BEFORE THE DISCIPLINARY COMMITTEE OF PAKISTAN MEDICAL COMMISSION

In the matter of

PF.8-2068/2022-DC/PMC

Younas Imran Vs. Dr. Muhammad Shafi & Dr. Muhammad Usman

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

Present:

Mr. Younas Imran	Complainant,
Barrister Khalique	Counsel of Complainant
Dr. Muhammad Shafi (50253-P)	Respondent No. 1
Dr. Muhammad Usman (53615-P)	Respondent No. 2
Mr. Sardar M. Yaqoub Mastoie	Counsel of Respondent No. 2
Mr. Malik Aijaz	Administrator, Rawal Hospital
Ms. Mahnoor Asad	Pharmacist
Rana Umar Shehzad	Chief Pharmacist
Dr. Khurshid Aalam	Expert (ENT)
Hearing dated	04.06.2022

I. FACTUAL BACKGROUND

1. The instant Complaint was lodged by Mr. Younas Imran (hereinafter referred to as the "Complainant) against Dr. Muhammad Shafi (hereinafter referred to as the "Respondent No. 1")

and Dr. Muhammad Usman (hereinafter referred to as the "Respondent No. 2") on 04.01.2022 alleging their professional negligence. The Complainant submitted that:

a. his wife Ms. Nazia Aslam got herself checked from Respondent No. 1 for nasal issue, who advised the procedure of "Polypectomy". The patient was admitted at Rawal General & Dental Hospital and operation was performed.

b. Next day, the patient complained of headache upon which the duty nurse allegedly administered injection Acuron 50mg conveying it to be a pain killer. Immediately, after injection was administered, the patient became unresponsive. The patient was shifted to ICU but shortly thereafter the doctor told the Complainant that the patient had expired.

c. The Complainant requested that strict action be taken against the Respondents.

II. SHOW CAUSE NOTICE

2. In view of allegations levelled in the Complaint, Show Cause Notice dated 17.01.2022 was issued to the Respondent No.1, in the following terms:

"...

4. ***WHEREAS***, *in terms of Complaint, it has been alleged that, Complainant brought his wife Mst. Nazia Aslam (37 yrs) to Rawal General & Dental Hospital on 7th December, 2021, where you were her treating ENT consultant. You prescribed medications for 7 days and advised the patient surgery (Polypectomy). Polypectomy was performed on 16th December 2021, around 11:30 am and patient was shifted from Operation Theater to room at around 02:00 pm, whereby, the family was assured the procedure remained uneventful; and*

5. ***WHEREAS***, *in terms of Complaint, it has been alleged that on 17th December 2021, at 4:30 am, the patient complained of headache, for which the nurse administered injection. Within 2 to 3 minutes of administration of the said injection, the patient became unresponsive. The patient was shifted to ICU but she couldn't survive and passed away within 10 minutes i.e. at 4:40 am; and*

6. ***WHEREAS***, *in terms of Complaint it has been alleged that the patient was prescribed Injection Acuron 50 mg along with other medications by you, which was purchased by the Complainant from the hospital's pharmacy at 8:52 pm, 16th Dec 2021; and*

7. ***WHEREAS,*** *in term of Complaint it has been alleged that at the time of incident, the patient was administered Injection Acuron 50 mg and not the pain killer as informed by nurse on duty. Due to administration of the said injection the patient had severe complications, leading to her death; and*

8. ***WHEREAS**, in terms of the facts mentioned in the Complaint you prescribed injection Acuron which was not the right treatment and injection was administered without close monitoring and supervision of doctor. It is failure on your part to fulfill your professional responsibilities towards your patient. Such conduct is breach of principles of ethics, amounts to professional negligence/ misconduct and is therefore in violation of the Code of Ethics of practice for Medical and Dental Practitioners, Regulations, 2011 in general and Regulation 9(1), 21(1), 25(2) (a)(g)(h) and 50 in particular; and*

9. ***WHEREAS,** you are registered with Pakistan Medical Commission under Registration No. 50253-P, whereby you have got the degree of Basic Medical Qualification (MBBS) only; and*

10. ***WHEREAS,** a general practitioner cannot practice in the field of specialty without requisite qualification duly recognized by the Commission and represent as having acquired or seek to practice a specialty unless same is recognized by the Commission. therefore, in view of facts mentioned in this notice your conduct of representing yourself as ENT specialist and carrying out Polypectomy of patient is in violation of Section 29(2), (8) & (10) of the Act, read with Regulation 8(2) of Code of Ethics of Practice for medical and dental practitioners, Regulations, 2011.*

3. Similarly, in view of the Complaint received at this Commission, Show Cause Notice dated 17.01.2022 was also issued to Respondent No. 2, in the following terms:

"...

4. ***WHEREAS,** in terms of Complaint it has been alleged that, Complainant brought his wife Mst. Nazia Aslam (37 yrs) to Rawal General & Dental Hospital on 7th December, 2021. The patient was advised medications for 7 days and planned to undergo surgery (Polypectomy). Polypectomy was performed by Dr. Muhammad Shafi and you on 16th December 2021, around 11:30 am and patient was shifted from Operation Theater to room at around 2:00 pm, where the patient remained under the care of Dr. Muhammad Shafi and you; and*

5. ***WHEREAS,** in terms of Complaint it has been alleged that, on 17th December 2021, at 4:30 am, the patient complained of headache, for which the nurse administered injection. Within 2 to 3 minutes of administration of the said injection, the patient became unresponsive. The patient was shifted to ICU but she couldn't survive and passed away within 10 minutes i.e. at 4:40 am; and*

6. ***WHEREAS,** in terms of Complaint it has been alleged that, the patient was prescribed injection Acuron 50mg along with other medications which the Complainant purchased on the evening of 16th December 2021, from the hospital's pharmacy at 08:52 pm at 16th December 2021; and*

7. ***WHEREAS,** in terms of Complaint, it has been alleged that at the time of incident, the patient was administered Injection Acuron 50 mg and not the painkiller as informed by the nurse on duty. Due to administration of the said injection the patient had severe complications, leading to her death; and*

8. ***WHEREAS,** in terms of the facts mentioned in the Complaint, Injection Acuron was not the right treatment and injection was administered without close monitoring and supervision of doctor. It is failure on your part to fulfill your professional responsibilities towards your patient. Such conduct is breach of*

principles of ethics, amounts to professional negligence/misconduct and is therefore in violation of the Code of Ethics of Practice for Medical and Dental Practitioners Regulations 2011, in general and Regulations 9 (1), 21 (1) and 25 (2) (g) & (h) in particular.

III. REPLY OF RESPONDENTS NO. 1 AND NO. 2

4. In response to the Show Cause Notice dated 17.01.2022, Respondent No.1 submitted his reply on 01.02.2022, wherein he stated that:

"

a) *I have been working in Rawal General & Dental Hospital, Islamabad as Registrar in ENT Department under the supervision of the Head of Department Professor Ashfaq Ahmed Malik, since November 2014. I completed MBBS Degree in 2005- and one-year house-job in 2007. I have passed FCPS-I exam (ENT) in 2008 & completed post graduate training in ENT Department of Benazir Bhutto Hospital, Rawalpindi in 2012.*

b) *Patient Mrs. Nazia Aslam visited ENT Department of Rawal General & Dental Hospital, Islamabad on 07th December 2021. I, being the attending doctor, diagnosed the case of Nasal Polyp. I prescribed medicines and told her to visit after one-week so that we can discuss the case with the Professor and plan ahead. Patient visited again on 13th December 2021 and I did the necessary pre-operative investigation and the Anesthesia fitness from the Anesthetist. The 'nasal polypectomy' was performed on 16th December 2021 after intimation and under supervision of our professor.*

c) *Surgery was successful without any complications and patient was shifted to recovery room, where I observed her being without any complaints. Patient was then shifted to private room on the insistence of the complainant though she was admitted in the ENT ward.*

d) *Post operatively, my colleague Dr. Usman, registrar ENT Department wrote the following medicines on the patient's file and an injection Transamine 1gm I/V stat. the three medicines were the following:*

i.	*Injection Augmentin 1.2 gms*	*TDS*
ii.	*Injection Provas 1gm*	*TDS*
iii.	*Injection Ketor 30mg*	*BD*

e) *Postoperative round was done on the same day, both in ENT Ward and private room, where patient was fine and in bed comfortably.*

f) *Next day, I was informed at 05:30am by the doctor from the ICU Department about the death of the patient. The doctor conveyed that the patient complained of headache in mid-night and was given an injection by the in-charge nurse after which she died in a few minutes.*

g) *On 27-12-2021, the Complainant had given an application in the Police Station where he has stated that the dealing doctor had not prescribed the injection 'Acuron'. Rather, it was the in-charge nurse who had asked the Complainant to purchase this injection in the night and later injected the injection to the patient without asking any supervising doctors.*

h) *I have been working in Rawal General & Dental Hospital for 07 years as Registrar, ENT and have always performed surgery after intimation and under supervision of professor. I have not prescribed the injection 'Acuron' to the patient, knowing well its nature.*

5. Similarly, in response to the Show Cause Notice dated 17.01.2022, Respondent No.2 also submitted his reply on 01.02.2022, wherein he stated that:

   a) *I have been working in Rawal General & Dental Hospital, Islamabad as Registrar in ENT Department under supervision of the Head of Department, Professor Ashfaq Ahmed Malik, since November 2014. I completed MBBS Degree in 2008 from Rawal Medical College and completed one-year house-job afterwards. I passed FCPS-I exam (ENT) in 2010 & completed post graduate training in ENT Department of Pakistan Institute of Medical Sciences, Islamabad in 2015 and also passed Intermediate module exam in the same field in January 2015.*

   b) *Patient Mrs. Nazia Aslam visited ENT Department of Rawal General & Dental Hospital, Islamabad on 07th December 2021. Dr. Shafi was the attending doctor at that time. I took a brief clinical history of the patient at the time of admission as per protocol of our department. Intra nasal polypectomy was performed on 16th December 2021.*

   c) *I did the postoperative round on the same day and entered the post-op notes. At that time, the general condition of the patient was satisfactory and her vitals were stable.*

   d) *Post operatively, as per routine, I wrote the following medicines in order to minimize the risk of infection and pain and an injection Transamine 1gm I/V only once to prevent the bleeding. The three medicines written post operatively were the following:*

      i. *Injection Augmentin 1.2 gms TDS*
      ii. *Injection Provas 1gm TDS*
      iii. *Injection Ketor 30mg BD*

   e) *Next day, I was informed early morning about the death of the patient. Then I visited the Hospital but the attendants had left with the body of the deceased patient.*

   f) *I did not perform the surgery. Furthermore, neither did I advise nor wrote the injection 'Acuron' to the patient as I know that it is anesthesia medicine and not a pain killer.*

IV. REJOINDER

6. The replies submitted by Respondent doctors No.1 and No. 2 were forwarded to the Complainant on 02.02.2022 for rejoinder. The Complainant submitted his rejoinder on 15.02.2022 reiterating his earlier stance and further added that:

   a) *Dr. Muhammad Shafi (Respondent No.1) is misrepresenting his qualification on https://oladoc.com as ENT specialist, MCPS, ENT Surgeon.*

   b) *Dr. Muhammad Shafi never told him that operation will be conducted under supervision of Professor.*

   c) *As per record, Dr. Shafi admitted the patient and performed procedure*

   d) *Dr. Shafi never visited the patient in her room pre or post-surgery.*

e) At 04:30 am, the complainant informed Dr. Usman that issue of bleeding has not settled to which he told that he will visit the patient shortly but he never visited again. At 05:00 am the Complainant was informed that Dr. Shafi and Dr. Usman have left the hospital and no doctor from ENT was available.

f) As per hospital enquiry Accuran was the cause of death of the patient.

V. HEARING

7. The matter was fixed for hearing before the Disciplinary Committee on 03.06.2022. Notice dated 16.05.2022 were issued to the Complainant and Respondents No. 1 and No. 2 directing them to appear before the Disciplinary Committee on 03.06.2022. The Medical Superintendent, Rawal General Hospital, Islamabad was also directed to appear before the Disciplinary Committee along with complete record of the patient.

8. On the date of said hearing, the Complainant along with his counsel appeared before the Disciplinary Committee. The Respondent No. 1 was present and Respondent No. 2 was present along with his Counsel. The Medical Superintendent of Rawal General Hospital, Islamabad was represented by the Administrator of the Hospital, who was in attendance at this hearing.

VI. DECISION

9. The Disciplinary Committee has noted that as per the record available, the 'consent form' and the 'admission form' of the patient have been signed by Respondent No. 1 as a 'consultant'. Respondent No.1 stated that he has completed training for FCPS-Part-II but has not cleared the exit exam, despite 05 attempts. He further admitted categorically that he has been performing surgeries *albeit* allegedly always supervised by his senior Dr. Ishfaq. However, he admitted that during his conduct of operation of the patient in the present case, his supervisor Dr. Ishfaq was not present with him as he was busy in supervision of the examination sessions being conducted. The Committee notes that as per the license of the Respondent No. 1 he holds only MBBS qualification and with this basic degree he does not qualify as a consultant. During the hearing, Respondent No. 1 himself admitted that he does not qualify as a consultant. On the contrary he and the hospital have misrepresented him as a consultant on the prescription pad of the hospital and he has also admittedly been performing independently surgeries as is evident in the instant case, which he is not permitted or privileged to do. The Committee further notes that despite lack

of qualification and credentials, the Respondent No. 1 blatantly signed the 'admission' and 'consent form' of a patient which can otherwise only be signed by a consultant. It is also pertinent that the invasive procedure known as Polypectomy performed by the Respondent No.1 is as a matter of practice and preference for years done endoscopically. However, since the Respondent No.1 admittedly is not qualified or trained for endoscopic procedures he elected to undertake the procedure using a method which is not ordinarily preferred or advisable. This in itself represented placing that patient at a higher risk than was required and occurred solely due to the Respondent No.1 not being a properly qualified consultant and having illegally undertaken the surgery.

10. Such practice is violative of the PMC Act 2020 and the Code of Ethics of Practice for Medical and Dental Practitioners Regulations, 2011 which clearly stipulates that a general practitioner cannot practice in the field of the specialty without requisite qualification duly recognized by the Commission and represent himself as having acquired or seek to practice a specialty unless same is recognized by the Commission. In view of foregoing, and notwithstanding the merits of the remaining matter, the Committee decided to impose a penalty of suspension of license to practice of the Respondent No.1, Dr. Muhammad Shafi, for a period of two years with immediate effect in view of not only having misrepresented his credentials but furthermore admittedly having carried out procedures on patients without the necessary qualifications and in the case of the patient in question performed an ill-advised procedure which as per protocol should not have been done other than endoscopically. Had the procedure been done by a trained specialist endoscopically it would not have resulted in the post operative care that became necessary or the pain management that followed leading to the ultimate injecting of the medicine which caused the patients death. Furthermore, the Authority is directed to report the matter to the Islamabad Health Regulatory Authority viz the hospital having not only permitted such illegal practice but been actively complacent in the same as per record .

11. In similar vein, the Respondent No. 2 stated before the Disciplinary Committee that while he has completed 4 years training for post-graduation in ENT but he did not appear in exit exam. He submitted that he has never performed any surgeries and only looks after the OPD patients. The patient in the present case was checked post-operatively by him on 16.12.2021 during his rounds and he had prescribed routine painkillers in his notes, available on record. The alleged injection

Accuron has not been prescribed by him as is also confirmed by the hospital record/notes. It was revealed to this Committee by Respondent No. 2 that he left the Hospital on 16.12.2021 at around 4:45pm after signing out from the Hospital. At that time, the Respondent No. 2, however, did not hand over the patient to another doctor rather he handed over the patient to the nursing/administrative staff, who then allegedly handed over the patient to next doctor on duty as per the policy and ROTA of the Hospital. This practice is entirely improper and this Committee taking notice of this issues a warning to the Teaching Hospital in question as well as the Respondent No. 2 to refrain from such conduct in the future. Be that as it may it is clear that the Respondent No.2 was neither responsible for nor prescribed the medicine in question and nor was in fact at the hospital when the medicine was injected in the patient. Therefore, the Respondent No.2 to the extent of the alleged negligence is exonerated.

12. The key issue in this matter which has come to light is that the patient was administered an Accuron injection which was neither prescribed nor could have been prescribed as it is a highly regulated medicine used for patients undergoing anesthesia or surgery. At no time is it used for merely pain management. Furthermore, Accuron cannot be administered without a prescription and in fact nor can it be sold by a pharmacy without a prescription. In this case it is admitted that; a) Accuron injection was administered to the patient, b) it was never prescribed by any doctor as per the records of the hospital, c) it was sold by the hospital pharmacy to the patient's husband without a prescription, allegedly on a list of medicines hand written by the nurse on duty, and d) no doctor was on duty when the injection was administered.

13. The Hospital Administration was enquired from during the hearing whether any investigation has been conducted in the matter to find out who prescribed the injection 'Acuron and why the hospital pharmacy sold it to patient's husband without a prescription. Hospital was further enquired from as to the doctor on duty when injection was advised and administered and what actions have been taken against the persons responsible for this incident. Administrator of the hospital submitted that an enquiry was conducted in the matter by any enquiry committee comprising of Brig. (R) Dr. Asjad Sharif (Prof. Anesthesia RIHS), Dr. Ashfaq Malik (Prof. ENT RIHS), Ejaz Malik (Administrator RIHS) and Dr. Syed Aslam Shah (Prof. Surgery & Dean RIHS). The Committee has seen the enquiry report and observes that important statement are missing to which administrator of hospital informed that only verbal statement were taken in some cases by the

enquiry committee. The enquiry report only holds responsible one nurse and has brushed aside the important facts and ignoring other persons involved in the incident.

14. Ms. Mahnoor Asad (Pharmacist) and Mr. Rana Umar Shehzad (Chief Pharmacist) were also called to attend the hearing. Ms. Mahnoor stated that she sold the injection to attendant of patient as per the slip sent by the nurse which contained only the name of injection. She was enquired whether she ordinarily dispenses or sells medicine as per the prescription of doctor or a slip sent by nurse. She stated it is routine matter that medicines are provided only on the basis of name of medicine written by staff of the hospital on a piece of paper and the pharmacy does not keep record of slips after selling medicine. She was enquired whether given the nature of the injection, did she call the nurse or any doctor on duty to verify the medicine as it came without prescription; she replied in negative. Mr. Rana Umar claimed that injection 'acuron' is not a controlled item therefor, their pharmacy does not keep record of slips, however, admitted that such medicine cannot be sold without prescription. He further stated that usually demand of injection 'acuron' comes from OT or ICU or CCU and not from normal ward.

15. The Hospital administrator was also confronted on the hospital allowing an MBBS degree holder to be represented as a consultant to the patients and allowing him to carry out surgeries independently; the administrator had no satisfactory answer. It is a matter of grave concern for Disciplinary Committee that Rawal General Hospital which has been approved as teaching hospital is complacent in such malpractices. Further, the hospital has shown such reckless attitude in this incident which calls for a criminal complaint in terms of section 34 of the PMC Act, 2020 for permitting an unqualified doctor to perform a surgery and failing to take appropriate measures or to properly investigate and holding the persons responsible, including the relevant staff and pharmacist who prescribed/advised/sold/administered the injection 'acuron'. Pertinently the pharmacy is located in the hospital premises and is allowed to admittedly sell such medicine without prescription and removing the evidence including prescription slip and empty ampule of injection. The Authority is therefore, directed to initiate appropriate proceedings before the Honourable Medical Tribunal in this respect against the Rawal General Teaching Hospital pursuant to the PMC Act, 2020.

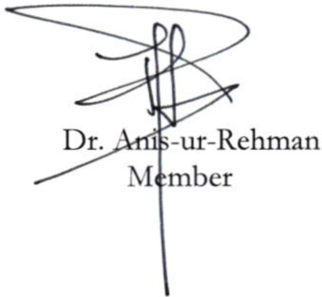
16. The facts of this case unfortunately involve allegedly at the least a nurse, a pharmacist and hospital administration, who are beyond the direct jurisdiction of the Disciplinary Committee, having been actively involved in what can only be termed as a criminal act of injecting a patient with not only an unprescribed and incorrect medicine but one which any qualified nurse or pharmacist is aware is only utilized during administering of anesthesia or surgery under controlled administration by a qualified doctor. For the above reason *prima facie* it does not appear to be an inadvertent mistake on the part of a nurse or some other staff at the hospital. Even a nurse had by mistake written the name of a piece of paper, which in itself is an illegal act in terms of procuring of medicine from a pharmacy, at the time of administering the person so administering would have seen the injection being administered and would have become aware that this is neither prescribed nor can be given without presence and approval of a doctor. In addition the timing of certain acts become pertinent including the fact that as per the nurse and the Complainant the medicine was procured in the evening but administered hours later late at night. This is also not the ordinary practice as medicine prescribed for a patient in a ward is normally to be done at fixed times and ordinarily such times are not late at night or hours after the medicine is called for. Another pertinent fact is that after administering the injection albeit incorrect, it would be almost immediately seen by the person administering or to any trained hospital staff that the patient is suffering acute adverse symptoms and in response to which immediate steps as per protocol in such events would be taken which would ordinarily cater to the ill effects of the medicine in question and save the patient's life. However, in this case it appears there existed a serious time lag between the administering of the injection and the patient having been moved to the ICU and where such delay was sufficient to have caused the patient's death in the absence of proper responsive treatment being provided. In short, the facts of this case *prima facie* represent more than a case of negligence on the part of the doctors involved. There appears to be a more sinister side to the unfortunate event and it appears to be a criminal matter and only a proper criminal investigation can determine the actual facts and persons involved and to what extent if there existed mens rea on any persons part.

17. For the above reasons the Authority is directed to:
    a. Refer the matter pertaining to the nurse involved to the Pakistan Nursing Council to the extent of their jurisdiction viz the license issued to the nurse in question;

b. Refer the matter pertaining to the pharmacist involved to the Pharmacy Council to the extent of their jurisdiction viz the license issued to the pharmacist in question; and

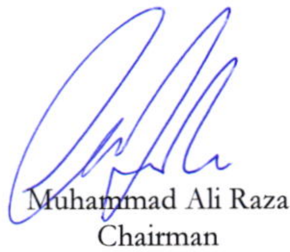
c. Refer the matter to the Inspector General Police, Islamabad to initiate an inquiry in accordance with law and procedure into the matter as it pertains to a criminal offence leading to the death of patient namely Ms. Nazia Aslam by administering of an unprescribed injection and failure of responsive treatment.

18. The Complaint is disposed of with the above noted directions to the Authority, references to relevant regulatory authorities and the penalties as imposed and warnings as issued.



Dr. Anis-ur-Rehman
Member

Dr. Asif Loya
Member



Muhammad Ali Raza
Chairman

20th July, 2022