



## BEFORE THE DISCIPLINARY COMMITTEE OF PAKISTAN MEDICAL COMMISSION

In the matter of

PF.8-1992/2021-DC/PMC

Waqas Akbar Vs. Dr. Hina Saud

Mr. Muhammad Ali Raza	Chairman
Dr. Anis-ur- Rehman	Member
Dr. Asif Loya	Member
<i>Present:</i>	
Waqas Akbar	Complainant
Dr. Hina Saud (25380-P)	Respondent
Brig (R) Dr. Ambreen Anwar	Expert (Gynecology)
Hearing dated	03.06.2022

### I. FACTUAL BACKGROUND

1. The instant matter came to the knowledge of the Disciplinary Committee through an order of the Honorable Lahore High Court, Lahore dated 02.07.2021 passed in Writ Petition No. 76126/2019 on 02.07.2021, where the Honorable Lahore High Court observed that:

*"... during the course of the proceedings it was pointed out that the Board of Commissioners of the Punjab Healthcare Commission vide its decision dated 02.09.2019 has referred the matter to Pakistan Medical and Dental Council ..."*

#### Reference from Punjab Healthcare Commission

2. Initially, Mr. Waqas Akbar (hereinafter referred to as the “Complainant) submitted a Complaint against Dr. Hina Saud (hereinafter referred to as the “Respondent) to the Punjab Healthcare Commission on 15.07.2017. The Punjab Healthcare Commission heard the complaint, where the Complainant submitted he brought the patient, 22 years of age, primigravida as an un-booked patient to the Respondent at the doctor’s hospital on 10.07.2017. The patient delivered a baby boy at Respondent’s hospital at 02:30 pm. At 03:00 pm, the patient started complaining about restlessness and dyspnea and her blood pressure started dropping. The Respondent doctor called another doctor for help who reached at 04:00 pm. The Respondent doctor asked the attendant for arrangement of blood at 04:35 pm, however, in the meantime the patient expired at 05:00 pm.
3. The Punjab Healthcare Commission conducted investigations and decided the complaint vide its decision dated 02.09.2019 and referred the matter to the erstwhile PM&DC as under:
  - a. *“Respondent Dr. Hina Saud’s case is therefore referred to PMDC for such action as deemed appropriate.”*
4. After the decision of the Punjab Healthcare Commission, the Complainant moved an application u/s 22-A and 22-B of Cr. P.C. on 15.10.2019 in which the Court directed the concerned SHO to record version of the petitioner u/s 154 Cr.P.C.
5. Respondent Dr. Hina Saud feeling aggrieved of the said order filed the above-mentioned writ petition in the Lahore High Court, Lahore which granted interim injunction (to the extent of registration of FIR) and held hearings. During the course of subsequent hearings, this matter came to the knowledge of the Pakistan Medical Commission on 02.07.2021.

## II. SHOW CAUSE NOTICE

6. In view of the above-mentioned order of the Honorable Lahore High Court and reference of Punjab Healthcare Commission, Show Cause Notice dated 24.08.2021 was served to Dr. Hina Saud in the following terms:

4. *WHEREAS, in terms of the reference of PHCC, Complainant brought his wife, Mst. Maria Anjum, 22 years, primigravida to Al-Falah Hospital, Mandi Bahauddin between 11:00-12:00 noon on 10.07.2017, where you were the attending doctor. The patient was admitted on 12:15pm and labour was augmented. Her HB was 9.4gm/dl. She delivered a baby boy at about 02:30pm through SVD with episiotomy; and*
5. *WHEREAS, in terms of the reference of PHCC, after the delivery at about 03:00pm the patient started complaining of restlessness and dyspnea. Her B.P. started dropping. When the patient became serious you straight away instructed the attendant for arrangement of blood which shows that there was blood loss. The blood samples of the patient were handed over to the attendant at about 04:35pm for arrangement of blood. The blood arrangements were under way when the patient suddenly collapsed. CPR was done but the patient could not survive and died at 05:00pm; and*
6. *WHEREAS, in terms of the reference of PHCC, you failed to foresee blood loss during the delivery and its ultimate consequences, you would have taken all the precautionary measures including arrangement of blood beforehand; and*
7. *WHEREAS, in terms of the reference of PHCC, you are only a medical graduate (MBBS) and not a gynecologist but you pose yourself as gynecologist, which is mentioned on your prescription pad as well; and*
8. *WHEREAS, in terms of the facts mentioned in reference of PHCC, it is a failure on your part to fulfill your professional responsibilities towards your patient. Such conduct is a breach of code of ethics amounting to professional negligence/misconduct.*

### III. REPLY OF RESPONDENT DR. HINA SAUD

7. In response to the Show Cause Notice dated 24.08.2021, Respondent Dr. Hina Saud submitted her reply on 22.09.2021, wherein she stated that:
  - a. *Patient Maria Anjum, primigravida, was presented to me at 11:45AM on 10.7.2017, in active labor. She was admitted and augmented with Syntocinonin Ringer's lactate. The patient delivered a healthy baby boy N.V.D at 02:30pm (within 2-3 hours of admission). Episiotomy was stitched in layers.*
  - b. *There was normal blood loss as per routine and no post-partum hemorrhage was observed. Uterus was well contracted and hemostasis secured. While shifting the patient from the labor room she complained of dyspnea and started collapsing with low BP and weak pulse. I tried to manage the patient by giving I.V fluids and taking all the precautionary measures asked the attendant to arrange blood donors and keep them on standby. Meanwhile, the patient went into cardiac arrest, we did CPR but she couldn't survive. As the present case was a walk-in patient, I took all the necessary measures.*
  - c. *I tried to manage the patient to the best of my knowledge, as I am practicing basic gynae and obstetrics for the last 25-26 years; with a one-year experience of house job as House Surgeon in gynae and obstetrics in DHQ Hospital, Rawalpindi affiliated with Rawalpindi Medical College.*



- d. *The learned CEO of Punjab Healthcare Commission simply brushed aside the expert opinion in his findings and disregarded the expert opinion which seriously prejudiced my fundamental rights. The expert opinion of the consultant gynecologist during proceedings at PHCC gave probable cause of death was 'amniotic fluid embolism' or cardiac arrest because obvious and clear cause of death couldn't be identified in the absence of autopsy and the complainant simply refused autopsy when they were asked about post-mortem examination by PHCC during proceedings.*

#### **IV. REJOINDER**

8. The reply submitted by the Respondent doctor was forwarded to the Complainant for rejoinder. The Complainant filed his rejoinder on 07.10.2021, wherein he reiterated his earlier stance, denying the comments of the Respondent Doctor and requested to process his case further for necessary action.

#### **V. HEARING**

9. After completion of pleadings the matter was fixed for hearing before the Disciplinary Committee on 03.06.2022. Notices dated 16.05.2022 were issued to the Complainant and Respondent Dr. Hina Saud directing them to appear before the Disciplinary Committee on 03.06.2022. The Complainant as well as Respondent Dr. Hina Saud appeared in person before the Disciplinary Committee on the said date.
10. The Disciplinary Committee enquired from the Complainant regarding his grievance to which he stated that he seeks to rely on the contents of his written complaint and does not want to add anything.
11. The Disciplinary Committee asked the Respondent to briefly state her version. She stated that the patient Mariya w/o Waqas visited her on 10.07.2017 at the hospital. It was her first visit and she was not a booked patient. She was in active labor. She examined her and found her in good dilatation. She was admitted and kept in the room where she checked her. Later, the patient was shifted upstairs to the labor room. As the patient was in active labor she was induced. She was fully dilated by 02:15 pm. A female attendant of the patient arrived in the hospital about 15 minutes prior to shifting the patient to the labor room. No male member of family reported at the clinic.

12. The Respondent further stated that the baby was delivered at 02:30 pm. She resuscitated and handed over the baby to the attendant. She stitched the episiotomy and checked the patient. There was no PPH or bleeding. During the whole treatment she stayed with the patient. When they were shifting the patient from labor room, the patient complained of heart sinking, she checked her pulse which was very weak. BP of the patient was checked which was also falling. One I/V line was already maintained another I/V line was maintained immediately and injection Haemaccel was administered. The anesthetist and OTA were also called to handle the patient.
13. Responding to questions put by the Disciplinary Committee, the Respondent Dr. Hina Saud stated that after administration of ringer lactate and haemaccel the patient became stable hemodynamically. She further stated that she once again examined the patient, her uterus was fully contracted and there was no bleeding. There was no tear in the episiotomy and it was stitched smoothly. In the meantime, anesthetist arrived and he after assessing the patient informed that the patient was stable.
14. The Expert asked the respondent that whether the Oxi meter was available at the hospital to which Respondent stated that Oxi meter and cardiac monitor were available at the hospital. At that time SATS of patient were recorded as 96. She further stated that the patient had symptoms of anemia therefore, the attendants were advised to arrange blood. There is only one blood bank in Mandi Bahauddin. The husband of the patient was given sample for arrangement of blood. In the meantime, the patient again collapsed and she started feeling jerks. The patient also started having froth. The patient was on oxygen and the anesthetist advised to shift her to tertiary care hospital however the patient went into cardiac arrest. CPR was done but she could not survive. Death was declared at 05:00 pm and she herself broke the news of death to the attendants. The Respondent further stated that the attendants of the patient along with other strangers gathered in the hospital and threatened the staff.
15. The Disciplinary Committee enquired from the Respondent that as she holds basic medicine degree then why does she write gynecologist with her name? The Respondent stated that to give a message to the community that she deals in simple gynae cases, she writes gynecologist. She



further stated that C-Section cases are referred to qualified consultant gynecologist. The Expert asked the mechanism of referral to which the Respondent stated that she herself liaise with the gynecologist and guides the patient to the gynecologist.

16. The Disciplinary Committee enquired from the Respondent whether the hospital was owned by her which clarified that it is a maternity home and she owns it. She further stated that no consultant gynecologist is available at her maternity home.
17. The Disciplinary Committee asked the Complainant whether the patient had her antenatal check-up during pregnancy. She stated that the patient's antenatal check-up was done at Darul-Shifa Hospital, Mandi Bahauddin. The Expert asked the Complainant why they changed the doctor at the last moment. The Complainant stated that wife was staying at his in-laws who live near to Respondent's Hospital. Therefore, they decided to visit Respondent Dr. Hina Saud. He further stated that at the time of admission they were informed that it was a normal delivery and they will be free in an hour or so. The Complainant further raised the question that if the patient was not bleeding then why 06 bottles of blood was asked for. He admitted that he broke the doors of hospital, however, that was done to get the dead body of his wife.
18. The Expert asked the Complainant why autopsy of the deceased was not conducted, the Complainant stated that he did not want to have autopsy done.

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

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

*"No evidence of clinical negligence.*

1. *Despite patient being un-booked she was accepted in emergency as she was in labour.*
2. *Delivery was un-eventful. Both mother and baby remained fine.*
3. *As soon as condition of the patient changed to worse, anesthetic team was summoned and appropriate care was administered by them.*
4. *Most likely the cause of death is Amniotic fluid embolism, a known lethal complication of pregnancy and delivery.*
5. *Exact cause cannot be established as patient was un-booked and had no ante-natal record. Furthermore, autopsy was not agreed upon by attendant."*

## VII. FINDINGS AND CONCLUSION

20. After perusal of the record and statements of Respondent doctor the Disciplinary Committee has noted that Complainant's wife Mrs. Maria Anjum, 22 years of age, primigravida, was brought to Al-Falah Hospital, Mandi Bahauddin. On 10.07.2017. She was in active labor. The patient was not booked with Respondent Dr. Hina Saud. The patient was admitted at 12:15 pm and labor was augmented with 10 mg syntocinon in 5% D/W. Her HB was 10.0 gm/dl as per report dated 04.07.2017. The patient delivered a baby at 02:30 pm through SVD. Episiotomy and cervical tear were stitched in layers.
21. After the delivery at 03:00 pm the patient started complaining of restlessness and dyspnea. As per Respondent her pulse was weak and BP also started dropping. I/V were started, oxygen was administered and Respondent Dr. Hina Saud called Anesthetist and OTA for help. The said anesthetist arrived assessed the patient and informed that the patient was now stable. The Respondent Dr. Hina Saud advised the attendants to arrange blood. The arrangements for blood were underway when the patient collapsed again. CPR was done but she could not survive and was declared dead at 05:00 pm.
22. Further, deceased Maria Anjum was not a booked patient of Respondent Dr. Hina Saud. She had her antenatal checkup from some other hospital however at the last moment they reported to Respondent Dr. Hina Saud for delivery as admitted by the Complainant. It is also on record that when the patient started collapsing the Respondent Dr. Hina immediately called for help from anesthetist and other staff. The patient was hemodynamically stable after administration of fluids, and it was decided to shift her to tertiary care for further management but she suddenly collapsed again and died at 05:00pm.
23. The Committee has also perused the opinion of the expert sought by the Punjab Healthcare Commission during investigation of the instant complaint. The expert of Punjab Healthcare Commission opined as under:



*“Patient Maria Anjum w/o Mr. Waqas Akbar, delivered on 10.07.2017 at Al-Falab Hospital by Dr. Hina Saud.*

*Patient was an unbooked patient with Dr. Hina and presented in active labor. She delivered virginally within about 03 hours of admission with alive baby.*

*According to the record, she had no PPH. The obvious and clear cause of death cannot be identified. But according to the available record, most probable cause of death may be “Amniotic fluid embolism” or cardiac arrest.”*

24. The Respondent doctor clarified during the hearing that there was no bleeding or PPH in the procedure of patient. The Disciplinary Committee has noted that the assertion of the Complainant that there was a blood loss due to which the patient collapsed cannot be relied upon for the reason that HB of the patient before the delivery was about 10 mg/dl and in such a short time period about an hour or so it cannot drop to that dangerous line which caused death of patient. As a matter of protocol blood arrangements are made when a patient faces complication in delivery cases, however, mere asking for arrangement of blood does not necessarily mean that it was a case of hemorrhage. Moreover, there is no evidence brought on record to substantiate the allegation of blood loss. Neither the autopsy was conducted to know the actual cause of death nor any other evidence in the form of medical record has been produced. The Complainant was specifically asked during the hearing regarding autopsy which he replied that he opted not to have autopsy done.
25. The expert gynecologist who was appointed to assist the Disciplinary Committee also opined that no evidence of clinical negligence has been found in this case and most likely the cause of death in this case was ‘amniotic fluid embolism’ as known complication of pregnancy and delivery. Relevant portion of the Expert opinion is reproduced hereunder:

*“No evidence of clinical negligence.*

- 1. Despite patient being un-booked she was accepted in emergency as she was in labour.*
- 2. Delivery was un-eventful. Both mother and baby remained fine.*
- 3. As soon as condition of the patient changed to worse, anaesthetic team was summoned and appropriate care was administered by them.*
- 4. Most likely the cause of death is Amniotic fluid embolism, a known lethal complication of pregnancy and delivery.*
- 5. Exact cause cannot be established as patient was un-booked and had no ante-natal record. Furthermore, autopsy was not agreed upon by attendant.”*



26. In view of submissions of parties, documents available on record and the expert opinion, allegation of professional negligence is not substantiated and established against the Respondent doctor. Therefore, the compliant is disposed of to the extent of professional negligence.
27. Apart from the allegations in the complaint the Disciplinary Committee has noted with concern that Respondent Dr. writes with her name 'gynecologist'. It is a matter of record that the Respondent is a simple MBBS doctor and she does not hold any post-graduate/additional or alternate qualification in gynecology. As such she is not entitled/authorized to use the title of gynecologist with her name.
28. The practice of medicine and its embodiment in the clinical interactions between a patient and a medical practitioner, is fundamentally a moral activity that arises from the obligation to care for patients. This relationship between a patient and a medical practitioner is based on integrity and principles of trust and honesty, which gives rise to a duty of care and the medical practitioners' ethical responsibility to place patients' welfare above the physician's own self-interest. Medical practitioner should not therefore, misrepresent or exaggerate their qualifications or experience which amounts to fraudulently inducing the patient to agree to be treated for his/her ailment or procedure. Medical practitioners are mandatorily required to be honest about their qualifications and skills in their area of expertise when representing the same to a patient. When a medical practitioner is not truthful about their capability and qualification and rather uses innuendos to lure patients to their practice, this constitutes a clear breach of the duty of care of the doctor to the patient and such actions fall in the definition of a legally recognized offence of misrepresentation. Such behavior of practitioner is unacceptable and strictly prohibited under PMC Act 2020.
29. It is important to mention here that in terms of provisions of the PMC Act 2020, a medical or dental practitioner can represent and practice as a specialist only upon having obtained the post graduate qualification which is duly recognized and consequently registered on their license by the PMC. Medical practitioners who have been granted license to practice basic medicine or dentistry as a general practitioner cannot practice as a specialist or use specialization or consultant titles

with their names as it amounts to deceiving the general public. Section 29 of the Pakistan Medical Commission Act 2020 explicitly prohibits in this regard as under:

***Section 29. Licensing***

*“(2) A general practitioner may treat all ordinarily recognized common medical or dental ailments and shall not practice in fields or specialties, as recognized by the Commission for which formal training is required ..... No practitioner shall represent himself as a specialist or practice as a specialist without having appropriate qualifications, recognized and duly registered by the Commission. ....”*

Sub-section (8) provides:

*“(8) No medical or dental practitioner shall be permitted to represent in Pakistan as having acquired or seek to practice a specialty unless the same is duly registered on his license by the Authority. ....”*

Furthermore, Sub-section (13) provides:

*No registered licensee shall use or publish in any manner whatsoever any title, description or symbol indicating or intended to lead persons to infer that he possesses any additional or other professional qualification unless the same has been duly recognized and registered on his license by the Commission.*

30. Furthermore, to highlight the intention to restrain such deceptive conduct of medical and dental practitioners, the PMC Enforcement Regulations, 2021 categorize the false representation of qualifications as a major offence. The regulation 13, is reproduced as under:

*13. (1) a) Major offence to includes offences of false representation of qualifications, gross negligence ...”*

31. In September 2021, the Pakistan Medical Commission widely circulated through public notice on its website and newspapers and warned all medical practitioners against using misleading titles with their names which cause misrepresentation to the general public and patients as to their qualifications and skills. It was made abundantly clear in the public notice that such misrepresentation as to specialized medical and dental practice is in Violation of the Code of Ethics and tantamount to misconduct. In addition, such act is in gross violation of the PMC Act 2020 and mandates a disciplinary action against medical and dental practitioners involved in such deceptive practices.

32. In view of above discussion, the Disciplinary Committee decides to impose a penalty of PKR 50,000/- (Fifty thousand rupees only) on the Respondent doctor Hina Saud and directs her to

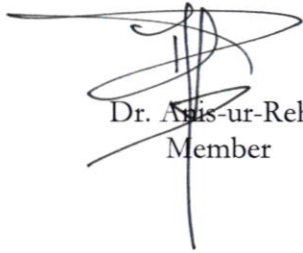
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*Decision of the Disciplinary Committee in the matter of Complaint No. PF.8-1992/2021-DC/PMC*



refrain from such violation in future. Dr. Hina Saud is directed to pay the amount of fine in the designated bank of the Commission within fourteen (14) days from the issuance of this decision and forward a copy of the paid instrument to the office of the Secretary to the Disciplinary Committee, failing which license of the Respondent doctor shall be deemed to be suspended and shall remain suspended until such time the fine is paid.

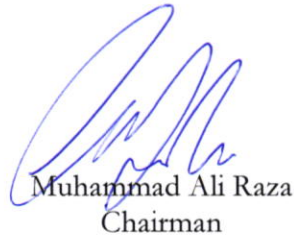
33. The subject proceedings stand disposed of accordingly.



Dr. Asis-ur-Rehman  
Member



Dr. Asif Loya  
Member



Muhammad Ali Raza  
Chairman

20<sup>th</sup> July, 2022