BEFORE THE DISCIPLINARY COMMITTEE OF PAKISTAN MEDICAL COMMISSION

In the matter of

PF.8-1856/2019-Legal

Dr. Ahmad Hussain Vs. Dr. Jahan Ara

Mr. Muhammad Ali Raza	Chairman
Dr. Anis-ur- Rehman	Member
Dr. Asif Loya	Member

Present:

Dr. Ahmad Hussain	Complainant
Dr Madiha	Patient (Complainant's wife)
Dr. Jahan Ara (717-P)	Respondent
Brig (R) Prof. Dr. Ambreen Anwar	Expert (Gynecologist)
Hearing dated	03.06.2022

I. FACTUAL BACKGROUND

1. Dr. Ahmad Hussain (hereinafter referred to as the "Complainant") filed a Complaint before the erstwhile PM&DC on 22.07.2019, against Dr. Jahan Ara (hereinafter referred to as the

"Respondent") working at Mid-City Hospital, Jail Road, Lahore, wherein it has been submitted that:

a. The Complainant's wife (the patient) consulted Respondent Dr. Jahan Ara on 18.06.2019. The doctor asked her to come on 19.06.2019 with urine complete and fresh ultrasound report. The ultrasound was performed which showed cord around the neck.
b. The Respondent examined the patient per abdominally and mutually discussed the USG report and informed that delivery would be per vagina and there was no need for a C-section.
c. That the foetus and the mother both were healthy with no comorbidity. The Respondent asked the Complainant and his wife to arrive on Thursday morning, 20.06.2019 for induction in the hospital.
d. They reached the hospital on June 20, 2019 at 09:30 am and the patient was inducted at 10:00 am. Her CTG was done prior to induction which was absolutely fine. The Respondent paid visit at 02:00 pm and inquired about her health and left without examination.
e. As per the fresh ultrasound report, cord was found strangulated around the neck. In these circumstances the Respondent should have opined and opted for a C-section as the first course of action instead of delivery per vagina.
f. The Respondent committed sheer violation of the code of ethics issued by the PM&DC while not fully disclosing the possible complications of the normal delivery per vagina. The Respondent in its true terms never obtained the informed consent of the patient.
g. The foetal heart rate was being checked at regular intervals with sonicaid till 08:15 pm after which nobody checked it. Complainant's wife was shifted to delivery room at 09:00 pm and was asked to push down baby by a junior doctor without proper monitoring and assessment.
h. The Respondent failed to take certain measures to save the baby during the delivery and pre delivery scenario including but not limited to the following:
    i. Respondent was not accompanying the Complainant's wife in delivery room.
    ii. There was no continuous CTG monitoring as it was a difficult SVD, there was no vigilant cardiac monitoring. After almost 20 minutes there was no progress, foetal heart rate was checked by sonicaid which showed severe bradycardia.
i. The junior doctor got panic, rushed oxytocin and asked to push again but all in vain. Oxytocin further caused foetal distress secondary to uteroplacental insufficient blood flow compromised by severe uterine contraction.
j. The junior doctor called Dr. Jahan Ara who instead of conducting the delivery was busy to fulfill her greed for money by doing OPD at that time when she already knew that the fetus

had the cord around her neck. When she came she first asked to push and bring instruments and vacuum then she examined per vaginally for the 1st time since they had consulted her.

k. The Respondent told the junior doctor that the head was high and transverse which she never knew. The fetus could not be delivered per vaginally, had to rush for caesarean section.

l. The patient was shifted to OT and general anesthesia was given besides epidural was intact. Finally, baby was delivered by emergency C section at 10:30 pm. He had severe bradycardia with no breathing. Ambo was done for 6 to 7 minutes and then put on ventilator.

m. Complainant, his wife and all family members were kept blind about all this situation. There was poor communication among doctor-patient and relatives.

n. Baby remained on ventilator for 8-days and unfortunately left the world at 9:00 am on 28th June 2019.

o. Baby was diagnosed Asphyxial neonatorum also known Hypoxic Ischemic Encephalopathy chiefly results from
   i. Medical malpractice, negligent care during birth.
   ii. Errors in foetal heart rate monitoring.
   iii. Failure to promptly and appropriately respond to sign of foetal distress.
   iv. Insufficient precautions taken for loop around neck.
   v. Mismanagement of an issue involving the foetal presentation (occipito transverse in cephalic).
   vi. Failure to give hypothermia therapy and normal air during resuscitation according to 2010 guide lines of resuscitation.

p. That the ultimate and resultant death of the deceased was caused by the immediate, proximate and direct negligent acts of the Respondent. The Respondent failed to exercise reasonable standards of due diligence, duty of care as per the accepted medical principles and standards. She failed to show the fair, reasonable and competent degree of skill which is expected from a professional gynecologist.

Reference from Punjab Healthcare Commission

2. The Complainant also filed Complaint of the same incident before the Punjab Healthcare Commission (PHCC). The Punjab Healthcare Commission conducted investigations and decided the Complaint vide its decision dated 30.04.2021 *inter alia* with the following observations.

   a. *Respondent Dr. Jahan Ara, having PMDC No. 717-P had been deficient in discharging her duties and that her case be referred to Pakistan Medical Commission in accordance with law.*

II. NOTICE TO RESPONDENT

3. In view of the allegations levelled in the Complaint, Notices dated 08.08.2019, 18.06.2020, 20.08.2020 and 04.09.2020 were issued to the Respondent Dr. Jahan Ara along with a copy of the Complaint and she was directed to submit her reply/comments.

III. REPLY OF RESPONDENT DR. JAHAN ARA

4. In response to the notices dated 08.08.2019, 18.06.2020, 20.08.2020 and 04.09.2020, the Respondent doctor failed to submit any reply. On 10.09.2020 a letter was received from the Respondent doctor wherein it was stated that record of the patient is at Punjab Healthcare Commission and will be shared as soon as it is received.

5. Respondent Dr. Jahan Ara finally submitted her reply on 03.06.2022 wherein it has been contended that:

Legal Objections:

a) *On Complaint of present Complainant, the Punjab Healthcare Commission investigated the matter and exonerated the Mid City Hospital. The PHC could not on one hand exonerate the Respondents of any wrongdoing and at the same time refer the matter to the PMC for action under law. Had the PHC found Dr. Jahan Ara's conduct in any way, liable for fine or penalty, they would have imposed the same as it is empowered under the law. The fact that no penalty has been imposed, is proof that no case has been made out against Dr. Jahan Ara. The Punjab Healthcare Commission has no jurisdiction to refer matter of Answering Respondent to the Pakistan Medical Commission.*

b) *Regarding the observations made by Punjab Healthcare Commission with respect to the conduct of Dr. Jahan Ara, it is crucial to note that the terms used are infinitely vague and cannot possibly merit any further action or inquiry against her. Therefore, it is respectfully submitted that the Disciplinary Committee of PMC cannot now, at this belated stage, enter into and conduct yet another roving inquiry into a matter that has already been investigated and put to rest, without any fine or penalty whatsoever being imposed on the Respondents. Since the same Complaint between the same parties has already been adjudicated and decided by the Punjab Healthcare Commission therefore the instant Complaint before the Disciplinary Committee is hit by principle of Res Judicata.*

c) *That the Complainant chose a forum of his choice i.e. Punjab Healthcare Commission which has decided the matter, now the same Complaint cannot be proceeded by the Disciplinary Committee of Pakistan Medical Commission.*

d) *Section 32(6) of the PMC Act provides that the Disciplinary Committee shall hear and adjudicate the matter within ninety days of issuance of the Show cause notice. The instant Complaint was filed in July 2019. The PHC Order was passed on 30.04.2021. Thus, if we are to consider the date of Order to be the time from when the Disciplinary Committee took cognizance of the matter again, the time*

mandated by Section 32(6) has lapsed. Section 32(6) is couched in mandatory terms and a violation thereof, would entail strict consequences.

Factual Background and Reply

e) *The Complainant and his wife consulted Dr. Jahan Ara (Respondent) on 19.06.2019. Ultrasound report dated 19.06.2019 showed cord around the neck (single loop). The Respondent further examined the patient and discussed the high probability of a vaginal delivery in the OPD. Dr. Madiha (Complainant's wife) came to labor room on 20.06.2019, at 09:38 am for induction of labor.*

f) *The opinion of Dr. Jahan Ara that cord around neck is not an indication of an Elective C-Section is reaffirmed by the expert opinion dated 28.04.2020 provided during the PHC proceedings dated 24.08.2020. The same is also supported by well-established medical studies and medical protocols worldwide.*

g) *Proper consent was taken from the Complainant's wife at the time of admission and prior to the C-Section. The Complainant's wife was left under the direct supervision of competent doctors namely, Dr. Shagufta Tayyiba (FCPS) and Dr. Uzma PGR, who went on to pass the FCPS and are currently working as specialists in Saudi Arabia.*

h) *Dr. Jahan Ara visited the patient in labor room at 12 noon, and then later at 03:15 pm (20.06.2019). At 12 noon, patient had mild labor pains and she was walking around in labor room comfortably. Dr. Jahan Ara checked the follow up sheet/ notes and observed that the condition of the mother and baby was satisfactory. Dr. Jahan Ara visited her again at 03:15 pm in her cabin, when the epidural was being fixed by the Anesthetist. The condition of the baby and mother was satisfactory and noted on the follow up sheet.*

i) *Fetal heart rate (FHR) was monitored throughout her stay in labor / delivery room and recorded as per the monitoring sheet (Available in original file and may be inspected). Patient was fully dilated at 9:30 pm and Dr. Jahan Ara was informed by the Doctor on duty. The Respondent at this time was present at hospital premises and directed the staff in the Labor Room to shift the patient in the delivery room and call the Respondent when the head comes down, as the head can take up to two hours to descend & deliver (the duration of 2nd stage of labor can take two hours).*

j) *At 9:45 pm FHR was 100-110/min oxygen inhalation started and IV infusion (Syntocinon) was stopped. At 09:50 pm FHR was 110-115/min, which then dropped to below 100, at 9:55 pm and the Respondent was informed. The Respondent came to delivery room immediately as she was at the hospital premises. She carried out pelvic examination in order to decide the mode of delivery. FHR was still below 100 at 10:00 pm.*

k) *Fetal head was at zero station and it was decided immediately to go for emergency C-Section without wasting any time. Fetal scalp blood sampling was not performed to confirm metal distress as it would waste further time. The Complainant, his wife and her family were informed and explained for the need of an emergency C-Section by the Respondent. Written consent was obtained at 10:05 pm as shown on the consent form.*

l) *The patient was shifted to operation theatre immediately and C- Section procedure was initiated at 10:10Pm and baby was delivered at 10:15Pm. As per the literature (see appendix) category I (Emergency) C-Section should be performed within 1/2 an hour.*

m) *The baby had bradycardia & was resuscitated by pediatric doctor. The APGAR score was 4/10 at birth, baby was intubated and shifted to the nursery. The baby was then put on ventilator. The Respondent explained the situation to the Complainant in detail.*

n) The Consultant pediatrician, Prof. Ashraf Sultan visited the baby in nursery at 12:45 am (Mid Night) on 21.06.2019 and gave instructions to the staff on duty. He met the family including the Complainant and counselled them in detail. Baby remained alive and on ventilator for 08 days.

o) The father of the baby (the Complainant) decided to change the consultant pediatrician at 12:20 p.m. on 21.6.2019 without any Complaint against primary physician, Prof. Ashraf Sultan.

p) The father of the baby contacted Dr. Naeem Zafar to look after his baby. The Consultant pediatrician, Dr. Naeem Zafar visited the baby at 5:15 pm on 21.06.2019 (one time) without the consent of treating physician Prof. Ashraf Sultan or the gynecologist (Dr. Jahan Ara). Subsequently, the Doctor on duty contacted Dr. Naeem Zafar at 6:00 pm, 6:30 pm and 7:00 pm on 21.06.2019, however all three times Dr. Naeem Zafar was unreachable and did not attend the call. Finally, at 8:15pm Dr. Naeem telephonically informed the doctor on duty that he will not visit the baby any further. He refused to look after the baby saying that it was unethical to shift the baby under his care without the consent of the primary physician. Dr. Jahan Ara's advice regarding changing of physician at this critical stage was not sought by the Complainant and had it been sought, she would have strictly advised against the same.

q) Then the Complainant contacted and engaged another (third) child specialist Dr. Ghazanfar who visited the baby (for the first time) at 11:50 pm on 21.06.2019. That means the baby was without consultant's cover for eight hours. It is important to understand that at this time the baby was alive and on ventilator. And in this critical condition the baby was being looked after by the medical officers on duty. These eight hours of critical period without any consultant supervision must have affected the baby's health adversely. For these eight hours the management of the baby was in chaos and confusion.

r) The Complaint mentioned that during labor the fetus was in transverse lie, however this was not the case.

IV. PROCEEDINGS OF DISCIPLINARY COMMITTEE UNDER PAKISTAN MEDICAL COMMISSION ACT 2020

6. Pakistan Medical & Dental Council was dissolved on promulgation of Pakistan Medical Commission Act on 23rd September 2020 which repealed Pakistan Medical and Dental Council Ordinance, 1962. Section 32 of the Pakistan 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 has decided to hear and decide all pending Complaints filed before the erstwhile PM&DC including the instant Complaint.

V. HEARING DATED 03.06.2022

7. The Complaint was fixed for hearing on 03.06.2022. Notices dated 16.05.2022 were issued to Dr. Ahmad Hussain (Complainant) and Respondent Dr. Jahan Ara, directing them to appear before the Disciplinary Committee on 03.06.2022.

8. On the date of hearing the Complainant and Respondent doctor appeared before the Disciplinary Committee. The Complainant asked the permission of the Committee to allow his wife to attend the hearing as she was the patient, which was allowed.

9. The Committee asked the Complainant about brief facts of the case to which he stated that they visited Respondent doctor on 19.062019 to show her the ultrasound report of the patient who was 39 weeks pregnant. It was clearly mentioned on the ultrasound that there is cord around neck of the fetus. They had informed the Respondent doctor about the incident during previous delivery in Mid city hospital, that they already had the same history in last pregnancy wherein, the baby had cord around neck, due to which there was prolonged labor and the then treating doctor had told that due to cord around neck the baby was cyanosed and had late cry. Complainant stated that the Respondent Dr. Jahan Ara didn't pay attention to the cord around neck of the baby as well the complication that may be faced after a normal vaginal delivery in such cases and told the Complainant that she will go with a normal vagina delivery.

10. The Complainant further stated that as per directions of the Respondent the patient was admitted at 09:40 am on 20.06.2019 and a junior doctor took history and examined the patient. The Respondent doctor visited twice that day but she never examined the patient till night 10:00 pm. As it was induced labor so, artificial rupture of membrane, Oxytocin and prostaglandin was administered but the dose of oxytocin was not according to standard which was also pointed out by PHCC in its findings. The patient was shifted to delivery room around 09:00 pm, and even till that time the Respondent doctor didn't visit to see the patient and had all the correspondence telephonically, with a junior doctor. The Complainant further submitted that it was the responsibility of the treating consultant to examine the patient / check head position and decide whether to shift the patient or otherwise. The patient was shifted to labor room and procedure was started, epidural anesthesia was given, the staff / junior doctor started pushing the baby, infusion oxytocin was rushed fast but the baby wasn't delivered. After a while the staff enhanced

the dosage of oxytocin and asked the patient to push, but of no use. This whole exercise took half an hour i.e. from 09:00 pm till 09:30 pm, but the Respondent doctor (primary physician) has not reached till then. The junior doctor attending the patient got panic as the baby went into bradycardia, and the reason for going into bradycardia was oxytocin and pushing which further complicated the cord around neck. After the baby went into bradycardia, Respondent doctor was again contacted but she didn't reach till 9:45 pm. At 09:55 pm the heart rate of baby reached to 78 bpm. Despite the fact that labor was induced and oxytocin was rushed, CTG was not performed. Furthermore, the Respondent doctor reached labor room at around 10:00 pm, who on first PV examination stated that head is at zero station, and that normal delivery is impossible and have to proceed for C-section. At 10:30 pm the baby was delivered through C-section.

11. The Complainant further submitted that after quiet a long time when the mother and baby were still in the OT, it came to his knowledge that doctor are performing ambo bagging of the baby. The baby was shifted to ICU and put on ventilator. The Pediatrician reached to see the baby on 12:45 am (21.06.2019). After about 2 hours of delivery the Respondent doctor came to the room of patient and explained and assured the healthy state of baby and mother. The Complainant further stated that they were never communicated by the Respondent doctor about such big event that took place. The mother was discharged the next day 11:23 am, dated 22.06.2019 and the baby remained in the hospital for 8 days i.e. till 28.06.2019.

12. Responding to question regarding change of the doctor/pediatrician the Complainant stated that the doctor of their first baby (girl) was Dr. Naeem Zafar, who was also on the doctors list of the hospital and the second reason was that the already assigned pediatrician Dr. Sultan when asked about the baby, he chose to talk less about the child's health or prognosis and more about the defense of Respondent doctor, that is why they requested the administration to arrange visit of Dr. Naeem Zafar as well to be aware of the factual situation of their child.

13. The Expert asked the patient that as she was given epidural anesthesia did she feel any pains and if she was able to push or not as a result of the effect of epidural anesthesia to which she responded that she had no pains and she was unable to push.

14. The Expert asked the patient whether there was anyone who was listening to the baby's heartbeat to which she responded that the heartbeat was very low for 15 to 20 minutes.

15. The Committee inquired from the Complainant if he ever met Respondent Dr. Jahan Ara after the incident to which he replied that he didn't see Respondent rather his brother met her and she assured that she did her best and baby will be fine. Complainant further added that being a doctor himself he accepts that life and death is in Allah's hands but a doctor has to be with the patient in such a case and in this case there is big failure of duty of care as well as counseling by the Respondent doctor.

16. The Committee inquired from the Complainant (patient) as to why they had changed their consultant to which she responded that she was a regular patient of Dr. Tayyiba who was consultant gynecologist in the same hospital, but at the time of delivery she was out of country and that's why they switched to Dr. Jahan Ara who was consultant in the same hospital.

17. The Committee inquired from the Respondent doctor about brief facts of the case to which she stated that the patient visited her in OPD and everything regarding cord around neck and vaginal delivery was discussed in detail, and after having a better understanding they agreed for vaginal delivery. The patient after reaching labor room was induced at 09:30 am on 20.06.2019.

18. The Committee asked the Respondent that on 19.06.2019, she advised on her prescription to get the patient admitted in labor room for induction but there is no other document on record mentioning the details or the other associated health issues / complications / risk factors involved, which can be considered in case the primary physician (consultant) is not available. The Respondent stated that there is a complete hospital file, when the patient arrived for admission the next day, all the history was taken from the patient and recorded in file.

19. The Expert asked the Respondent as to why she decided to induce the patient on 39+3 weeks. She responded that her fetal weight was 3.7, whereas the weight of her first baby was 3.3 kg, so she advised that if they wanted to go for a normal delivery then its better to get induced by that time, because with more time the fetus will gain more weight and normal delivery may not be possible.

20. The Expert asked the Respondent that was it a free head or was it engaged, to which the Respondent replied that it was palpable 3/5.

21. The Expert asked the Respondent that as it was a full planned induction with position, sinto and amniotomy, then why there was a delay from 9:00 pm till 9:45 pm. The Respondent stated that at 09:30 pm she was informed that the patient was fully dilated, the fetal heart rate was normal by then and patient was shifted to delivery room at 09:45 pm. It took 15 to 20 minutes in shifting after which at 09:50 pm the lowering trend of heart rate was noted. Once the heart rate lowering trend was noted, the on duty doctor stopped Inj. Sinto and gave oxygen to the patient with which the heart rate had improved.

22. The Respondent further stated that after about 10 minutes she was called again to come as the heart rate was again dropping. She reached the delivery room and immediately decided to perform C-section. C-section was performed and male baby was delivered. Respondent further stated that after delivery of the baby there was still bradycardia and the baby didn't cry. The Expert inquired the Respondent if the fetal scalp sampling was done or not to which she responded that they do not have the said facility at the hospital.

23. The Committee inquired from the Respondent as to why the neonatologist was not called in the theatre to which she responded that as this was an emergency case and a 4th year PG trainee doctor from neonatology was present.

24. The Expert asked the Respondent as to why there is no CTG record in the second stage. The Respondent stated that those 10 to 15 minutes were very crucial as it became an emergency situation and that there was no time to perform CTG. The Committee showed concern over not performing CTG in already established bradycardia.

25. The patient stated that she was too much stressed about cord around neck but the Respondent has not explained anything about it nor had the Respondent given the best choice as C-section. The Respondent after the first examination at time of admission never examined again. She further added that nothing was told to them. It was the duty of her consultant to explain everything.

26. The Committee enquired from the Respondent about communication with the patient and the family as it appeared that the parents were not communicated to properly and made aware of the exact situation. The Respondent stated that the PG Trainee had explained each and everything to the Complaint in detail, and once the procedure was completed she personally visited the Complainant who was sitting in room with his other kid and told him the whole scenario, as well as about the low APGAR and intubation.

27. The Committee asked the Respondent if she visited the patient after the operation, to which she responded that she visited the patient as the patient was admitted for two days. The first visit was on the morning of first post-op day and second visit was on the evening of first post-op day.

28. The Committee asked the Complainant about his actual grievance to which the Complainant stated had the Respondent doctor timely briefed them about the C-section their child could have been saved. He further added that there was lack of communication/counseling.

29. The Committee asked the Respondent doctor if she accepts the fact that it was a mistake at her end by not communicating properly with the patient to which she responded that she did the best to her abilities.

VI. EXPERT OPINION BY BRIG (R) PROF. DR. AMBREEN ANWAR

30. Dr. Ambreen Anwar (Gynecologist) was appointed as expert to assist the Disciplinary Committee. The salient points of the expert opinion are as under:

"Evidence:

1. Cord around the neck on ultrasound is not an unusual finding. The baby wriggles out of cord, as it keeps on swimming in the amniotic fluid. This condition does not mandate elective cesarean section.
2. During labor patient was continuously monitored by sonicaid and fetal hearts remained fine. Patient herself is witness to the fact.
3. Vaginal examination was not required by the senior-most doctor as labor was progressing normally.
4. The time between onset of fetal bradycardia and cesarean section was only 30-40 minutes which is very brief to end up in this degree of distress. Cord gases or neonatal arterial blood gases are not available in the records.

5. Overall management seems according to the guidelines.
6. However, the communication of respondent prior to the incident, and after the operation regarding queries of the couple (which was their right/ right to know basis) was sub optimal. This breech of communication led to the Complaint.

Opinion:

1. No clinical negligence, but sub optimal communication and lack of empathy is evident, leading to rightful resentment of the Complainants.
2. Dr. Jahan Ara be advised accordingly".

VII. FINDINGS AND CONCLUSION

31. At the outset the Committee has taken notice of the legal objections raised by the Respondent in her written reply. As far as objection regarding, instant disciplinary proceedings in presence of decision of PHCC, jurisdiction of PHCC to refer the case to erstwhile PM&DC and election of forum by the Complainant are concerned it is important to note that PHCC established under section 3 of the Punjab Healthcare Commission Act, 2010 is a provincial regulatory body which is mandated to improve the quality of healthcare services and to ban quackery in all its forms and manifestation. The preamble of the Punjab Healthcare Commission Act, 2010 is very clear about the mandate provided to the Punjab Healthcare Commission. The said provision is reproduced hereunder:

Whereas it is expedient to provide for establishment of the Punjab Healthcare Commission, to make provisions for the improvement of quality of healthcare services, to ban quackery in all its forms and manifestations and to provide for ancillary matters;

32. The Punjab Healthcare Commission Act regulates the healthcare environment which includes regulating the healthcare establishment and the services. The Punjab Healthcare Commission is mandated to ensure that all those in the business of providing healthcare are following the prescribed standards and are working towards improving the health of the people.

33. On the other hand, being successor of the PM&DC the Pakistan Medical Commission constituted under section 3 of the Pakistan Medical Commission Act, 2020, is fully mandated to regulate and control the medical profession. Hence any person professing to be a medical or dental practitioner must be recognized/ registered and licensed with the Pakistan Medical Commission under the

Pakistan Medical Commission Act, 2020. Section 32 of Pakistan Medical Commission Act, 2020 provides among others a procedure for disciplinary proceedings against a registered medical/dental practitioner. The said section empowers the Disciplinary Committee of Pakistan Medical Commission to initiate and decide the disciplinary proceedings against a registered medical/dental practitioner on a Complaint of any person or authority or of its own motion on information received. It needs to be highlighted here that previously under the PM&DC Ordinance 1962, similar provisions were contained in Pakistan Registration of Medical and Dental Practitioners Regulations, 2008 ("Regulations").

34. It is reiterated that the Pakistan Medical Commission Act, 2020, regulates the medical and dental profession meaning thereby that it governs the conduct of individuals licensed by the Commission to practice as a doctor or dentist in Pakistan. The Pakistan Medical Commission Act, 2020 does not regulate any of the healthcare services or establishments which will be used by the medical or dental practitioners during the process of providing medical or dental services. Hence the PMC Act, 2020 clearly does not regulate clinics, dispensaries and diagnostic centres or testing procedures or any other related area which forms part of the ambit of healthcare services as defined under the Punjab Healthcare Commission Act, 2010. The mandate of the Pakistan Medical Commission is quite distinct from that of the Punjab Healthcare Commission and the argument that since the Punjab Healthcare Commission has conducted investigation into the instant Complaint and passed an order therefore, proceedings before the Disciplinary Committee of PMC are hit by principle of res judicata is sheer misinterpretation of law. PHCC certainly lacks jurisdiction to the extent of individual practitioners and that is the reason PHCC after conducting investigation referred the matter of Respondent doctor to the concerned regulator of medical profession who has exclusive jurisdiction to look into matters pertaining to professional negligence and misconduct of a medical and dental practitioner. It is noted that the PHCC in its finding recorded that the Respondent doctor "*had been deficient in discharging her duties*". In view of the jurisdiction of the PHCC as explained above, this finding when read with the further direction referring the matter to the Commission, must be read as a *prima facie* finding rather than a finding of fact. Therefore, legal objections of the Respondent doctor as to election of forum by the Complainant by filing compliant before PHCC, jurisdiction of Disciplinary committee to hear

instant matter after conclusion of enquiry and passing order by PHCC and further referring the matter to PMDC do not merit consideration.

35. As for the other objection of the Respondent that the procedure laid down in Section 32 of the PMC Act, 2020 has not been followed in her case and that the Complaint was required to be disposed of within 90 days as provided under section 32, it is a matter of record that the Complaint against the Respondent was submitted before the Registrar of the erstwhile PM&DC on 22.07.2019. On receipt of Complaint as per the procedure applicable at that time, a copy of the Complaint was forwarded to Respondent Dr. Jahan Ara vide Notice dated 08.8.2019 for her comments/reply. Thereafter, reminders dated 18.06.2020, 20.08.2020 and 04.09.2020 were issued to Respondent Dr. Jahan Ara directing her to submit her reply/comments however she failed to do so. The Committee observes with concern that such conduct of the Respondent who is a senior practitioner is highly unbecoming and objectionable. Furthermore, the Respondent cannot seek relief on the basis of time when she herself was deficient in responding to repeated notices.

36. Even otherwise, since the Complaint against the Respondent was received prior to coming into force of the PMC Act, 2020, therefore the argument that procedure of Section 32 of PMC Act, 2020 has not been complied with has no merits. The Complaint had been processed as per the then applicable law and the procedure laid down thereunder. The Disciplinary Committee of Pakistan Medical Commission took cognizance of all pending disciplinary proceedings and decided to hear and conclude all such pending cases including the complaint against the Respondent doctor.

37. After perusal of the record and statements of parties the Disciplinary Committee has noted that wife of the Complainant Dr. Madiha, 29 years old, G2P1A visited Respondent Dr. Jahan Ara on 19.06.2019 for checkup and delivery. Her EDD was 24.06.2019. Ultrasound Report dated 18.06.2019 mentions *"Cord seen around the neck at present"*. Dr. Jahan Ara advised admission in labor room on 20.6.2019 for induction.

38. Next day i.e. 20.06.2019, the patient was admitted for induction of labor at 39+3 weeks. At the time of admission CTG of the patient was performed and FHR was recoded as 140-148

beats/min. P/V findings at the time of induction were OS-1.5 cm, Cx Soft, posterior full length, Vx-3, membrane intact. Patient was given ½ tab Breeky sublingual at 10:00 AM for induction of labor.

39. At 03:00 pm Pelvic examination was repeated and findings were OS 2cm, Cx-soft, 50% effaced, artificial rupture of membranes done, clear liquor drained. At 03:15 PM, Dr. Jahan Ara visited the patient.

40. Pelvic examination repeated at 08:30 pm and it was noted that OS 5cm Cx-70% effaced and Vx -2/-1. At 09:30 PM the patient was fully dilated, cervix fully effaced and FHR was 140-149 beats/ min. At 09:30 PM, Dr. Jahan Ara was informed by labor room duty doctor that patient was fully dilated. Meanwhile around 09:45 PM the patient developed fetal bradycardia. FHR was recorded as 100-110 beats/ min. O2 inhalation & plain Ringer was administered. At 09:55pm, FHR was recorded as 72-85 beats/min, persistent bradycardia was noted and it was decided to conduct emergency C-Section.

41. Consent was obtained at 10:05pm which was signed by the patient and her mother. Respondent Dr. Jahan Ara performed the surgery which started at 10:10pm and completed at 11:15pm. The indication for emergency C-Section was mentioned as fetal distress. As per operation findings baby was delivered as cephalic at 10:25 PM (head Right Occipital-transverse), complete delivery of placenta and membrane. Tight loop of cord around the neck. Baby's APGAR Score was 4/10.

42. The baby was shifted to nursery. As per receiving notes baby received from OT, 3.6 Kg, APGAR 4, 6. ETT was passed- on Ambo-baging, put on ventilator. The baby was seen by Consultant Dr. Ashraf Sultan. Later on, the Complainant requested to change the Consultant and put the baby under care of Dr. Naeem Zafar. The baby remained in critically sick condition on ventilator for 8 days and passed away on 28.06.2019. As per death certificate cause of death was ANN, Pulmonary hemorrhage and sepsis.

43. The Committee has noted that the Complainant has alleged that they were never explained about the risks of normal delivery associated with cord around neck, Dr. Jahan Ara never examined the patient throughout the day though she visited her around 02:00 pm for round. There was no

continuous CTG monitoring to assess the fetal heart during labor. Dr. Jahan Ara responded late to emergency. She never communicated a single word regarding the ominous status of the baby before or even after delivery. She visited family post-delivery in the room and told them that everything was fine.

44. As for the allegation of the Complainant that the Respondent Dr. Jahan Ara didn't pay attention to the cord around neck of the baby as well the complication that may be faced in a normal vaginal delivery in such cases and told the Complainant that the patient will go with a normal vagina delivery, it is clarified that cord around the neck is not an indication to opt for C-Section straight away. Cords are common and occur in about 15-35% of pregnancies. Often, cords do not impact pregnancy outcomes and babies are born safely with multiple loops of cord around their necks through normal delivery. Therefore, the allegation that Respondent doctor delayed the C-Section is not tenable and that too in a private set-up. However, it was an obligation of Respondent doctor to explain to patient about the risk associated with normal delivery in the given circumstances so that the parents could take an informed decision.

45. It has been noted that as per record there are two visits of the Respondent doctor on 20-06-2019; first visit was around 12:00 pm and the other at 03:15 pm. The record further reveals that the patient was being monitored by PGR who documented the whole labor progress and in such scenario when the labor was progressing normally the Respondent doctor instead of examining the patient took briefing from the doctor monitoring the labor and left. It is also a matter of record that periodic pelvic examination of the patient was done by Dr. Tayyaba and Dr. Uzma. FHR was continuously monitored and recorded throughout the day which is also well documented.

46. The record further reveals that bradycardia was noticed at 09:50 to 09:55pm and it was decided to conduct emergency C-Section. Consent was signed at 10:05pm and C-Section was started at 10:10 pm. The average response time in such emergencies is 30 to 40 minutes.

47. The Expert gynecologist has also opined that overall management of the patient was according to guidelines, however, communication of the Respondent prior to the incident and after the operation was suboptimal. The relevant part of the opinion of the expert is reproduced hereunder:

1. *Cord around the neck on ultrasound is not an unusual finding. The baby wriggles out of cord, as it keeps on swimming in the amniotic fluid. This condition does not mandate elective cesarean section.*
2. *During labor patient was continuously monitored by sonicaid and fetal hearts remained fine. Patient herself is witness to the fact.*
3. *Vaginal examination was not required by the senior-most doctor as labor was progressing normally.*
4. *The time between onset of fetal bradycardia and cesarean section was only 30-40 minutes which is very brief to end up in this degree of distress. Cord gases or neonatal arterial blood gases are not available in the records.*
5. *Overall management seems according to the guidelines.*
6. *However, the communication of respondent prior to the incident, and after the operation regarding queries of the couple (which was their right/ right to know basis) was sub optimal. This breech of communication led to the Complaint.*

Expert Opinion:

1. *No clinical negligence, but sub optimal communication and lack of empathy is evident, leading to rightful resentment of the Complainants.*
2. *Dr. Jahan Ara be advised accordingly.*

48. The Committee has noted that the actual issue involved in the instant complaint is clear lack of counseling and communication by the Respondent doctor with patient and the family which the Complainant has termed as professional negligence and failure to exercise reasonable standards of due diligence and duty of care. The Committee would like to clarify here that professional negligence and failure to exercise duty of care are two distinct standards of ethics and entail different parameters and consequences. Professional negligence is to be tested on touchstone of competence of doctor and degree of skill expected in the treatment and procedure caried out by the doctor. On the other hand duty of care includes amongst other obligations counselling and communication with patient/attendants and are referred as clinical empathy. It is fundamental right of the patient/attendants to receive information from their physician and to discuss the benefits, risks, costs of appropriate treatment, alternatives and optimal course of action.

49. Overall management of the patient by the Respondent doctor was as per protocol and no element of professional negligence has been found in this matter, however, the Committee has observed with concern that there existed serious gaps in the patient/attendant's counselling and communication by the Respondent doctor. The patient as well as her husband (Complainant)

both are medical doctors and their Complaint to the extent of better counselling/communication carries weight.

50. Complainant submitted during the hearing that they had informed the Respondent doctor about the incident during previous delivery. They already had the same history in first pregnancy, wherein the baby had cord around neck, due to which there was prolonged labor and the then treating doctor had told that due to cord around neck the baby was cyanosed and had late cry. The patient stated that she was too much stressed about cord around neck but the Respondent did not explain anything about it nor the Respondent had given the best choice as C-section.

51. The Committee is of the considered view that although the Respondent doctor has asserted that she counselled the patient before the surgery, however such assertion of the Respondent is not supported by any notes of the Respondent and the testimony of the patient, complainant and the Respondent herself confirms that there was a serious lack of communication and counselling on the part of the Respondent doctor.

52. During the hearing when Respondent doctor was enquired about communication with patient and the family; the Respondent stated that the PG Trainee explained everything to the Complainant in detail, and once the procedure was completed she personally visited the Complainant to explain to him the whole scenario as well as about the low APGAR and intubation. Similarly, when the Respondent doctor was asked if she visited the patient after the operation, she responded that she visited the patient on the morning of first post-op day. Both parents have denied the assertions of the Respondent doctor and emphasized that they were not explained about the incident and baby's condition after surgery by the Respondent doctor.

53. The reason for dissatisfaction of Complainant and patient in this case arises due to a lack of empathy shown by the Respondent doctor to the patient/attendants. Clinical empathy is an ability to understand the personal experience of the patient and constitutes an important communication skill for a health professional. Empathy includes three dimensions; the emotional, cognitive, and behavioral. Hence, it requires skills from the practitioner to correctly understand the patient's experience and acknowledge the emotional state of the patient through cognitive processes and express it through behavior and good communication skills.

54. Being empathetic to a patient is initiated from the time that the medical practitioner is engaged with the patient, continues during the time the patient is under the medical practitioner's care and extends until the patient is no more under his/her care including referral/transfer of a patient. Clinical empathy has been considered as a main component of patient-doctor relationship in all developed jurisdictions. General Medical Council, UK in its publication "Good Medical Practice" dictates the practitioners, from the initial engagement and during the course of the patient being under the doctor's care, to listen to the patients, give the information that they need to know, furthermore, being considerate to those close to the patient. Particularly, when a situation arises when a critical decision has to be taken or when informed consent is needed during patient's treatment, doctors' must be accessible to patients. The same holds true as a standard expected of medical practitioners in Pakistan.

55. Empathetic physicians share understanding with patients, which serves to benefit the patient in their physical, mental and social well-being. Both a practitioner's ability to provide empathetic care as well as a perception of this care by the patient are important in diagnosis and treatment. Practicing empathy in a clinical setting leads to greater patient satisfaction, better compliance and fewer professional negligence complaints/litigation.

56. Empathy is one of the fundamental tools of the therapeutic relationship between the carers and their patients and it is a well-founded principle in foreign jurisdictions and the superior courts of Pakistan have also enlightened upon the issue in various dictums. The August Supreme Court of Pakistan in its judgement reported as 2015 SCMR 663 while referring to decision of the UKSC; Montgomery vs Lanarkshire Health Board has observed and held as under

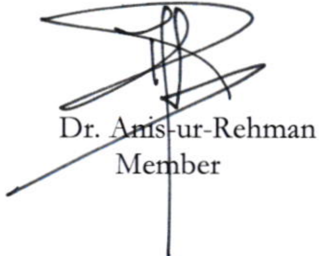
> *"... 85. It is also true that the doctor must necessarily make a judgment as to how best to explain the risks to the patient and that providing an effective explanation may require skill ...*
>
> *90. secondly, the doctor's advisory role involves dialogue, the aim of which is to ensure that the patient understands the seriousness of her condition and the anticipated benefits and risks of the proposed treatment and any reasonable alternatives, so that she is then in a position to make an informed decision."*

57. An empathetic professional comprehends the needs of the health care users, as the latter feel safe to express the thoughts and problems that concern them. Although the importance of empathy is undeniable, a significantly high percentage of health professionals today seem to unfortunately find it difficult to adopt a model of empathetic communication in their everyday practice. A patient and their family expect rather demand absolute honesty and blunt truth from their health care provider albeit communicated in an appropriate manner and matters explained in detail specially to a bereaved family to enable them to understand the reasons and at the end accept one of the most difficulty losses of a loved one. Life as per our unquestionable faith belongs exclusively to Allah Almighty and He alone determines when each of us are to return unto Him. Yet for those left behind the healthcare providers are seen as messiahs who alleviate our pain and disease albeit with the amazing grant of the gift of 'shifa' unto them by Allah Almighty and are in addition the providers of solace and closure in such difficult times. It is unfortunate that a large number of medical practitioners have put one of the most fundamental pillars of medical practice; empathy and due care, to one side. Whether this is due to it not being properly communicated to medical students and young doctors by their teachers or it has been sacrificed in return of accepting a higher number of patients or elective cases by doctors hence reducing the time required to give to each patient, it is an important aspect of practice which needs to be urgently attended to and rectified.

58. The Committee in this case on the basis of evidence is of the considered view that had the Respondent Dr. Jahan Ara adopted a more proactive approach in counselling the patient/attendants and taken them into confidence regarding the developments both before and after the procedure the instant complaint may not have arisen in the first place.

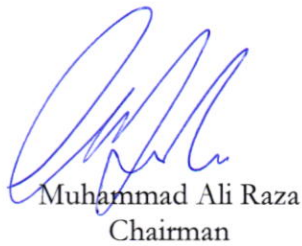
59. In view of the above discussion and after considering the statements of parties, medical record and the Expert opinion the Committee concludes that no case of medical negligence has been established against Respondent Dr. Jahan Ara. The Committee, however, finds that Respondent Dr. Jahan Ara failed to show empathy and in doing so a lack of duty of care occurred on her part. It is compounded by the fact that the Respondent is a senior consultant and is expected to lead by example for the young doctors training under her or working alongside her. On such count

the Respondent Dr. Jahan Ara is issued a warning and any future complaint of similar nature if established shall result in imposition of a penalty.



Dr. Anis-ur-Rehman
Member

Dr. Asif Loya
Member



Muhammad Ali Raza
Chairman

20th July, 2022