauzia Anis Khan (Anesthesia Expert) was appointed as an expert to assist the Disciplinary Committee in the matter. Her expert opinion is attached herewith. The relevant parts of the opinion as reproduced as under:

I have observed some missing information/ lack of details in anesthetic care management;

- *No differential diagnosis, regarding the sentinel event that happened and what could have been the likely causes of the event , was mentioned in the chart / patients notes by the consultant anesthetist (Dr. Sheraz).*
- *No immediate post arrest investigations were done/ or documented perioperatively. Immediate ABGs, and electrolytes as well as blood sugar sample should have been sent post arrest.*
- *The amount of fluid administered intraoperatively and the blood loss were not documented on the chart. On enquiry both Dr Sheraz and Dr Fatima said that there was minimal blood loss (no tourniquet was present). Post op Hb done next day showed a fall of 2 gms.*
- *Only dialed concentration of inhalational agent was charted. The actual concentration received by the patient maybe different to this under low flows. I queried Dr Sheraz whether MAC values were available on the monitor, but got a somewhat unsatisfactory answer.*
- *Temperature monitoring intraoperatively. Was this done? Dr Fatima said it was but it was not charted on the form.*
- *Postoperatively the consultant anesthetist (Dr. Sheraz) failed to meet the parents and inform them of the serious event that took place intraoperatively. Cardiac arrest is a serious event.*
- *Postoperative management was focused on hyperglycemia and not on cerebral hypoxia event.*
- *Time periods: The period of cardiac massage is mentioned as 45 seconds everywhere in documentation. Was someone monitoring this period on a stop watch? There is no formal documentation of time of call of code and when cardiac massage was stopped.*
- *Also the time interval of 10 minutes between time of induction of anaesthesia and skin incision appears doubtful, if this includes preoxygenation, induction, placement and confirmation of LMA, closed manipulation of fracture by the surgeon, skin preparation and then skin incision.*

Based on the available case notes my opinion on the case is as follows;

Looking at the course of events the most likely cause of the sentinel event in my opinion, was a hypoxic insult leading to global ischemia postoperatively.

Cerebral hypoxia was possibly due to either or;
a)Late recognition of hypoxic episode (Likely cause);
b)Delay in providing cardiac massage (Likely cause); or
c)Ineffective CPR due to poor technique (Unlikely as Dr Sheraz was trained)

Although Dr Sheraz insisted that it only took him 10 secs to get back to the OR but this time period appears to be somewhat an unlikely estimation. Dr Fatima first became aware of event then sent a technician to call Dr Sheraz who was a couple of rooms away, who then arrived and ordered atropine and only then resumed cardiac massage. The current recommendation for Pediatric Life Support is to start cardiac massage if the heart rate of the child falls below 60 /minutes. Outcome in such cases depends on effective CPR. Best outcome is if this happens in less than 2 minutes and a delay by one minute decreases outcome by 10%.

Dr Sheraz had left the operating room after induction, this is acceptable and common practice in all teaching hospitals and is part of training of residents, provided the resident is at a level of training that is judged that he/she will be able to look after the patient, and the consultant is immediately available within the premises of the operating room for immediate help. DrFatima was a year 2 resident and should fulfil this criteria.

After the initial meeting of the PMC disciplinary committee on 6/8/2021, it was decided to get an input from both Dr Asia Taqi and Dr Arshad Taqi, both senior anesthesia consultants who were involved in the postoperative management of the patient after the event.

I have also received and reviewed these two reports signed by Dr Asiya Taqi and Dr Arshad Taqi. Both reports outline the management that the patient received in detail and all events are clearly documented. This management is consistent with current standard of care in case of a hypoxic insult.

Expert Opinion of Dr. Riaz Ahmed

31. Prof. Dr. Riaz Ahmed (Orthopedic/Surgical Expert) was appointed as an expert to assist the Disciplinary Committee in the matter. He opined after the conclusion of the hearing that there appeared to be no negligent conduct on the part of the surgeon Dr. Bilal who carried out the procedure as is ordinarily required in such cases. Cardiac arrest amongst other risks exist in every surgery specially when it is under general anesthesia. There existed no act on the part of the surgeon which can be directly relatable to the event or the consequence.

VII. FINDINGS/ CONCLUSION OF THE DISCIPLINARY COMMITTEE

32. During the hearing the legal representative of the Complainant raised certain preliminary objections which are addressed as under at the outset:

a. Objection was raised that the Show cause notices have been issued to particular doctors and not all other doctors, nurses and technical staff named in the letters sent by the Complainant.

The Disciplinary Committee proceeded to issue show cause notices on 31st March, 2021 to Dr. Muhammad Sheraz, Dr. Fatima TuZehra and Dr. Mujtaba Sajid based on the information provided by the Kaul Associates. In response to a later letter of Dr. Umer Farooq dated 8th April 2021, Mr. Umer Farooq was specifically asked vide letter dated 20th April, 2021 if he wished to proceed against a particular doctor and if so he should write a formal complaint along with medical evidence (as per regulations). On 4th May, 2021 Mr. Umar Farooq sent a letter to the Disciplinary Committee along with a "Mortality Committee Report on Baby Hafsa Umar". The attached committee report gave finding against four doctors namely (i) Dr. Muhammad Sheraz Saleem, (ii) Dr. Muhammad Bilal, (iii) Dr. Mujtaba Sajid and (iv) Dr. Fatima Tuz Zahra. Since show cause notices were already issued to three members of the anesthesia team therefore, a further show cause notice to Dr. Muhammad Bilal and one to Dr. Tipu Sultan on the insistence of Mr. Umer Farooq, were issued on 6th May, 2021. The notice to Dr. Tipu Sultan was based on the allegation by Mr. Umer Farooq that the EEG team falsely made the report signed by Dr. Tipu Sultan when he was not present.

This objection was also in detail addressed and responded through letter dated 26th July, 2021 to Mr. Umar Farooq.

It is further, clarified that under Regulation 3 of the PMC Enforcement Regulation 2021 the Disciplinary Committee only takes action against licensed doctors and not nursing or technical staff members. Further a show cause notice is issued under Regulation 8, when substantial evidence is available on record. Though Mr. Umar had named numerous other doctors in his letter dated 4th May, 2021 but there was no specific allegation or information and sufficient material available on record to substantiate allegations of professional negligence/misconduct to proceed against any of them.

b. The Complainant Mr. Umar Farooq raised an objection that he had not been given the opportunity to file re-joinder, particularly, in show cause notices proceedings against three doctors of the anesthesia team.

Under regulation 9 (5) of the PMC Enforcement Regulations, 2021 the reply submitted by the respondent doctors in response to show cause notice are forwarded to the Complainant directing for a rejoinder to be submitted within 14 days if so desired, else the matter is proceeded on the

available record. Pertinently, the Show Cause Notices dated 31st March, 2021 were issued to three doctors of anesthesia team on the information of Kaul Associates and not on the basis of any complaint by Mr. Umar Farooq. Therefore, no rejoinder was required from Mr. Umar Farooq in terms of Regulation 9 of the PMC Enforcement Regulations.

It is clarified that copies of these show cause notices were duly provided to family of deceased and also replies to these show cause notices were forwarded to Mr. Umar Farooq. He was specifically asked vide letter dated 6th May 2021 to file comments to replies received from three anesthesia doctors in response to their show cause notice, however, Mr. Umar Farooq never filed any comments/rejoinder in response.

Further, show cause notices were issued to Dr. Muhammad Bilal and Dr. Tipu Sultan on the basis of allegations raised by Mr. Umar Farooq along with the findings given in the patient mortality report. Replies to these show cause notices were provided to Mr. Umer Farooq on 26th and 27th May, 2021 for rejoinders which he has also failed to file. Instead of filing rejoinders/comments the Complainant filed a writ petition before Lahore High Court seeking adjournment of proceedings before the Disciplinary Committee.

The Complainant was duly provided all replies and given time to file rejoinders, however he chose not to and instead through the proceedings before the Honourable Lahore High Court and thereafter, before the Committee primarily sought adjournment of the proceedings on the ground that the Punjab Health Care Commission may first conclude the proceedings. Therefore, the objection has no merit and nor is the Complainant prejudiced in any manner as he was given full opportunity to be present at the hearing and submit his detailed arguments through counsel.

c. The Complainant further objected that the Disciplinary Committee has to undertake internal inquiry before lodging a complaint. The Complainant asserted that his letter dated 04-05-2021 cannot be termed as a 'fresh complaint'. He only provided information. Further it was objected that there cannot be two complaints in one matter.

The Complaint has made self-contradictory assertions. On one hand the Complaint has asserted that he only provided information to Disciplinary Committee and no fresh complaint was filed. On other hand it has been objected that he has not been provided with the opportunity to file rejoinder in terms of Regulation 9 of the PMC (Enforcement Regulations) which is only filed by a complainant as explicitly provided in the said Regulation. The Complainant failed to point the Committee to the provision of law either under the PMC Act 2020 or the relevant regulations

which requires the Disciplinary Committee to initiate an inquiry before lodging any complaint for disciplinary action against doctors. Further, there is no provision restricting number of complaints pertaining to the same event. The fact is the Committee received a request with information to consider a matter of potential negligence. A *prima facie* review satisfied the Committee that it was a fit case for issuance of Show Cause Notices.

Later information was placed before the Committee by Mr. Umar Farooq in response was asked to submit a complaint with evidence against the other two named doctors. He did so relying on a report prepared by the hospital. Pursuant to the same Mr. Umar Farooq was recorded as the Complainant and further Show Cause Notices to Dr. Bilal and Dr. Sultan were issued. There exists no prejudice to the Complainant in terms of the procedure followed.

Therefore, these objections do not have any merit and are rejected.

d. The Complainant further objected to the proceedings before the Disciplinary Committee and that these proceedings be adjourned till the decision by the Punjab Health Care Commission.

Pakistan Medical Commission is the regulator of medical practitioners. Under the PMC Act 2020, the Commission has been mandated to grant license to medical practitioners and take disciplinary actions against them in case of negligence or violation of the provisions of the PMC Act 2020. Proceedings of Disciplinary Committee are not subservient to the proceedings before the Punjab Health Care Commission. Punjab Healthcare Commission is an independent regulator with a distinct mandate to proceed against the healthcare facilities operating within its territorial jurisdiction. The Pakistan Medical Commission and the Disciplinary Committee do not have jurisdiction over healthcare institutions unless they are teaching hospitals or medical or dental colleges registered with the Commission and in respect of educational matters falling within the domain of the Commission. The Conversely the Healthcare Commission does not have jurisdiction over the medical practitioners in terms of matters of discipline or negligence. Therefore, there is no question of conflict with the proceedings and decisions of the Punjab Health Care Commission. Hence, this objected is declined.

e. The Complainant also objected that Dr. Fatima was suspended by Kaul Associate but still she is serving at National Hospital Lahore. License of Dr. Fatima shall be suspended on interim basis.

It is clarified that power to suspend license of a professional doctor lies only with the Disciplinary Committee, which is to be considered as a penalty after due adjudication of a complaint and not as

an interim measure. Such interim measures can only be adopted by the health care institution which has the prerogative to suspend the privileges of a doctor. The concern in taking such interim measures is always the fine balance between ensuring that a practitioner's reputation is not destroyed while also ensuring patient safety and hence it is the healthcare institution which carries the principal liability of care towards patients admitted to the hospital that is best placed to take such interim steps.

33. Before proceeding with the detailed findings in the case it is noted that during the course of hearing the Complainant requested for withdrawal of his Complaint to the extent of Dr. Tipu Sultan. The Disciplinary Committee at the hearing had also questioned Dr. Tipu Sultan and has reviewed the record specifically in terms of the conduct of Dr. Tipu Sultan. It has been found even otherwise that the evidence on the record confirms no case has been made out against the Dr. Tipu Sultan for professional negligence/misconduct. Therefore, on the request of the Complainant to withdraw complaint against Dr. Tipu Sultan and pursuant to an appraisal of the record and evidence, the Show Cause Notice to the extent of Dr. Tipu Sultan is disposed off at the very outset.

34. Coming to the critical event of ischemic injury which occurred to patient Hafsa Umer. The patient was a girl aged 4 ½ years, who had fallen from the bed and sustained injury on left elbow/arm. She was brought to Hameed Latif Hospital, Lahore past midnight on 20-03-2021. She was diagnosed with supracondylar fracture and after consultation with the surgeon Dr. Bilal was scheduled for surgery on 20th March, 2021 at around 6:00 am with a plan of closed reduction and if required, to be followed by open reduction. On the morning as per schedule the patient was taken to the Operation Theatre after Preop and was inducted by Dr. Sheraz as the consultant assisted by Dr. Mujtaba and surgery was started around 7.10am. Meanwhile Dr. Fatima was handed over the case in the OT by Dr. Mujtaba on her arrival. Dr. Sheraz as per record was not present during the handover. At 7:40am according to Dr. Fatima she noticed a drop in heart rate and pulse and infirmed Dr. Sheraz who according to his evidence came within 10 seconds to stabilize the patient which included responding to a cardiac event as per the record. After assurance by Dr. Sheraz, the remaining procedure of surgery was completed, however, the postop recovery was delayed. After about 30minutes of termination of anesthesia, generalized seizure activity with up rolling of the eyeballs was observed. Patient was shifted to Post Anesthesia Care Unit and consultation were sought from the Neurologist and Pediatrician. EEG done on the following day showed generalized seizure activity. CT scan showed global ischemic injury, both cerebral hemisphere. On the morning of 22nd March, 2021 the patient's pupils become unresponsive to neurological examination carried out 12hours apart, which confirmed brain stem death. She was disconnected from the ventilator

on the morning of 23rd March, 2021. The particular details and evidence has already been noted earlier hereinabove and hence is not repeated.

35. There are three critical time periods in this case which are required to be reviewed; Preop, OT and Postop care, to determine what as per the evidence caused the critical event or events and actions or lack thereof on the part of any of the medical practitioners involved in the case. It is established that the sentential event was a hypoxic insult leading to global ischemia postoperatively. Cerebral hypoxia caused the brain damage which led to the stem death or brain death in the patient. As per the expert's opinion and as also corroborated by a comprehensive review of the medical evidence it stands established that the cerebral hypoxia in this case was caused by either; a late recognition of hypoxic episode or a delay in providing cardiac massage, or a combination of both. Therefore, the key to determining relevant conduct or actions or lack thereof which may have led to cerebral hypoxia rests in the events that took place in the OT between 6.55am and 8.00am.

36. Before dealing with the evidence to determine the responsibilities and consequent liabilities of the persons involved, it is necessary to deal with the other two time periods. As per the evidence on record nothing untoward occurred PreOp which was carried out by Dr. Mujtaba and consequently no action during PreOp can be connected to the occurrence of the critical event as a cause or otherwise. The PostOp care time period from the time that the surgery was completed till the unfortunate demise of the patient has also been considered minutely in view of the evidence brought on record from the hospital record as well as the statements provided by all the relevant consultants who treated the patient and provide care during that period. The Committee has found no evidence of negligence or conduct less than required in terms of due care of a patient during the PostOp time period and thereafter on the part of any of the doctors, including but not limited to Dr.Tipu Sultan, Dr. Qasim Bashir, Dr. Adnan Gill, Dr. Asiya Taqi and Dr. Arshad Taqi, who treated the patient right upto 23rd March 2021. It is pertinent that all these doctors treated the patient after the actionable critical event of hypoxic insult had taken place in the OT. This fact is further confirmed by the experts report. If anything, the care that was provided to the patient PostOp and up to her unfortunate demise was strictly within the recognized and expected medical protocols in such cases and all steps taken and actions of each consultant treating the patient are found to have been properly and correctly taken in response to the critical event that had occurred with every attempt made to restrict further damage as well as potentially record the damage which had already occurred. The parents of the patient were fully and properly advised as per the highest standard of protocols incumbent upon medical practitioners.

37. As per the statement of Dr Fatima who was present in the OT; *"at 07:40am I noticed disappearing of pulse oximeter waveform initially suspecting the dislodgement of finger probe, I readjusted the probe and changed the finger for it. While I was doing so I noticed the drop in heart rate up to 47bpm accompanied by decrease in ETCO2".* She then called for Dr. Sheraz. When Dr. Sheraz arrived she stated that; *"Dr Sheraz arrived, I briefly updated about the status of patient and management steps I had taken till that point. He advised me to give a third atropine 0.2mg bolus, as heart rate still had declining trend, assured 100% oxygen delivery and switching off of Isoflourane".* Dr. Sheraz checked her pulse which was absent.

38. Dr. Sheraz entered OT he stated that; *"when I entered in the theatre, I witnessed the heart rate to be around 45/min and asked to repeat atropine and give adrenaline 10mcg IV stat. The surgeon was notified to stop the surgery. The heart rate kept declining with absent pulses. I started chest compressions immediately with continued ventilation with 100% oxygen and made sure that Isoflurane was turned off and advised Dr. Fatima to give injection adrenaline 100 mcg IV stat followed by flush. The baby achieved return of spontaneous circulation with in 45seconds.*

39. After maintaining hemodynamics, adequate ventilation and oxygenation the surgery was resumed and was finished in next 20 to 25 minutes. After surgery the patient was breathing spontaneously, reversal was given by Dr. Sheraz according to the body weight at around 8:35am. However, the recovery of patient was delayed. Dr. Sheraz was preparing to give Naloxone to reverse the effect of Nalbuphine which had been administered when Dr. Asiya Taqi the senior morning consultant arrived at the OT and was briefed about the patient. Dr. Asiya noticed up-rolling of eyes which was not a normal response and a cause for concern. Dr. Asiya in her statement has mentioned that; *"on reaching HLH I went straight to operation room and did a rapid assessment of the situation. The child had resumed spontaneous breathing, reversal of muscle relaxant was given at 8:35. Dr. Sheraz was preparing to give Naloxone to reverse the effect of Nalbuphine which was administered. The child was hemodynamically stable, breathing was smooth and regular, however I noticed that eyes were up rolling which was not the normal response and was a case of concern".* Dr. Asia Taqi checked the blood sugar level of the patient which was 337mg/dl, therefore the insulin infusion was started to manage the child's blood sugar level. She further asked for arterial blood gases to further assess her metabolic status.

40. The CCTV footage as provided by the Hospital has been consulted by the Disciplinary Committee to have a fair idea of events and the movement of concerned doctors. In the CCTV video it is observed that the patient was brought to OT at 6:50:13 am from observation room in the lap of nurse. At 6:54:05 am. Dr. Sheraz entered the OT. While Dr. Bilal moved to the OT at 6:56:26 am. It is observed that Dr, Sheraz comes out of the OT at 7:02:40. Dr. Sheraz then went to the consultants' room. In view of foregoing, Dr. Sheraz spent only 8 minutes in OT for induction and

then monitoring of patient. As per the CCTV footage Dr. Sheraz was seen reentering the OT at 7.39am.

41. Dr Fatima first became aware of the critical event as per her statement around 7.40am and sent a technician to call Dr Sheraz who was sitting in consultants' room. He arrived at 7.39am as per the CCTV footage. Therefore, it is clear that Dr. Fatima's evidence as to time in incorrect and she had clearly observed the change in pulse oximeter earlier and given the steps she has stated she took before Dr. Sheraz arrived a safe time frame would be at least 5 minutes prior to Dr. Sheraz entering making the time of her noticing a change in the pulse oximeter to be somewhere between 7.30am and 7.34am.

42. Dr. Sheraz on arrival ordered atropine and only then resumed cardiac massage. The current recommendation for Pediatric Life Support is to start cardiac massage if the heart rate of the child falls below 60 /minutes. Outcome in such cases depends on effective CPR. Best outcome is if this happens in less than 2 minutes and a delay by one minute decreases outcome by 10%. Based on Dr. Fatima and Dr. Sheraz's evidence this did not happen. With these observations it would be relevant to have a further detailed look at the chain of events that took place in this case to assess the monitoring and accorded management of patient by the resident doctor and then the consultant doctor.

43. As per the statement of Dr Fatima the heart rate of the patient was 74 bpm at 7:35 am and then at 7:40 am she noticed dis-appearance of pulse oximeter waveform and while she was adjusting finger probe she noticed drop in heart rate to 47bpm accompanied by decrease in ETCO2. It is already established that this happened probably around 7.30-7.34am. As per her statement heart rate dropped from 74 to 47 in five minutes. There is nothing in the statements given by the doctors regarding monitoring of vitals, even otherwise the important details and monitoring readings (MAC) have not been provided by the hospital. Only dialed concentration of inhalational agent was charted. The actual concentration received by the patient maybe different to this under low flows. The expert queried Dr Sheraz during the hearing whether MAC values were available on the monitor, but no satisfactory answer was given. Whereas when she asked Dr. Mujtaba that do they have MAC (Monitored Anesthesia Care) Monitoring System, his answer was in the affirmative. Therefore, when MAC was available there is no reason for Dr. Sheraz, or the Hospital for that matter, not to have referred to the relevant data or provided the same.

44. Dr. Sheraz entered the OT and was first briefed by Dr. Fatima. When he observed the patient the heart rate of the patient was 45bpm and he prescribed to repeat atropine and give Adernalin10mcg IV state. Dr. Sheraz stopped Dr. Bilal from surgery as the heart was further dropping with absent

pulse and then he started CPR. In view of foregoing, Dr. Sheraz started giving IV medication when heart rate was 45 and when he found absent pulse and further decline in heart rate only then he stopped the surgeon and performed CPR which is contrary to current recommendation for Pediatric Life Support. Cardiac massage is started if the heart rate of the child falls below 60 /minutes. Outcome in such cases depends on effective CPR. Best outcome is if this happens in less than 2 minutes and a delay by one minute decreases outcome by 10%.

45. Dr. Sheraz in his statement has mentioned that he observed the patient for about 10 mins after resuming spontaneous circulation and then the surgeon was allowed to proceed. It is pertinent to highlight that the management of pulse less/BP less patient by Dr. Sheraz started between 7.39am and 7:40am when he entered the OT and included briefing from resident doctor, administration of various lifesaving drugs, waiting for response on monitors & after failure to successful response by IV administration initiation of CPR which at the minimum takes 4 to 5 minutes. Statement of Dr. Shearz that after stabilizing the patient he observed the patient for next ten (10) minutes essentially means that Dr. Shearz would have been present in OT for minimum 15-20 minutes during this process. As per available CCTV footage, Dr. Sheraz entered OT at 7:39am and came out at 7:46am, which shows that Dr. Sheraz remained inside OT for a total of 5 minutes and 30 seconds during this crucial and critical event. Therefore, the statement of Dr. Sheraz in its entirety become questionable and more importantly as to all the steps he claims to have taken and which to some extent Dr. Fatima has sought to corroborate in her evidence.

46. The events after Dr. Sheraz's departure from the OT at 7.46am are also telling. Dr. Sheraz came out of OT at 7:46am and again entered the OT at 7:48 am. He left OT again at 7:51 after a short less than 3 minute stay and went to the dressing room and then again reentered OT 7 minutes later at 7:58 am. Therefore, between 7.39 where he entered the OT on Dr. Fatima's call, he spent a total of approximately 8 minutes out of the next approximately 20 minutes in the OT leaving and reentering twice. Confronted with a sentinel event of the given nature and whereas per his evidence he had conducted CPR on the patient the conduct of Dr. Sheraz and the timeline noted above does not convey the expected response from a consultant. In view of the life threatening event which had occurred it required a differential diagnosis to determine what and how it happened and what could have been the likely causes of the event to address the same. No differential diagnosis was provided by Dr. Sheraz as also noted by the expert. No immediate post arrest investigations were done/or documented perioperatively by Dr. Sheraz. Immediate Arterial Blood Gases, and electrolytes as well as blood sugar sample should have been sent post arrest immediately which had not been done till 8.30am when Dr. Asiya Taqi arrived.

47. The above facts, evidence and most importantly timelines lead to the conclusion that Dr. Sheraz and also Dr. Fatima failed to recognize the severity of the incident and in doing so failed to take all steps expected in such an event and hence failed to discharge the duty of care obligated towards the patient. It is also abundantly clear that all the steps stated to have been taken in Dr. Sheraz and Dr. Fatima's evidence during that critical period between 7.35am and 7.58am were not taken as the time line doesn't support the time ordinarily required for all that has been explained by both the doctors. It appears that at the very outset Dr. Fatima did not in all probability notice the change in the condition of the patient on an immediate basis and this initial delay combined with the delayed response from Dr. Sheraz including CPR having been done well beyond the 2 minute prescribed delay started the chain of events which ultimately led to the event of cerebral hypoxia in the patient.

48. Furthermore and far more concerning is that the evidence of Dr. Sheraz and Dr. Fatima appears to represent a collective attempt on their part to hide the actual events as they occurred and their individual and collective failures. The steps allegedly taken by them do not match the actual time lines, which also the two had tried to alter through their evidence and had it not been for the CCTV footage their claimed actions in the OT could not have been critically tested and reviewed. Dr. Sheraz with some assistance from Dr. Fatima during their evidence then also sought to try and shift the responsibility onto Dr. Asiya Taqi claiming she had arrived much earlier than the recorded time of her arrival and also falsely stating the arrival time of Dr. Arshad Taqi much before his recorded arrival at the hospital after 9.30am. In doing so they both tried to insinuate that the apparent unknown reason for the event was Postop handling by the other doctors. An allegation which stands disproved by the evidence discussed above and the record as well as the opinion of the expert.

49. The haphazard exits and entries of Dr. Sheraz from the OT during the critical event between 7.39am and 7.58am point towards either his failure to have realized the seriousness or true nature of the event or conversely represented a knowledge of the errors which had occurred and hasty attempts being made to either cover up the error or conjure an alternative explanation. The latter failure to produce some of the relevant data as was requested by the expert and the Committee and ambiguous answers given by both him and Dr. Fatima unfortunately leads to the latter conclusion specially when coupled with the rather feeble attempt to shift the blame onto others during the evidence.

50. Another telling feature of the evidence is that postoperatively Dr, Sheraz, as the consultant anesthetist who had performed CPR on the patient, failed to meet the parents of the patient along with the surgeon at 8.10am and inform them of the serious event that took place intraoperatively.

Cardiac arrest is a serious event, it should have been properly explained to the family immediately and also the management of the patient. Such conduct further leads to an attempt to avoid assuming responsibility of the event and instead seeking ways to cover up the mistake which had been made and was in his knowledge.

51. It stands established that Dr. Fatima and Dr. Sheraz failed to deliver on their obligation of duty of care to the patient and further to follow the norms of Pediatric Life Support and carry out differential diagnoses of a critical event and failed to deliver the proper medical and critical management at the right time which led to the ultimate demise of the patient.

52. The conduct of Dr. Mujtaba has been reviewed in detail and the evidence confirms that till such time as he was responsible for the patient and then handed over to Dr. Fatima the patient was fine and no untoward incident had occurred. For such reasons Dr. Mujtaba is held to have not in any manner caused the event or been negligent in his duty toward the patient.

53. While there was no medical negligence found on the part of Dr. Bilal during the surgery, it is observed that Dr. Bilal failed to inform the family about the critical event which had occurred during the surgery. As per the statement of Dr. Bilal during the course of hearing when he was enquired by the Chairman Disciplinary Committee, he stated that at 07:55am, we had the final images, and case was closed. At 08:10am he met the family, told them the details and he asked them that they can go home in the evening. Dr. Bilal failed to inform the family regarding critical event. His poor counseling the family regarding a critical event is not only in breach of code of ethics but resulted in creating a later confusion in the minds of the parents of the patient who expectedly presumed all kinds of cover ups and involvement of one and all. Had they been properly counselled and informed of the incident at 8.10am by Dr. Bilal and not had to wait till Dr. Arshad Taqi immediately on arrival counselled them over an hour and a half later to their meeting with Dr. Bilal, they would have been able to understand properly when and what had happened to their daughter rather than running pillar to post to try and piece together evidence under an already existing cloud of presumptive distrust. It is for this very reason that patient and attendant counselling is one of the keys to proper and professional medical practice. Therefore, a warning is issued to Dr. Muhammad Bilal and he is directed to undergo a certified course of ethics and submit a compliance report to Disciplinary Committee within six months of issuance of this Order.

54. Lastly, the Committee has observed with concern that the Hameed Latif Hospital failed to provide the complete record of the case despite the undertaking given by the legal representative of the hospital during the hearing. Hameed Latif Hospital was specifically asked to provide the CCTV footage of the event right upto 9.30-10am and also provide list/chart of the doctors who examined

the patient along with timings. After the hearing, the CCTV footage sent by Hameed Latif Hospital vide letter dated 07 August 2021 which was received on 11 August and contained four videos shifting to OT at 6:50 am (22 seconds), shifting from OT to ICU at 1:58 pm (28 seconds), entering ICU a 2:00 pm (2 minutes) and a mock video from OT to surgeon office (22 seconds).

55. The record shared by the Hamid Latif hospital was irrelevant and did not comply with the directions of the Disciplinary Committee. Thereafter, Several reminders were sent to the hospital and phone calls were made in this regard. The Disciplinary Committee in exercise of its power under section 32(7) of the Pakistan Medical Commission Act, 2020 as a civil court under the Code of Civil Procedure, 1908 passed the order to summon the record from the Hospital to assess the movement of doctors during the event in the operation theater from 6:40 am to atleast 10am and preferably till 2.00 pm. and also the chronology of events mentioning the names of doctors on duty in this case from 6:40 am till the patients shifting to PACU. The hospital finally provided CCTV footage only from 6:00 am to 8:00 am which is not a complete recording of all doctors entering the OT. Moreover, no summary of all doctors involved in the case and their timings was provided in writing. Apart from the failure to provide the requisite record to assess the movement of the concerned doctors in the matter and to comply with the directions of the Disciplinary Committee, it is further observed that the hospital failed to bring essential material on record which include readings of MAC (Monitored Anesthesia Care) Monitoring System. Failure to provide the requisite record amounts to concealment of information and misleading the adjudicatory forum.

56. In view of the established attempts by Dr. Sheraz and Dr. Fatima to shift the responsibility onto other doctors and specifically Dr. Asiya Taqi and then Dr. Arshad Taqi in this case as well as their incorrect initial evidence as to the critical timing of Dr. Sheraz's arrival and departure from the OT, the failure of the Hospital first to provide the relevant CCTV footage and instead only provide selectively few seconds video which would not have allowed the Committee to juxtapose correctly the evidence of Dr. Sheraz and Dr. Fatima with video evidence and specially the two extra exits and entries of Dr. Sheraz from the OT between 7.39am and 7.58am, when they admittedly had and in all probability reviewed the entire video, unfortunately appears to represent an attempt by the Hospital to wrongfully support the false evidence of Dr. Sheraz and Dr. Fatima and indirectly seek to protect the Hospital from any possible liability that may occur. Pertinently the Hospital still failed to produce the CCTV footage between 8.00am and 1.58pm which would have established even otherwise what later stood confirmed in evidence as to the arrival time of both Dr. Asiya Taqi and Dr. Arshad Taqi well after the critical incident had already occurred. It can only be presumed the Hospital did so in an attempt to further lend some indirect support to the story being weaved by Dr. Sheraz and Dr. Fatima before the Committee by withholding video evidence which would

have established further false statements made by Dr. Sheraz. The Committee expects that the Punjab Healthcare Commission will take such conduct of the Hospital into consideration while hearing the case pending before it as per the statement of Mr. Umar Farooq relating to this incident.

57. In view of what has been discussed and medical and professional negligence as well as a patent failure to discharge the obligation of duty of care towards the patient on the part of Dr. Sheraz Saleem Chaudhary and Dr. Fatima Tu Zehra having been established and further compounded by the conduct specifically of Dr. Sheraz Saleem Chaudhary in giving false evidence and concealment of critical information and failure to assist the Committee with a half hearted attempt by Dr. Fatima Tu Zehra to support such false evidence by way of a failed attempt to corroborate it, the Committee imposes major penalty on Dr. Sheraz Saleem Chaudhary of cancellation of his license on a permanent basis and suspension of Dr. Fatima Tu Zehra's license for a period of three (3) years with a further direction that her training period towards her fellowship in Anesthesia shall not be considered or given credit for in the future.

58. Before parting with this decision, it is important to note that the practice of medicine is not a perfect science and it is acknowledged that mistakes will be made by practitioners sometimes beyond their control and sometimes as a result of their *bona fide* assessments and diagnosis. It would be absurd to presume otherwise. However, it is for this reason that the code of ethics of a medical practitioner imposes a duty of care by the practitioner towards the patient and in addition expects absolute honesty and integrity on the part of the practitioner for that is the corner stone of the trust and confidence that must exist between a patient and their doctor. Dishonesty and lack of integrity on the part of a medical practitioner is as serious or more so than medical negligence as a practitioner who cannot be trusted with telling the truth and admitting a mistake cannot be trusted to carry the heavy burden of trust that a patient seeks to repose in their practitioner whom the patient sees as their messiah and will be the conduit to deliver *shifa* to them.

59. The Committee would like to record its gratitude to the experts who put in extensive time in view of the detailed and complicated medical record involved. Also the Committee would like to note that it is aware of the multiple communications received from Mr. Umar Farooq during the period between the hearing and the announcement of this order, as the proceedings had been concluded and the order reserved no further action sought by Mr. Umar Farooq could be entertained notwithstanding that most of his concerns we believe stand addressed in this order and while the Committee even though not required to but did seek to await a short while to await the final decision from the Punjab Healthcare Commission in response to Mr. Umar Farooq's earlier request and even inquired as to its status however, as the same does not appear to be forthcoming anytime

soon the Committee decided to issue its final order. The subject proceedings stand disposed of in terms of above findings and directions. No order as to costs.

Aamir Ashraf Khawaja
Member

Dr. Asif Loya
Member

Muhammad Ali Raza
Chairman

14 February, 2022