BEFORE THE DISCIPLINARY COMMITTEE OF PAKISTAN MEDICAL COMMISSION

In the matter of

Complaint No. PF. 8-1983/2021-DC/PMC

Irfan Saleem Vs. Dr. Shahadat Hussain

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

Present:

Irfan Saleem	Complainant
Dr. Shahadat Hussain (28483-P)	Respondent
Brig. (R) Prof. Dr. Qasier Khan	Expert (Cardiology)
Hearing dated	04.06.2022

I. FACTUAL BACKGROUND:

1. Mr. Irfan Saleem (hereinafter referred to as the "Complainant") filed a complaint on 06.08.2021 against Dr. Shahadat Hussain before the Disciplinary Committee of Pakistan Medical Commission. It was alleged in the complaint that the Complainant's brother was advised angiography by Dr. Shahadat Hussain (hereinafter referred to as the "Respondent"), however angioplasty of patient was caried out on 09-08-2019 without consent of the family. Further, severe post op complications occurred and the patient died on the same day. Initially, the Complainant

investigation in the complaint referred the case to the Pakistan Medical Commission for disciplinary action against the Respondent Dr. Shahadat Husain. The Complainant requested that in view of decision of Punjab Healthcare Commission strict action be initiated against the Respondent.

Findings of Punjab Healthcare Commission

2. The Punjab Healthcare Commission after investigating the matter decided the same with the following observations:

21. after careful perusal of the record, thorough deliberations, considering the oral as well as documentary evidence and hearing the parties, the Board of Commissioners (the Board) has noted that mishandling of the case at the hands of Dr. Shahadat Hussain stands established.

We therefore direct that the case of Dr. Shahadat Hussain be sent to Pakistan medical Commission (PMC) for appropriate action, in accordance with law. …"

II. SHOW CAUSE NOTICE

3. In view of the allegations levelled in the complaint and reference of Punjab Healthcare Commission, a Show Cause Notice dated 22.09.2021 was issued to the Respondent Dr. Shahadat Hussain mentioning the allegations in the following terms:

4. ***WHEREAS,*** *in terms of reference of PHCC, Complainant brought his brother Mr. Rizwan Saleem to new Cardiac Center Bahawal Victoria Hospital on 07.08.2019 at 10:30 pm, where he was advised angiography, where you were the treating doctor. On 09.08.2019, the patient gave consent for angiography only and you assured that if angioplasty is required the same would be conducted after informing/ consent from the family/ attendants; and*

5. ***WHEREAS,*** *in terms of reference of PHCC, the patient was carried to the operation theater/ lab and after about one and half hour the patient was brought out of the lab and it was told to the family that a vein was blocked and two stents had been implanted (without consent). At around 1:20 pm the procedure completed, patient was shifted to CCU and consequently severe post op complications occurred and that patient died on 4:19 pm on the same day; and*

6. ***WHEREAS,*** *in terms of reference of PHCC, you did the angioplasty of the patient without due consent of the family / attendants and performed a major surgery / procedure. That you failed to foresee the possible post*

op complications. You failed to extend counseling session of the patient family. You failed to take consent of the patient family before the procedure / surgery; and

7. ***WHEREAS,*** *in terms of facts mentioned in the reference of PHCC, it is failure on your part to fulfill your professional responsibilities towards your patient. Such conduct is a breach of Code of Ethics in general and specifically Regulation 21(5)(d), 22, 34 read with Annex-III and Regulation 50 of Code of Ethics amounts to professional negligence / misconduct...."*

III. REPLY TO SHOW CAUSE NOTICE

4. In response to Show Cause notice, the Respondent submitted his reply on 07.10.2021 wherein he contended that:

a) *On 09.08.2019, I attended the Patient and advised rescue/emergency PCI because patient was young, chain Smoker and had ongoing ischemia. My staff told me that patient initially refused the procedure but later consented. My pre-Angio team had taken consent from the patient which was signed by an advocate (who showed to be brother of Complainant but was actually not). During procedure we discussed with the patient about the stents to which he replied that the consent has already been given at the start.*

b) *There was a tight lesion in the left circumflex artery and 2 DES were put in. As per ECG suspicion of lesion was in LAD but it was in the left circumflex. After PCI, ECG changes in the anterior lead were improved. I came out of the Cath and seeing brother of Complainant, Irfan Saleem, told him about the stents to which he said OK.*

c) *Afterwards, I checked up the patient in CCB Emergency and talked to him. He was stable, relaxed and thanked me with a smile. After performing Jumma prayers, I myself checked from* Dr. Majid SR who sent me the ECG through whatasapp and informed that patient had developed tachycardia, to *which I advised medicine.*

d) *Dr. Majid called me again and I reached in 15-20 minutes and checked the patient but found nothing significant except hypotension and tachycardia. There were no signs of retroperitoneal bleeds either and I advised I/V to which patient's heart-rate and blood pressure improved.*

e) *I then counselled six (6) attendants of the patient and tried to get further history of the patient from them. One Saeed Aziz and the brother of the patient asked more questions from me but I did not find present Complainant there. I left for my home, but reached hospital again after 15-20 minutes due to a telephonic call. CPR was started when I arrived but in spite of all efforts the patient expired.*

f) *Cause of death was not Non-ST acute coronary syndrome. The concern regarding the CBC Report dated 09.08.2019 showing HB as 2.1g/dl is wrong and all these stories have been developed after the post procedure blood report which was a dilutional effect or Lab error because it did not correlate with scientific and clinical evidence. This Report not only misguided the relatives of the patient but also our doctors and the Inquiry officers.*

g) *The average adult blood volume represents 7% of body weight (70 ml per kg body weight). Estimated blood volume (EBV) for 70 kg person is approximately 51. Massive hemorrhage may cause loss of total EBV within 24 hours or loss of half of the EBV in 03 hours. When volume losses are not replaced during*

hemorrhage, hemoglobin concentration will remain constant. In the case of Rizwan when a blood sample is taken I/V fluid just started. So without many liters' fluid replacement his hemoglobin should not drop so much.

IV. REJOINDER

5. Reply received from the Respondent doctor was forwarded to the Complainant for his rejoinder. The Complainant submitted his rejoinder dated 10.03.2022 wherein he contended that:

   a) *The patient underwent a simple procedure, where there is no room for complication, unless gross negligence is committed. Further, the blood report of the patient was concealed even from the Punjab Healthcare Commission.*

   b) *The respondent obtained consent from patient during the procedure and himself admitted that seeing the worsening condition of the patient, he inquired about patient's medical history from the attendants. The respondent did not attend the patient even when his condition worsened and had left the patient when he visited him after Jumma prayers.*

V. HEARING

6. After completion of codal formalities the matter was fixed for hearing before the Disciplinary Committee on 04.06.2022. Notices dated 18.05.2022 were issued to the Complainant as well as Respondent directing them to appear before the Disciplinary Committee on 04.06.2022.

7. The Complainant as well as Respondent Dr. Shahadat Hussain appeared before the Disciplinary Committee on 04.06.2022.

8. The Disciplinary Committee asked the Complainant about brief facts of the event that took place and especially the allegation leveled that mishandling took place during the procedure. The Complainant stated that all these facts have already been established in the Punjab Healthcare Commission and after a detailed deliberations the Punjab Healthcare Commission has given their decision, in which it is clearly mentioned that mis-handling has been established and therefore, referred the case to Pakistan Medical Commission for necessary action.

9. The Disciplinary Committee enquired the Respondent Doctor regarding the event that took place. The Respondent doctor stated that the patient was admitted through Emergency section on the

night between Wednesday and Thursday. Patient remained admitted on Thursday having recurrent chest pain / un-easiness of chest. The Respondent further stated that there are two procedures in hospital which are free of cost in Emergency; one is rescue PCI and other is primary PCI. The Respondent doctor further stated that Friday was his Cath day/Emergency day. Patient was shifted from ward to Emergency. During the round he advised the patient that he is a young patient with recurrent chest pain and that he needs angioplasty with Cath which is a procedure of 15 to 20 minutes. The said patient was advised with rescue PCI.

10. Respondent doctor added that in their hospital there is a team of professionals who are equally involved in management of the patient's procedures and it is not done alone by the professors or unit in-charge. The first team is involved in bed side management in Emergency and they also take consent in Emergency/pre-Angio. In the subject case consent had been signed by a friend of the patient. The patient once received in Cath lab, the senior registrar and Cath team verify the document and directs regarding the procedure which has to be carried out. In the subject case, the consent form was counter signed by AMS stating that this is emergency procedure and should be expedited. The Respondent doctor also referred to notes of doctor who prepared pre-Angio documents after perusal of complete record and after discussing with patient, which is countersigned by Senior Registrar. The Respondent further stated that when he was informed that the said patient has consented for the procedure, only then the procedure was started.

11. The Disciplinary Committee inquired from the Respondent doctor regarding the investigation performed after admission of the patient to which he responded that various ECG's were performed which showed bi-fid pattern, i.e. high risk of Left Anterior Descending Artery (LAD). However, when angiography was performed it was not LAD. Respondent further stated that during angiography the condition usually varies from what is expected. The angioplasty and angiography are usually performed together and likewise the pre-Angio form/documentation was filled.

12. The Respondent doctor submitted that Dr. Tariq Abbas HOD also visited to see the patient on the request of patient. After discussion with Dr. Tariq Abbas, two stents were placed and

procedure was completed at 1:20pm and patient was shifted to CCU. Respondent stated that while going out of Cath lab it was the first time when he met Complainant (brother of patient), and that he never saw him before. Respondent further added that the patient was shifted and after changing OT dress he visited the patient at bed side, talked to the patient in a pleasant mood and then left for home as he was off duty by then.

13. Responding to another question the Respondent stated that he called senior registrar to ask about another patient who had some complications and he was informed that rest of the patients were fine but this particular patient was having hypotension, tachycardia and uneasiness. Senior Registrar shared ECG on whatsapp and he reached hospital within 20 minutes, examined the wound site, palpated abdomen, examined neck and eyes (for any bleed/peritoneal bleed) which were already examined by the SR. At that time Dr. Tariq HOD was also present who is a family friend of the patient. Also, a general surgeon was present and his advice was also sought as a general surgeon can easily pick up if there is any peritoneal bleed. The patient was treated symptomatically. His blood pressure and heart rate were normalized.

14. The Respondent further stated that after doing management of the patient he went to his office where 8-10 family members of the patient followed him. He briefed them about the status of the patient and treatment provided. He remained in contact with SR and when the patient was stabilized he left for home. The Respondent further stated that he was on way back home when he received call from SR that patient's condition is serious so he rushed back to hospital to see the patient. Upon reaching the hospital two other SR (FCPS Cardiology) were also on bed side for management of the patient. The patient was having Ventricular Fibrillation and shock. CPR was performed but he couldn't revive and died on 4:19pm.

15. Respondent stated that he received a call from his SR at 6:00pm to inform about the reports of the blood sample sent to lab on 3:00 pm which showed Hb as 2.1g/dl. Respondent further added that 2.1g/dl of Hb is not possible in a person well oriented with time, place and person.

16. The Disciplinary Committee inquired the Respondent doctor as to what other reason could have caused the drop of Hb to 2g/dl, to which he responded that the report was result of dilutional effect and scientifically such severe / abrupt drop of Hb is not possible.

17. The Disciplinary Committee asked Complainant if he want to add anything to which he responded that his younger brother had chest pain at 10pm, and he took him to hospital emergency. The patient remained in emergency overnight and seen by Dr. Tariq Abbas in the morning who advised angiography after seeing the investigations. Complainant stated that initially they refused the angiography but after getting information about Dr. Tariq Abbas they agreed for the angiography. The Complainant further submitted that he visited Dr. Tariq Abbas at his private clinic in the evening to discuss about the angiography and if all the facilities were available in the said facility and he was fully satisfied with the well-equipped facility. Further, Dr. Tariq promised that he will supervise the procedure therefore he visited the patient during procedure.

18. He further stated that they opted only for angiography and not for angioplasty. The consent form was signed by friend of the patient in a rush and that they were not briefed about it. The normal angiography procedure takes 15-20 minutes, whereas in this case the procedure took 1 hour and 20 minutes. As soon as the patient came out of Cath lab, family was informed by the Respondent doctor that stents has been placed upon which there was some argument but due to stressed condition the matter was not discussed in detail.

19. The patient was carried to cardiac emergency but the patient was not feeling well since then. The Respondent doctor was called and briefed about the condition of the patient but the response of the Respondent was very casual as he tried to manage the medications of the patient on WhatsApp and reached back to hospital at 3:30pm. Complainant stated that there was blood on wound site which was seen by the Respondent doctor and he told that the dresser will change the dressing after Juma prayer which was also very casual way of handling such a serious patient.

20. The Committee inquired the Respondent doctor that when the blood sample was sent to lab, to which he responded that it was sent between 2:50 and 3:00 pm because when he reached hospital

at around 3:00 pm he was informed that the blood sample has already been sent. He further added that he received the results of the said blood sample around 6:00 pm.

21. The Committee asked the Respondent doctor about the most likely cause of death in this case, and if any complications happened/seen during the procedure. The Respondent submitted that in this patient the Thrombolysis in Myocardial Infarction (TIMI) score was 5. With this TIMI score there are 41 % chances of cardiac events during hospitalization and the mortality rate in 14 days is 26 %. Respondent further added that the stenosis was on such a site which cannot cause death even if it was totally blocked. The most likely cause of death in this case is Non-ST Elevation-Acute Coronary Syndrome (NSTE-ACS).

VI. EXPERT OPINION BY BRIG (R) PROF. DR QAISAR KHAN

22. Brig (R) Prof. Dr. Qaisar Khan (interventional cardiologist) was appointed as an Expert to assist the Disciplinary Committee in the instant complaint. The Expert opined as under:

"After thoroughly reviewing the document's and relevant investigations at the time of admission, before and after the procedure. I have come to the conclusion as:

- *He performed PCI on the patient which was appropriate keeping in line the aim to provide relief to the patient. this rescue PCI procedure was free of cost as per govt policy's, so no element of greed was present.*
- *Prof shahadat Hussain Chaudhry is well qualified and trained with vast experience in Interventional Cardiology.*
- *Dr. Shahadat performed the procedure after receiving the informed and signed High risk consent from the patient.*
- *The routine lab report received which revealed a HB level of 2g/ dl,this report was received in system without any emergency highlight and after the death of the patient. In my opinion this was a faulty report and should have been immediately repeated. Since the stated Hemoglobin level is not compatible with life, indicating most likely Hemodilution.*

- *The cause of death in this case appears to be a fatal arrhythmia, which is a common complication of [illegible] ST elevation Myocardial Infarction, regardless of PCI procedure.*

Final Conclusion:

- *No element of Professional Negligence was found in the present case.*
- *It was a very unfortunate event and my deep condolence towards the family of the deceased.*
- *However, there seemed to be a lack of communication between the attendants and the treating team.*
- *My advice to Prof Shahadat Chaudhry, he needs to show more empathy and sympathy towards the patients and their relatives.*

VII. FINDINGS AND CONCLUSION:

23. The Disciplinary Committee after perusing the record and statements of parties has noted that on 07.08.2019 the Complainant's brother Mr. Rizwan Saleem ,38 years of age, was brought to Cardiac Emergency of Cardiac Center Bahawal Victoria Hospital, Bahawalpur with chest pain and shortness of breath. The patient was provisionally diagnosed with NSTE, ACS (Acute Coronary Syndrome) and admitted for observation and further investigations.

24. Next day i.e. on 08.08.2019, different investigations were conducted and as per reports the patient's HB was 12.4, WBC 16.89x103/ul, Urea 53 g/dl and creatinine 1.6. Urea and creatinine were slightly raised. The patient was attended by Dr. Tariq Abbas who according to the Complainant advised Angiography.

25. Respondent Dr. Shahadat Hussain examined the patient on 09.08.2019 in Emergency during the round. He advised rescue/emergency PCI (Percutaneous Coronary Intervention) in view of young age, chronic smoking and ongoing ischemia of the patient. As per statement of the Respondent the attendants initially showed some reluctance for the procedure however they later decided to undergo the procedure.

26. The Disciplinary Committee has further noted that a printed consent form was signed by one Mr. Asif Peerzada, who mentioned himself as brother of the patient. The Consent Form contained the permission for Angiography, Angioplasty, Pacemaker and medication.

27. The patient was shifted to the procedure room and Respondent Dr. Shahdat Hussain (assisted by Dr. Asif Ali FCPS Senior Registrar) performed the procedure. As per the Coronary Angiography

Report dated 09.08.2019 *"Non-dominant vessels. Moderate to severe proximal stenosis followed by long segment of severe stenosis in distal part"* was observed in left circumflex artery.

28. Respondent Dr. Shahadat Hussain proceeded with the Angioplasty and placed two stents. As per Angioplasty Report dated 09.08.2019.

"XB 3.5, 6F guiding catheter was placed in left coronary ostim and BMW wire was used to cross the lesion and was placed in distal LCX. Proximal LCX was directly stented with Resolute Integrity 3.0 x 12 mm Stent deployed at 16 ATM. Distal LCX was pre-dilated with Sprinter 2.0 x 15 mm balloon at 16 ATM, which was then stented with Resolute Integrity 2.5 x 30 mm stent deployeat 14 ATM for 30 seconds. Proximal LCX was then post dilated with NC Sprinter 3.25 x 09 mm balloon at 18 ATM. Final check injection showed no residual lesion at stented site and TIMI-III flow in distal LCX.

Conclusion:

Successful PCI to LCX.

Routine post PCI care"

29. After the procedure the patient was shifted to Critical Care Unit (CCU). Dr. Shahadat visited the patient in CCU and left the hospital as this was the last case of the day and he was off duty. After some time the patient started feeling restlessness and tachycardia. Dr. Majid (SR) attended the patient and advised CBC and planned ultrasound abdomen if portable machine available. Dr. Majid shared ECG of the patient with Respondent Dr. Shahadat Hussain and discussed the case telephonically. Respondent Dr. Shahadat came back to hospital examined the patient and advised to push fluids. After stabilizing the patient he left the hospital. Subsequently, the condition of the patient deteriorated again. Respondent Dr. Shahadat was informed telephonically and accordingly he arrived the hospital. CPR was underway, however the patient could not survive and was declared dead at around 04:20 pm.

30. The Disciplinary Committee has noted that the Complainant has raised two concerns; first, that they did not give consent for the procedure of Angioplasty and the Respondent Dr. performed

the procedure without informed consent. Secondly, the Complainant alleges that during the procedure the Respondent negligently ruptured some vein due to which internal bleeding occurred which led to death of the patient. In support of his allegations he referred to a CBC Report dated 09.08.2019 which shows HB of the patient 2.1 g/dl.

31. As far as the allegation to the extent of performing Angioplasty without informed consent is concerned, the Committee has noted that the consent form available on record is a printed form which contains name of procedures including, Angiography and Angioplasty. The consent was signed by a friend of the patient. The Complainant during the hearing admitted that *"the consent form was signed by friend of the patient"*. Furthermore, pre-Cath order sheet also mentions about the consent. As per the pre-Cath order sheet in the column of consent it is mentioned *"understand the procedure and signed the consent"*. The pre-Cath order sheet was signed by Senior Registrar. So the fact of consent obtained from the attendants was also endorsed and verified by the Senior Registrar.

32. The Expert in the field of cardiology has also opined that *"he performed PCI on the patient which was appropriate keeping in line the aim to provide relief to the patient. This rescue PCI procedure was free of cost as per govt policy's, so no element of greed was present. Prof shahadat Hussain Chaudhry is well qualified and trained with vast experience in Interventional Cardiology. Dr. Shahadat performed the procedure after receiving the informed and signed High risk consent from the patient"*.

33. Regarding the second allegation of the Complainant that during the procedure the Respondent doctor ruptured some vein which led to peritoneal bleeding, it has been noted that HB of the patient as per CBC Report dated 08.08.2019 was 12.1 g/dl. The procedure was performed at around 01:00 pm on 09.08.2019 and the sample for CBC was sent by Dr. Majid after the procedure at around 03:00 pm i.e. about two hours after the procedure. It is important to mention here that such a sharp decline of HB of the patient as 2.1 g/dl in a short interval of two hours is scientifically not possible. The only possibility of the CBC Report dated 09.08.2019 is dilutional effect. It is a common phenomenon that in some cases due to dilutional effect the lab report can be affected. The normal course adopted by labs in such danger line results is that the lab sends request for fresh sample to verify the result which was not done in this case.

34. The Expert cardiologist has also mentioned in his opinion his concern about the result shown in CBC Report dated 09.08.2019 in the following manner:

> *"The routine lab report received which revealed a HB level of 2g/dl, this report was received in system without any emergency highlight and after the death of the patient. In my opinion this was a faulty report and should have been immediately repeated. Since the stated Hemoglobin level is not compatible with life, indicating most likely Hemodilution."*

35. Therefore, allegation of the Complainant regarding rupture of vein and blood loss and negligence of Respondent during the procedure is not established. As discussed above the result of that lab report was a result of dilutional effect. Furthermore, the Expert in his opinion has clarified regarding the probable cause of death that "*this case appears to be a fatal arrhythmia, which is a common complication of Non-ST elevation Myocardial Infarction, regardless of PCI procedure.*

36. However, the Disciplinary Committee has noted with concern that in this case although the procedure was upto mark and the Respondent doctor was qualified to perform the same, yet the attendants left complaining about all the events. The reason for dissatisfaction of attendants in such cases is lack of empathy shown by the doctor to the patient/attendants. Empathy is one of the fundamental tools of the therapeutic relationship between the practitioner and their patients and its contribution is vital to better health outcomes and patient/attendants' satisfaction. It is also an immense tool in a medical practitioner's armory as it allows the practitioner to detect and recognize the patients' experiences, worries, and perspectives. It strengthens the development and improvement of the therapeutic relationship between the two parts i.e. the healthcare service provider and the healthcare service user.

37. 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 out 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 seen as messiahs who alleviate our pain and disease albeit with the amazing grant of the gift of 'shifa' unto them by Allah Almighty are in addition the providers of solace and closure in such difficult times. The Committee in this case is of the considered view that had the Respondent Dr. Shahadat Hussain adopted a more proactive approach in counselling the 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.

38. 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. Shahadat Hussain. The Committee, however, directs the Respondent Dr. Shahadat to show more empathy and sympathy to his patients and being a teacher inculcate these valuable tools in his students. Hence, the instant complaint stands disposed of.

Dr. Anis-ur-Rehman
Member

Dr. Asif Loya
Member

Muhammad Ali Raza
Chairman

20th July, 2022