BEFORE THE DISCIPLINARY COMMITTEE OF PAKISTAN MEDICAL COMMISSION

In the matter of

Complaint No. 12-Comp-88/2016-DC

Muhammad Tahir Vs. Dr. Atif Kazmi

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

Present:

Ms. Bushra Ruba Hamayun	Sister of Patient
Dr. Atif Kazmi (1968-P)	Respondent
Rana Bilal (Advocate)	Legal Representatives of MS, Mayo Hospital
Dr. Mushtaq Haroon	Expert (Medicine)
Hearing dated	11.12.2021

I. FACTUAL BACKGROUND

Reference from Punjab Health Care Commission

1. Mr. Muhammad Tahir (hereinafter referred to as the "Complainant") filed a complaint on 22.12.2012 against Dr. Atif H. Kazmi (hereinafter referred to as the "Respondent") before the Punjab Healthcare Commission, Lahore. The Complainant took his father Mr. Ejaz Hussain to private clinic of the Respondent on 08.10.2012. He prescribed injection Decadron and injection

Methotrexate (25 mg) and advised the patient to come back after one month. On 13.10.2012, the Respondent was informed that patient was in agony and the color of his skin had started to get blackish. The Respondent advised to bring the patient to his clinic the next day. The patient was taken to his clinic on 14.10.2012. After examining the patient, the Respondent directed to stop the medicines prescribed on 08.10.2012 and advised to get the patient admitted in Mayo Hospital, Lahore.

2. The patient was admitted in Mayo Hospital on 15.10.2012 and the Respondent prescribed some tests. The reports came the same day but by that time Respondent had already left. Next day the Respondent was on leave and did not come to the hospital. It has been alleged that on 17.10.2012, the Respondent doctor came and after going through the reports, discharged the patient by saying that as he remains busy most of the time, so the patient may be taken to some private hospital.

3. The patient was taken to National Hospital Defense on 17.10.2012, where doctors initially refused to admit him but after speaking to Respondent doctor allowed the admission. The patient was given antidote injections to counter the effects of Methotrexate injection prescribed by Respondent, but the infection had spread in the entire body due to which the patient ultimately died on 23.10.2012.

4. The Complainant further alleged that his father died due to the non-professional attitude of the Respondent doctor and injection Methotrexate prescribed by him. Moreover, the patient was treated in an unprofessional manner and was discharged from Mayo Hospital in a bizarre way which can be verified from the hospital record.

Findings of the Board, PHCC

5. The Board of Commissioner Punjab Healthcare Commission decided the above complaint on 12.05.2016 in the following terms:

The case of Dr. Atif Kazmi (Respondent) be sent to PM&DC for the following reasons: -

a. Not following the protocols before prescribing a highly toxic medicine i.e. Methotrexate injections.

b. Not properly communicating the risks involved, to the patient or his attendants especially when such high-risk medicine was being prescribed by him.

c. *Illegible hand writing which contributed to the death of patient.*

II. NOTICE TO RESPONDENT

6. In pursuance of the reference received from Punjab Healthcare Commission, notice dated 04.08.2016 was issued to Dr. Atif Kazmi and he was directed to file his comments.

III. REPLY OF RESPONDENT

7. Respondent doctor submitted his reply on 25.08.2016 wherein he has stated:

a. That the patient Ijaz Hussain came to my clinic with a skin problem. After detailed history & examination I found him to be suffering from Erythrodemic Form of Psoriasis (almost 90% of body area was covered with the disease). It is submitted that this is a very severe form of Psoriasis. The patient's weight was almost 75 Kg. I prescribed him injection Methorexate I/M in a dose of 25mg per week. (The recommended Dose of Methorexate is 0.3 to 0.5 mg/kg body weight per week). The dose prescribed by myself to this patient is lesser than practiced in the treatment of Psoriasis. All necessary investigations i.e CBC, LFTS, RFTs and urine examination were carried out before administering Methotrexate. These investigations were written on a different slip of paper as is the routine in my clinic.

b. It is further stated that a few days later the patient called me that he has developed some kind of complications with the medication. I called him again at my clinic and on examination found him to have developed Methotrexate toxicity. On enquiry the patient told me that he was having daily injections of Methotrexate rather than weekly as prescribed by myself. The attendant of the patient Miss Bushra accepted that there has been an over dose of the injection by mistake and injections were given daily not weekly. I explained to the patients that he has been taking wrong dosage of drug which has caused severe toxicity. I advised the patient to be admitted in skin department Mayo Hospital LHR as I do not admit patients in any private hospital or clinic. The patient was adamant to be admitted in a private hospital because he was of the view that the Govt. Hospital do not provide proper care to the patients. But I again advised them for admission in skin department Mayo Hospital so that all the staff is well versed in Dermatology care and would look after the patient in an efficient way.

c. After admission in skin department all my staff members including senior registrar, registrar and post graduate residents looked after the patient. The standard treatment for Methotrexate toxicity is Leucovorin 20mgs, 6 hourly which was provided to the patient. While admitted in the skin department the attendants kept on insisting to take their patient to a private hospital as they were not satisfied with the general conditions of the ward.

d. On my advice the doctor in charge of the bed took the patient to the medical emergency department and discussed the case with the senior doctors in the medical emergency who examined the patient and advised special care of this patient in isolation. Even in the emergency the attendants of the patient were complaining of unsatisfactory treatment given by the medical unit on call. As there was no special isolation facility in the skin department

and relatives were insisting to take the patient to some private hospital so I allowed the relatives of the patient that they can take the patient to a private hospital of their own choice for better management to which the patient agreed and hence the patient was discharged on request which is on the record in hospital sheets.

e. At the time of discharge of the patient from the hospital the patient was improving and the attendants of the patient gave a written consent of taking the patient to a private hospital which is available in the hospital record. However, surprisingly the record of the patient was illegally taken away by the attendants without informing the staff of the skin department, which was recovered from the family of the patient at the time of hearing at the commission office, which is on record with the commission as well as with the MS Mayo Hospital LHR. This shows the intentions of the family that they did not exhibit the investigations advised to them, at the time of their cross examination at the Commission.

f. I further helped the family to get their patient admitted in National Hospital and also personally requested the doctors to take care of the patient in that hospital.

g. I always advise required investigations on a separate slip or a piece of paper to my patients. My staff additionally explains to the patients regarding the details of investigations and they go to the laboratory of their own choice. The investigation report is a property of the patient which they take away after the examination from the consultant. The same practice was adopted with this patient. Following investigations were advised before the start of treatment CBC, LFTS, RFTs, Urine examination complete. The Dose of Methotrexate (25mg) weekly is below minimum for one week in patients of psoriasis vulgaris as prescribed in the literature.

h. I always explain the disease and the medications to my patients verbally and then my trained attendant outside who is with me for the last 30 years also explains the same to the patient. As Psoriasis Vulgaris is a chronic skin disease so the patients are always in touch with the Doctor. The attendants called me many a times during the treatment regarding the progress of the disease which I explained to them regularly. The patient was under my treatment and visited me many a times so I had already conveyed to them the risks and side effects of medication.

IV. HEARING

8. Notice dated 29.11.2021 were issued to Muhammad Tahir (Complainant), Dr. Atif Kazmi and Medical Superintendent, Mayo Hospital, Lahore (Respondent/s), directing them to appear before the Disciplinary Committee on 11.12.2021.

9. On the date of hearing, the sister of the deceased patient, Ms. Bushra Ruba Hamayun appeared on behalf of the Complainant who has since also expired. Respondent Dr. Atif Kazmi and legal representative/counsel of MS Mayo Hospital Lahore were present before the Disciplinary Committee.

10. Ms. Bushra stated that the patient had reaction due to the medications being injected on daily basis and when the doctor was informed over a call for opinion that the patient's skin has darkened and having pain to which the doctor replied that the patient can have a checkup with him by tomorrow i.e. 14th Oct 2012. The patient visited the Respondent doctor the next day and patient was admitted in Mayo hospital on 15th Oct 2012 at the Respondent's direction. The Respondent doctor was on leave on 16th Oct 2012. On 17th Oct 2012 the Respondent doctor after checking the report and the patient's condition asked the patient to be moved to National Hospital for further management. The patient was accordingly shifted to National Hospital, where he remained under treatment for some days and then passed away.

11. The Respondent doctor submitted that he is practicing Dermatology for the last 40 years and was working as Head of Dermatology Department Mayo Hospital when the incident happened. He further stated that the injection Methotrexate was supposed to be given once weekly, but it was administered on daily basis which ultimately caused overdose toxicity. The Respondent doctor stated that he does not admit patients in his private clinic so he admitted the patient in dermatology department of Mayo hospital which is on record, to provide the best possible treatment to the patient. On insistence of the patient's family the patient was discharged for further admission to a private hospital. In this regard, the patient's family gave a written statement before shifting the patient to a private hospital of their own will. After shifting the patient to National Hospital he talked to Dr. Tanver ul Islam who was looking after this patient at National Hospital for taking extra care of the patient. The patient passed away after few days.

12. The Committee inquired from the Respondent doctor what was the prescribed dose of the injection to which the Respondent doctor stated that this injection had to be administered once weekly and the normal dose is 0.3-0.5mg/kg body weight. Further stated that he does not prescribe injection methotrexate to all patients of psoriasis except in severe cases. This patient was suffering from erythrodermic psoriasis and methotrexate is a treatment of choice in such condition which is being prescribed for the last hundred years.

13. The Committee inquired from Ms. Bushra as to who had administered injections to the patient and who told them to administer this injection on daily basis, to which she replied that they

purchased the medicine from a pharmacy near Jinnah Hospital and then called a compounder at home to administer this injection. Further she stated that by mere reading of the prescription they felt that it was to be administered on daily basis and even the pharmacy sold them multiple injections based on the prescription of the respondent doctor.

14. The Committee asked the Respondent regarding illegible writing on the prescription specially where the prescription was for such a highly toxic drug and in view of its known serious consequences and why such injection was not administered at clinic and the necessary protocols not followed. The Respondent doctor replied that after prescribing medicine he explained each and every medicine to the patient and then his assistant also explained in detail. Further, his mobile phone is 24hrs open for his patients. The Respondent doctor further stated that the overdose toxicity can occur in any drug e.g. anti-malarial and others. He does not have the facility of administering injectable at his clinic which functions on OPD basis. Further stated that he always advises his patients to administer injections at any hospital or under the supervision of a doctor.

15. The Committee inquired from Ms. Bushra that how many injections did they purchase from the pharmacy to which she replied that the pharmacy was not giving them the medicine for two days due to its toxicity but after two days they had to convince the pharmacy after a lot of push and shove to get the injections. The Committee asked did they not contact the Respondent doctor when the pharmacy was not giving the medicine to which Ms. Bushra could not give an appropriate answer.

16. The Committee inquired from the Respondent doctor whether any emergency treatment was given to patient when he visited him at his clinic on Sunday 14th October 2012. The Respondent replied that when he saw the patient on Sunday, the patient had over dosage of drug and whenever there is toxicity due to over dosage of drugs, the patient is always hospitalized. The reason for not admitting this patient in the dermatology department of Mayo Hospital is that it was Sunday and no admissions are made in skin department on Sunday but only in emergency department.

17. The Respondent further added that the patient was told to go to the emergency department of Mayo Hospital to be admitted starting treatment immediately and the patient will be shifted to dermatology department on Monday, 15th October 2012, however the patient insisted that they

will make admission only in the presence of the Respondent doctor in dermatology department on Monday 15th Oct 2012 and that one day is not an issue for them. The patient was admitted in dermatology department of Mayo Hospital and the treatment was started as per protocols.

18. The Committee inquired from Ms. Bushra that how they came to know that the drug has been over dosed, to which she replied that they presumed it from the change in skin color of the patient and reviewing the prescription. She further stated that they were also told by the Compounder about drug overdose. She was asked when the Respondent doctor initially checked the patient and handed over the prescription, did they read/understood or asked the doctor about the administration of medicine written on the said prescription. Ms. Bushra answered that they did not ask the Respondent doctor about the dosage and the administration of medicine, not being aware of the such toxic medicine. She added that assistant of the Respondent also did not explain to them.

V. EXPERT OPINION BY DR. MUSHTAQ HAROON

19. Dr. Mushatq Haroon, medical specialist, was appointed as an expert to assist the Disciplinary Committee in the matter. He has opined that:

> *"As a medical specialist after reviewing the file and listening to both parities I have come to the following conclusion:*
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> *a. The treatment given for the disease was appropriate.*
> *b. The patient and relative misunderstood the dose.*
> *c. The writing of the doctor is rather illegible, even so the patient should have inquired if in doubt.*
> *d. Due to inadvertent overdose of the patient suffered serious side effect of the anti cancer drug.*
> *e. Appropriate antidote was given.*
> *f. It is unfortunate the patient died.*
> g. *It is for the Commission to decide about the truth of the statements given by each party and the account of the events that happened over time."*

VI. FINDINGS & CONCLUSION

20. The record has been perused minutely and the submissions and statements of the parties have been carefully considered. The patient Ijaz Hussain was taken to Respondent Dr. Atif Kazmi at

his private clinic on 08.10.2012. Respondent after examination diagnosed it a case of severe psoriasis. He prescribed injection Methotrexate and other medicines. Injection Methotrexate was prescribed 25 mg once in a week. It is the treatment of choice in such cases.

21. The attendants of the patient administered the injection Methotrexate on daily basis due to which he developed drug reaction. The patient was again taken to the Respondent doctor on 14.10.2012 who diagnosed it to be a severe case of drug reaction and advised the attendants to get the patient admitted at Mayo Hospital Lahore immediately for management of toxicity. The attendants took the patient home and bought him to Mayo Hospital next day i.e. on 15.10.2012. The patient remained admitted at Mayo Hospital till 17.10.2012 and thereafter he was shifted to National Hospital Lahore. Later on, the patient expired on 23.10.2012.

22. Certain pertinent facts are that the prescription written by the Respondent Dr. Atif Kazmi is not clear, rather it is illegible and even the members of the Committee found it difficult to read and comprehend in terms of dosage. This can easily have caused confusion as to the administration of the highly toxic injection. This is a known highly toxic drug and the protocol is to administer it in the presence of a medical practitioner or at a hospital in view of known toxic reactions. This was not ensured by the Respondent who simply prescribed it to a patient at his private OPD clinic. Furthermore, had the Respondent properly warned the patient and his attendant as to the lethal toxic reaction the medicine can have including the fear of overdose or instructed that they should get the injection administered at a hospital, it would be unlikely that the patients attendants would have run from pillar to post for two days to get the medicine when the pharmacy initially refused to sell it.

23. Ms. Bushra during the hearing informed that when they went to purchase the injection methotrexate, the pharmacy initially refused to give the medicine. The attendants procured the medicine statedly forcibly from the pharmacy. Refusal of the pharmacy to give medicine should have alarmed the attendants and they should have contacted the consultant regarding clarity of prescription. While the attendants failure to act prudently to some extent might mitigate the failure of the Respondent doctor in terms of ensuring the clarity with which the prescription was to be provided and the obligation to ensure protocols for administration were set down, the fact remains that the principle duty of care is that of the practitioner and it must be assumed that a patient is

neither well informed of medications and their toxicity levels and nor is a patient or even the attendants in a state of mind due to the emergency and concern surrounding an illness to be depended upon to manage administration of treatment or drugs carrying a high toxicity risk.

24. The Respondent doctor admittedly prescribed the correct medicine for the ailment however, failed to follow and fulfil the known protocols as to the prescription and administration of the medicine being aware of the side effects and risks. Why was such a treatment prescribed to a patient during a visit to his private clinic and why was the patient not asked to come to Mayo Hospital the next morning to have the medicine administered under a controlled environment? This is a case which more than anything points towards the continuing debate of consultants engaging in private OPD practice while working full time at a hospital rather than undertaking their private OPD practice at the hospital which would avoid such situations.

25. The family of the patient admittedly called the Respondent doctor on Saturday night, 13th October 2012 to inform him about the worsening condition of the patient. The Respondent doctor at that time told them that his clinic will remain open on Sunday so the patient can visit his clinic next day. When the patient visited the Respondent doctor at his clinic on Sunday no emergency treatment was given to the patient and instead the patient was told to go to Mayo Hospital. The Respondent was the head of department at Mayo Hospital and immensely experienced. The call on Saturday itself should have raised immediate alarm and the patient should have been directed to rush to a hospital emergency for administration of antidote. This was not done by the Respondent. Instead he called the patient the next day to his private OPD clinic. It is the Respondent's own statement that he does not admit or administer medicine to patients at his clinic. If that was the case then why would be call a patient the next day to his private clinic when the call on Saturday had already alerted him that this was potentially a case of toxic reaction.

26. The patient and his attendants advised to take the patient to Mayo Hospital on Sunday while being told that the doctor himself would be there on Monday, decided to take the patient to the hospital on Monday for the obvious reason of having the comfort that their doctor will be present. This is a normal reaction of a patient when they are not told that its an emergency and a life threatening one at that. The conduct of the Respondent which raises concern is that on Sunday 14th October 2012 when he had in fact physically examined the patient why did he not have the patient rushed

to emergency of any available hospital and prescribe the antidote and have it administered. It was his patient and it was hence his duty to ensure all steps were taken in terms of the obligation of duty of care of a practitioner towards a doctor.

27. The antidote folinic acid was finally administered on 15th October, two days after the doctor should have ensured this was done. The delay admittedly deteriorated the condition of the patient as the toxic levels increased affecting the patients organs and vital systems. The Respondent doctor failed to take any emergent action to save the patient and as evidenced left it more or so for the family to decide.

28. It is part of a practitioners duty of care towards a patient and part of professional ethics that before writing prescription for any patient a doctor must take into account the patient's level of understanding, concerns, expectations and also the consequence and side effects of the medicine being prescribed. Due care has to be taken and recorded while dealing with highly toxic medication including following known protocols for administering of such medication. Prescribed medicine or the course of treatment may be appropriate, however, lack of communication and counseling and poor management of the patient has the consequence of placing at risk the life of a patient as have been observed in this case. Good care and proper practices demand that prescription is unambiguous and it must contain the name, dosage and administration of the medication in an explicit and legible manner. Further, the patient and the attendants need to be explained particularly where prescribed medicine may have serious side effects and there should be clear instructions in the prescription as to administration of such cytotoxic medicine under supervision of a doctor at a health care facility. Furthermore, where a practitioner finds an emergency situation it must be communicated to the patient in the clearest terms including using all possible communication skills to make the patient aware of the dire consequences that may result. No sane patient or attendant made aware of the possible life threatening consequences behaves in a laid back or lackadaisical manner which is witnessed in this case.

29. Another aspect of serious concern is the shifting of the patient to another hospital when the doctor was aware of the serious condition of the patient and one which had been caused due to the Respondent doctors initial prescription and the consequent failure to respond with due care when becoming aware initially of the possibility of a toxic reaction on the evening of 13th October and

thereafter being fully aware of it at the time of physical examination of the patient on 14th October. If the patient was moved as per the doctors claim on the patients attendants insistence, which statement is contrary to the claimants statement that the doctor advised the shifting, the record at Mayo Hospital should have clearly recorded this in view of the known condition of the patient and risks involved. This is also why National Hospital initially was reluctant to admit the patient. Mayo Hospital is the leading tertiary care hospital in Lahore and the Respondent was the head of the department. It is unthinkable that the Respondent doctor was unable to ensure proper care of his patient suffering from a toxic reaction to his prescribed medication. Furthermore, the conduct throughout of the patient and his attendants has been of absolute confidence and faith in their doctor so much so that they waited till 15th October to take the patient to Mayo Hospital when their doctor would be himself present. Hence, their apparent alleged insistence to shift the patient to National Hospital a day after the patient had been administered the antidote and treatment had been initiated at Mayo Hospital does not appear to be a correct representation of facts by the Respondent doctor. It is unfortunately a known practice amongst some practitioners where the patient becomes visibly high risk they tend to advise shifting of the patient to another healthcare facility in order to avoid direct responsibility. This is a practice which must end and practitioners being trusted and trained professionals in whom patients vest full confidence and hand over the responsibility of their health must not shy away from the responsibility and must accept the responsibility including and specially where a mistake is potentially made by the practitioner. Mistakes will be made for every practitioner is human and that is where the difference between an error and negligence must be drawn. An error of judgment in good consciousness is not negligence. Failure to do what one is required to do or conversely do what one is not trained to do is negligence. If this inherent balance of trust is not protected and ensured between the doctor and the patient, it will become impossible for patients to be treated or doctors to treat a patient in the absence of absolute trust between the two.

30. As much as we may be inclined to take into consideration the mitigating circumstances in this case as to the conduct of the patients attendants as advocated by the Respondent doctor, the fact remains that the Respondent on multiple occasions failed to discharge the inherent obligation of duty of care towards his patient. Starting with prescribing a highly toxic medication to a private patient at his private clinic when he could have easily advised the patient to come to Mayo Hospital the next day and have the medicine administered there under a controlled environment. Added

to the mix a prescription which in the best of times could not be read by any educated person. Thereafter, critically his conduct from 14th October onwards represents a patent failure of duty on the part of a practitioner towards his patient in the knowledge that the patient's life is at risk and finally the attempt to disassociate himself from the case when he felt the risk to the patient's life had become too great and the responsibility would fall on his shoulders, cannot be ignored or brushed aside on account of mitigating circumstances. Lastly, such conduct by such a senior consultant with decades of experience in fact compounds the negligence.

31. In view of the facts and evidence in this case, the Respondent Dr. Atif Kazmi is found to have failed in discharging the duty of care expected towards his patient and acted negligently in his practice as a consultant towards the deceased patient and further acted in violation of the code of ethics imposed on a practitioner. Therefore, a penalty is imposed whereby the Respondent Dr. Atif Kazmi's license is suspended for a period of two (02) years from the date of this Order.

Dr. Anis-ur-Rehman
Member

Dr. Asif Loya
Member

Muhammad Ali Raza
Chairman

31st January, 2022