DECISIONS AND RECOMMENDATONS OF THE DISCIPLINARY COMMITTEE OF PAKISTAN MEDICAL & DENTAL COUNCIL ISLAMABAD

A meeting of the Disciplinary Committee was held on 28th June, 2019 at Pearl Continental Hotel, Lahore. The following Honorable Members / Subject Experts attend the meeting:

1.	Prof. Dr. Amer Bilal	Chairman
2.	Mr. Muhammad Ali Raza	Member
3.	Prof. Dr. Mirza Khan Tareen	Member
4.	Prof. Dr. Shehla Baqi	Member
5.	Dr. Aliya Bashir	Expert
6.	Prof. Dr. Khurram Attaullah	Expert
7.	Prof. Dr. Haroon	Expert
8.	Prof. Dr. Rizwan Butt	Expert
9.	Assistant Prof. Dr. Sadaf Arooj	Expert
10.	Dr. Farah Naz Zaidi	Assistant Registrar

The committee heard and considered the following cases and gave recommendations/decisions for placing the same before the Council for approval.

The Medical & Dental Council, Pakistan Medical Commission after due consideration has approved the recommendations/decisions in each of the following cases including the imposition of penalties as recommended.

CASE NO.1

PF.12-Comp-117/2016-Legal

Mr. Mian Bilal Bashir

Versus

Ikram Dental Surgery, Samanabad, Lahore.
Dr. Shahid Manzoor Ahmad (5914-D)

Submissions by Parties at the Hearing:

Both parties were present and were heard at length.Complainant stated that the respondent is promoting quackery. Respondent stated that he is a qualified dentist and he had left the HCE in 2016 when the case was reported to PHCC. He added that both parties have been heard at PHCC. The committee asked the respondent as to who had conducted the grinding of the teeth and respondent answered that he had not performed grinding. The complainant, who is an advocate himself, added that the dentist is the co-owner therefore his plea that he has left the HCE should not be accepted. He added that there are evidences that the respondent is still in relation with the HCE.The committee asked the complainant who was primarily involved for the procedure of grinding and the complainant answered that Mr. Ikram who is a quack had performed the process.

The committee then asked the respondent that whether he removed his name from the HCE. The respondent replied that he still goes to HCE for some old cases. Before 2016 he was full time and after 2016 he did not visit HCE as a full time or part time practitioner and joined another HCE.
The committee asked him about his qualification and he replied he is a qualified dentist and the owner is a paternal uncle to him.The committee showed displeasure on misrepresenting to public regarding his association with the HCE.

Findings

The expert opined as follows
Dr. Shahid Manzoor &Mian Bilal Bashir was allowed to speak uninterrupted and later questioned by the committee & me. Dr. Shahid Manzoor admitted that he has been working at the said HCE Ikram Dental Surgery, and continues to work on part time / visiting basis. Dr. Shahid had not performed any treatment but as per the HEC report he had introduced himself as the owner of the HCE.
In my opinion Dr. Shahid Manzoor Chaudhry has played a significant role in promoting quackery and covering it up. The council is right-ful in imposing penalty / fine as per rules and regulations of PM&DC.

RECOMMENDATION:

One year suspension of the respondent is recommended for misrepresentation to public. This considered as professional misconduct and deception. Advisory will be sent to PHCC to shut down the clinic.

Pakistan Medical Commission Islamabad

CASE NO.2

PF.12-Comp-184/2017-Legal

Nighat Yasmeen House No. 38,1-C, Shah Rukan-e- Alam Colony, Multan.
0300-7324639

Versus

Al-Khaliq. Patients Care ' Medical & Surgical Complex Nishtar Road, Multan. 614573703, 0331-7037'135
Dr. Tariq Ahmed (12944-P)

Brief of the Case:-

The Complainant Nighat Yasmin consulted the Respondent Prof Dr. Tariq Ahmad, Neurosurgeon at Faisalabad on 2l-10-2015 for the treatment of the Patient, her brother namely Imran Majeed who had been operated 04 years ago at Lahore. It is pertinent to note that the Patient was not physically present during the said consultation. The Patient was a case of recurrent right Temporoparietal SOL Brain with gross midline shift. The Respondent, after going through the investigations of the Patient, advised re- exploration and advised the Complainant to get the Patient admitted at the HCE, Al-Khaliq Patient Care Medical and Surgical Complex, Multan on24-10-2015 in the evening.

- The Patient was admitted at the HCE on 24-10-2015 at around 1800 hours. He was shifted to operation theatre at 0115 hours on 25-10-2015 and his craniotomy was done. He was brought out of the operation theatre at about 0515 hours. At that time, he had high grade fever and developed fits. The Respondent was called many times but he was busy in another operation. The Respondent subsequently examined the Patient and requested CT scan.
- Since the Patient had to be sent for Brain CT Scan, his airway hadto be secured and due to his altered state of consciousness, a tracheotomy of the Patient was done.
- The CT Scan check showed brain edema with mid-line shift. Respiratory rate of the Patient was also high.
- Therefore controlled ventilation was required and the only sole solution was to shift the Patient on ventilator. Later on the Patient was shifted to Medicare Hospital, Multan for ventilator support and ICU as these facilities were not available at Al-Khaliq Patient Care Medical and Surgical Complex. The Patient developed Acute Renal Failure duringadmission at Medicare Hospital.
- The Patient was transferred to CMH, Multan on request of his attendants at2000 hours on 29-10-2015 and, he expired on 30-10-2015 at around 0830 hours.

Preliminary Findings/Observations

As per expert opinion of PHCC
'The patient had a Recurrent Cystic Glioma in the Right Temporoparietal region with neurological deterioration 'Palliative surgery could have helped rather than aggressive excision. It has been manifested by recurrent seizure and high grade fever".
The post-operative care was severely compromised due to non- existent ICU facility and in-house CT scan availability' Any craniotomy patient, how so ever simple, can deteriorate and may need these facilities immediately- Immediate post-operative ventilator support in the ICU could have led to control of seizures and further brain damage. '

PROCEEDING OF DC MEETING 28TH JUNE, 2019 AT P.C HOTEL LAHORE:

Submissions by Parties at the Hearing:

The complainant was absent. The respondent was heard at length.

When asked he replied that Dr. Nasir who is FCPS neurosurgery as informed by respondent sees his patients when he is not present as the respondent works at Multan as well as Faisalabad

The committee asked why Dr Nasir did not see the patient in his absence and was the complainant aware of the internal arrangement between the respondent and Dr. Nasir, and was it part of the consent and is it documented.

The respondent said yes the complainant was aware and this was documented at that time

The respondent had to go to Faisalabad on Monday and he was asked whether it was his choice to perform the surgery at night. The committee mentioned that a patient with seizures should not have been operated after midnight, by a surgeon that had been traveling over 4 hours on public transportation.

Moreover, the committee was of the opinion that surgery should not be done in a suboptimal facility.

The committee observed with great concern that the respondent traveled on weekends and did surgeries throughout the night, though respondent had shown his element of sincerity.

The committee also questioned why the patient was not referred to Nishtar Medical Centre though the surgeon also worked in Nishtar Medical centre.

Findings:

1. Cranial surgery on a high risk patient who was actively seizing was performed in a hospital which lacked CT scan + ICU with ventilator facilities.
2. Patient was anesthetized for more than 4 hours.
3. Surgeon was operating after midnight while working the whole day, after long travel, on an elective case, can increase the risk of post-operative complications.
4. There was no continuity of care. The surgeon left in the morning for Multan.

RECOMMENDATION:

Two-year suspension for operating on a high risk patient and admitting patient to a sub-optimal facility.

Pakistan Medical Commission Islamabad

1. Mian Muhammad Mujahid R/o Abu Bakar Street, Nasheman Park, Housing Colony, Sheikhupura.

Versus

1. Dr. Iffat Cheema (20589-P) (Surgimed Hospital Lahore).
2. Dr. Khilat-un-Nisa (20590-P) (Surgimed Hospital Lahore).
3. Dr. Syed TaifurUl Islam Gilani (5503-P) (Surgimed Hospital Lahore).
4. Dr. Nabeela Shami (11070-P) (Surgimed Hospital Lahore).

Salient features of the Case:-

The complainant's wife Dr. Sana Mujahid developed labor pains and he took her to Surgirmed Hospital for S.U.D and she got admitted at 2:41pm on 14-08-18

Patient remained under laboring process till 6:00 pm and delivered healthy male baby under supervision of Dr. Iffat Cheema

Then later doctor informed that patient needs to go through the process of D&C as the placenta was adherent.After D&C, patient came out in semi- conscious state with a complaint of severe lower abdominal pain.

FINDINGS OF DC MEETING 27 APRIL 2019

The counsel states there is an order of Supreme Court and the matter is subjudice. Although none was provided.

It is a case of normal vaginal delivery followed by D&C for retained placenta and not a case of C-section.

According to Dr. Iffat, blood loss could have been around 1500 ml. It was observed that 1500ml loss could have been easily managed, let alone 4 pints were given meaning thereby that the actual blood loss was more than that. It appears to be more than a localized bleeding, that caused excessive blood loss.

It was observed that the Surgimed advertises having a hematology service, with a resident hematologist and a blood bank; however B positive, being the commonest blood group could not be arranged by the hospital. It was clarified that blood products arrangement is the responsibility of hematologist advertising hematology services. If the hematologist cannot arrange for blood products then he should only advertise for consultation.

With regards to differential diagnosis, it was pointed out that the differential diagnosis on the death certificate issued by Dr. Hassan is written as HELPP syndrome. However, the same has not been put in the treatment chart/notes anywhere by Dr. Iffat negated/ disagreed with the diagnosis mentioned on the death certificate. She stated she became aware of the diagnosis mentioned on the certificate later on but she made no effort to rectify it. She submitted that her diagnosis was DIC leading to multi- organ failure which she established in consultation with the ICU physician and nephrologists.

Consultant's/attending physician's whose name is mentioned on the certificate, was out of country and did not attend the patient.

There is no evidence of hematologist involvement or documentation.

Preliminary Findings/Observations

As stated by the parties the matter is still subjudice before the Supreme Court and Punjab Healthcare Commission under PHC Act, 2010.

Therefore the inquiry proceeding by PMDC may kindly be suspended/held-up till decision of the case by PHCC under direction of the Honorable Chief Justice of Pakistan.

RECOMMENDATIONS/DECISION OF DISCIPLINARY COMMITTEE MEETING HELD ON 27.4.2019

1. Punjab Health Care Commission (PHCC) will be asked for certified copies of the inquiry.
2. Record is of utmost importance and needs to be seen. Therefore, PHCC will be asked for the same.
3. The parties may provide any other additional information/ evidence e.g order of Supreme Court order etc to settle maintainability issue by 2nd of May.
4. Dr. Hina was asked to provide her submissions of her view / any other additional material that she wants to put on record.
5. Name of attending physician was mentioned who was abroad. Names of doctors on duty who were actually monitoring the patient should have been mentioned on the certificate. An advisory will be issued that the name of only an attending physician who is present at the time of consultation/procedure can be used. Using a physician/ consultant's name who has not seen the patient amounts to being false evidence and destroys a legal case. Moreover, it is misleading and deceiving.
6. Surgimed had a critical patient, but the diagnosis was not established until the patient passed away. It was concerned that right at the very outset, a haematologist should have been engaged and this needs to be identified so as whether any haematologist was engaged during the admission.

Adjourned. Notices to Dr. Hassan (Intensivist), Dr. Shamayl (Medical Physician), Dr. Zafar Iqbal (haematologist), Dr. Zahid Rafique (nephrologist), visiting doctors of Surgi Med.

PROCEEDING OF DC MEETING 28TH JUNE, 2019 AT P.C HOTEL LAHORE:

Submissions by Parties at the Hearing:

Both parties were present and were heard at length. The complainant stated that his daughter remained in critical condition for 20 hours and could be saved if appropriate management was done. He added that blood was not arranged in time and that timely transfusion of blood would have saved the patient.

Dr Zafar stated that a diagnosis of DIC was established and appropriate treatment was started. The committee asked if he is a hematologist or a pathologist hematologist and he said he was patho-heamatologist. The committee further asked why a hematologist rather than a pathologist had not been taken in loop and the respondent said that being a patho-haematologist, he had taken all measures.

The committee asked Dr. Shamayl whether he had seen the patient and ordered investigations. Dr. Shamayl stated that he had proceeded as per SOP but he was Prof of general medicine and not the primary consultant.

The other respondents when asked also stated that they had followed the SOPs during treatment of the patient

The committee noted that amount of blood loss was not anticipated.

The committee further noted that appropriate treatment for DIC was not available and a hospital offering private care should have been able to provide blood in time whenever required.

When asked, Dr Zafar stated that they have license from blood bank and they have blood bank service. The committee askedthe question whether the HCE has a blood storage facility or a blood bank, since there is a difference between the two. Dr. Zafar said that the HCE had blood storage facility.

The committee showed displeasure on the failure to arrange the blood and further asked Dr. Zafar why appropriate management had not been done when an emergency occurred. The committee further asked as to who was the person involved in making the diagnosis and Dr. Zafar replied that he was the physician involved in making the diagnosis

The committee further asked why clinical hematologist was not considered.

Next the nephrologist Dr. Zahid Rafique was asked to describe his management of the patient and he replied that he saw the patient within half hour of being called and TLC was approximately 16000-17000 and it was rising despite antibiotics and the condition was deteriorating despite all team efforts. He said that the differential diagnosis ranged from DIC, HELLP, fatty liver, SEPSIS in all of which conditions the laboratory parameters are overlapping. When asked what he considered was the final cause of death, he replied it was sepsis and multi-organ failure. The Creatinine was 2.5 and the GFR was around 40ml/min. Potassium was around 5, but there was no bradycardia. The symptoms were suggestive of HELLP syndrome. Dialysis was delayed due to deranged INR.

The committee further asked whether the patient had a hematoma or retained placenta and the gynecologist replied that retained placenta was removed well in time and later on a hematoma developed. The committee asked whether removal of the placenta was complete and the gynecologist replied that the placenta was removed completely as delivery was at 6:10 pm and placenta was removed at 7 pm. The committee commented that this means that the placenta was not removed completely initially and so later proceeded removal of retained placenta. The gynecologist Dr. Iffat further stated that at 2:45 am there was a bulge in vagina noted and she called her senior, Dr. NabilaSahmi, though she was not on call, for further expert management. The expert asked why hematoma was not managed and was it above the episiotomy or on side and who inserted the pack. The gynecologist said the doctor on duty had picked up the hematoma. Then the expert asked whether the patient was bleeding externally. The gynecologist Dr. Iffat called Dr. Nabila while shifting to OR and Dr. Gillani was monitoring the vitals and the anesthetist part. Dr Nabila said that the tissues were extremely friable. There was one point above the right fornix which was hard to access, so called Dr. Waseem for additional help, though he was not on call.

The committee appreciated the role of Dr Nabila and Dr Waseem for coming immediately to see the patient in the middle of the night when they were not on call. Regarding the nephrologist, he too was following SOPs

OBSERVATION

During discussion the expert opined that with Hb approx 7.1 the condition should not have deteriorated and 7 or 7.5 is the threshold for starting hemodynamic management. The committee further asked whether it was ischemic ATN. Dr Nabila stated that the situation

was settled to the extent of bleeding along with the help of Dr. Waseem and committee appreciated as they came at 4 am immediately on being called and observed the patient for one hour and managed the patient well thermodynamically.
The committee showed displeasure with CEO Dr. Gillani that patient was admitted under the name of a consultant Dr. Shaheena who was not in the country.Dr. Gillani sought guidance as to what the process should be if a consultant is unavailable and refuses admission of a patient on that basis. The committee recommended that in such a case, informed consent should be taken in writing before refusal. The committee further asked Dr. Iffat why Dr. Nabila was called and she replied that the patient had a vaginal hematoma and vitals were not stable.

The committee further advised Dr. Gillani that no anesthesia should be done without the accompanying primary physician and similarly it should always be ensured for other disciplines as well.

Findings by Expert
"I heard the case and investigation of the parties. I am of the opinion that it is a known complication of obstetrics to have placenta retention after normal vaginal delivery which sometimes need to be removed under GA which is what happened in the case. Vaginal hematoma formation is also a known complication of obstetrics, which can be easily missed till patientcomplains of vaginal discomfort or pain or there is deterioration of vital signs of the patient, at which point the hematoma needs to be drained under general anesthesia. This was done in Dr. Sana Mujahid case. Dr. Iffat Cheema responded in time as soon as she was called by doctor on duty along with Professor Nabeela Shami. To me it was all complications of NVD in which patient deteriorated because of vaginal hematoma."

RECOMMENDATIONS:
The hospital practices are not upto the standards regarding admission policy and the blood arrangement.An advisory should be sent through PHCC for blood bank.
Dr. Iffat is issued a suspended sentence for six months.
The pathologist Dr. Zafar Iqbal may be warned to be careful in future not to advice on clinical management.
The hospital must streamline their admission policy and blood bank service.

Pakistan Medical Commission Islamabad

CASE NO. 05
12-Comp-34/2014-Legal

Forwarded by Additional Secretary to Chief Minister Punjab, Lahore.
Malik Muhammad Akbar,
231-C PGSHF Scheme, Defence Road Opposite Bahria Town, Lahore. 0334-4094416.

Versus

Dr. Khalida Sultan (WMO), (34246-P) Mola Baksh Hospital, Sargodha.
Dr. LubnaAdeeb (WMO) (48021-S), Mola Baksh Hospital, Sargodha.
Dr. Sadia Babar (Gynecologist) (34479-P) Mola Baksh Hospital, Sargodha.
Dr. SairaTayyab,Mubarik Medical Complex, Sargodha
Dr. Guftar ,DHQ Hospital, Sargodha.
Dr. Nasir(Senior MO) (21381-P),DHQ Hospital, Sargodha

Salient features of the Case:-

A complaint has been forwarded by Additional Secretary to Chief Minister Punjab, Govt. Of the Punjab, Lahore enclosing the complaint of Malik M. Akbar (Ex-DG PTA) against Dr. Sadia Baber and Dr. Khalida Sultan of Mola Bakhsh Hospital Sargodha for committing gross negligence in the delivery case of his daughter namely Huma Nadeem which resulted in death of both of her kids.

Comments from the MS, DHQ Hospital, Sargodha submitted that the patient never died in their hospital. The Medical Officer was granted bail by the court. The death caused was due to shifting of the patient from Mubarak Hospital Sargodha to DHQ Hospital Sargodha at their own risk & cost.

Preliminary Findings/Observations

A report of inquiry has been enclosed by the respondent doctor hold by Directorate Health, Sargodha in which Dr. Sadia and Dr. Khalida were exonerated from charges of negligence. Dr. Lubna Adeeb was also exonerated having no role in the treatment and in management of the patient.

The complainant had also filed a WP No. 7929/14 wherein the court vide order dated 25.03.2014 had referred the case to Secretary Health Department to decide the matter within 30 days. The Secretary Health vide its order dated 20.05.2014 exonerated from charges to respondent doctors.

A report of inquiry has been enclosed by the respondent doctor by Directorate Health, Sargodha in which Dr. Sadia and Dr. Khalida were exonerated from charges of negligence. Dr. Lubna Adeeb was also exonerated having no role in the treatment and in management of the patient.

A report of inquiry enclosed by the complainant in rejoinder which are contradicted report enclosed by the respondent doctors, wherein the Additional Principal Medical Officer DHQ Teaching Hospital Sargodha recommended disciplinary action against respondent doctors under PEEDA Act 2006.

DECISION OF THE DISCIPLINARY COMMITTEE MEETING HELD ON 19-04-2015

The committee heard both the parties with detailed deliberation and respondent doctor stated that the patient left LAMA at 08:30PM and died in a private hospital. It has been established. In light of expert opinion it is a case of hemopenotorium, that the patient. Dr. Sara Tayyab of Mubarak Medical Complex and Dr. Guftar at DHQ Hospital Sargodha and Dr. Nasir Senior MO, DHQ Hospital be called.
The case is **adjourned**.

FINDINGS/DECISION OF DC MEETING HELD ON 18TH APRIL, 2017 AT UHS, LAHORE

The committee recommended that the Registration certificate of Dr.Lubna, Dr. Sadia and Dr.Khalida be suspended for one year and Dr. Nasir shall be suspended for 6 months

THE CASES WAS CONSIDERED BY COUNCIL IN ITS 196TH SESSION HELD ON 18.5.2019.

"The Council decided that the minutes of the Disciplinary Committee meeting dated 17.4.2017 are referred again to Disciplinary Committee for review."

PROCEEDING OF DC MEETING 28TH JUNE, 2019 AT P.C HOTEL LAHORE:

Submissions by Parties at the Hearing:

Rafiullah pleader of Dr. Sadia and hearing is fixed before additional session judge on 5/7/2019 and also raised question why inquiry officers were not called for personal hearing.
The committee said that this hearing was fixed under PPC however PM&DC is a regulatory and licensing body and PM&DC will evaluate the extent of professional negligence and decision regarding suspension of license and calling of inquiry officer is entirely upto PM&DC if to call them in next hearing
Dr. Sadia, the gynecologist, and Dr. Lubna the medical officer also appeared in the meeting.
The meeting began with the statement of complainant that his daughter expired due to professional negligence and tried to settle the matter by bribing the inquiry officer to get exonerated however no CTG etc was done and patient could have been saved if treated and managed as per SOPs.
The committee asked about who was the main consultant and Dr. Lubna replied that there were 2 medical officers including herself and Dr. Khalida and Dr. Lubna was not the doctor on duty and Dr. Khalida was the primary officer.
Dr. Sadia stated that she came at 8 am and saw the patient, who had been admitted late night/early morning, sitting in a chair in the Labour Room, and there was the Medical Record but no laboratory results and was told that labs had been sent early morning. She then advised to send the patient for an ultrasound and to follow-up on the laboratory results, and she then started examining other patients. She left at 5 pm for home at which point there was no sign of the patient as she had not returned from the Ultrasound and she assumed that the patient had left LAMA.

The committee asked about documentary evidence regarding documentation of LAMA and the Dr. Sadia said that the medical officer had mentioned on the file that patient left LAMA.
The committee showed displeasure on non-documentation of events and the expert asked how a full term pregnant lady could walk out of the setup to another hospital without any medical reference.
Dr. Sadia said that on clinical examination patient had looked well and there were no signs of labour pains and the only complaint at presentation was diarrhea and patient informed them that she is 9 months GA but did not have any records of antenatal checkups. Dr. Sadia said that she planned that after checking the labs she would carry on with the required management plans. She added that there was no autopsy requested by their hospital. The committee asked Dr Sadia why the patient had been referred or had come to a gynecologist for complaint of diarrhea. Dr. Sadia replied they receive patients for all symptoms and almost half of the patients are mishandled by quacks that are around. The patient gave history of castor oil ingestions as recommended by some quack as told by attendants so Dr. Sadia had the perception that the diarrhea could be because of castor oil
Dr. Lubna added that the duration of stay of the patient may be checked from records however as far as Dr. Sadia remembers she saw the patient at 8:15 and sent for her for ultrasound and the patient never came back.
The committee asked Dr. Sadia that when was the LAMA done and whether the ultrasound was done or not. Dr. Sadia replied that she is not exactly sure about the time of LAMA and that the patient had gone for the ultrasound as evident from the ultrasound records however she can not specify time of leaving.
The committee asked why the attendants were angry.
Dr. Nasir from DHQ said he was in the emergency ward when he received referral from Maula Bux hospital which is the Gynea wing of the DHQ and at that time patient was critical and restless and it was even difficult to record a BPand when he was asked he replied that he thinks patient was brought on stretcher and left DHQ LAMA again when referral to private hospital was not given by him..
Dr. Guftar added that if Dr. Sadia had referred to cardiologist, then U/S could have been done there. Dr. Sadia replied that she had only asked for ECG.

OBSERVATIONS

The committee asked that why ECG was advised for a young patient with no cardiac symptoms and to a full term patient with only complaint of diarrhea which is how Dr. Sadia had initially described the patient to be, and in such a patient referral for ECG toemergency was not needed. Therefore had condition suddenly deteriorated further from when Dr. Sadia had first seen the patient? Dr Sadia failed to answer appropriately and she said she felt she should advice for ECG. She said that patient had shortness of breath and she felt that she should order an ECG just to be sure.
The committee further added that restlessness could have been due to hypoxia and therefore not receiving enough oxygen for herself and the baby and sending her was a drastic decision.
Dr. Sadia mentioned that she has reservations as Dr. Nasir statement was not recorded at all by inquiry officer and Mubarak hospital mentioned two different statements, one mentioning received dead and the other one that patient died after resuscitation.

Findings by Expert:

"Dr. Sadia Babar (Gynecologist) was unable to satisfy the Board with her statements regarding patient management (patient was young only 26 years old) her statements were

contradictory regarding patient management. Patient got some sudden event leading to death of patient."

RECOMMENDATION:

The committee recommended for one year (01) suspension of Dr. Sadia for professional negligence and incompetence.
In addition, Dr. Sadia should attend the Advanced Life Support in Obstetrics (ASLO) course in order to be reinstated.

Mr. Muhammad Arshad , SaknaTarlai Muzaffargarh.

Versus

Dr. Abdul Khalid Khanzada Jinnah Hospital Lahore.

Salient features of the Case:-

The Commission obtained expert opinion on 08.04.2015 and the same is as under:

"Mrs. Ayesha Siddiqa age 4l-yearsGI4P9A4

The patient appears healthy /fatty.

The patient was referred by the gynecologist to a radiologist while she visited Ejaz Ultrasound Centre on 6.08.2014 where she was reported Mono-amniotic, Di-chorionic twins which puts doubt on the credibility of the report.

In the multipara fatty lady, sometimes single fetus may look like twins known as "mirror image " ghost twins (ref attached).

Twins report must have been verified in the last trimester for biophysical profile / presentation, weight etc.

On 21.11.2014 she was again referred to a place while she again visited other clinic.

The image attached with US report of 16.8.14 shows only the umbilical cords Doppler study of one fetus and not the twins.

From the evidence available, it appears that it was a single fetus which was ghost image. "

The expert in gynecology & obstetrics opined as under: "Seems to be an USG error and not a case of twin pregnancy.G 14 A4, 4l-yrs Mrs. Ayesha Siddiqa. In multipara pts lower abdominal fat may obstruct accurate USG findings. Antenatal visits are not regular. First trimester USG was never done. Available picture shows Doppler of one baby only.

It seems that OB/GYN specialist assumed that there were twins and based on that C/S was planned and done.

As soon as it was discovered that it was a single fetus the family was brought in and showed that there was only one baby who has been confirmed in evidence (theatre staff. Placental sample could have been instrumental of singleton or twin pregnancy but the placenta was wasted / buried by the family. "

Preliminary Findings/Observations

The Board also noticed that all the expert opinions supported the version that there was single fetus, the relevant portion of expert in radiology reads as under, "from the evidence available, it appears that it was a single fetus which was ghost image." The expert in Gynae recorded, "it seems that OB/GYN specialist assumed that there were twins and based on that C/S was planned and done" but seeing one child on delivery, she immediately called the attendants and informed about one baby. The 2nd expert Gynea/Obs. also opined that it was single pregnancy

The case of Dr. Abdul Khalid Khanzada is referred to PMDC for issuing flawed and inconsistent ultrasound report.

A warning is issued to Dr. Saira Ayub and Dr. Rashida Amir for destroying the medical record of patient Mrs. Ayesha Siddiqa.

PROCEEDING OF DC MEETING 28TH JUNE, 2019 AT P.C HOTEL LAHORE:

Submissions by Parties at the Hearing:
The respondent admitted that it was dichorionic diamniotic pregnancy.
Complainant was absent.

Findings by expert:
There are ways to combat artifacts in ultrasound which must be followed.

RECOMMENDATION:

The committee recommended for warning to the respondent to make sure correct documentation next time as there was no direct professional negligence involved and a typographical error had occurred with the old radiology report.

CASE NO.7

PF.12-Comp-124/2016-Legal

Sajjad Gul MizaJarmol Kalan, Tehsil Gujar Khan, District Rawalpindi. 0311-1484691

Versus

Aftab Hospital, Gujar Khan,
Dr. Sadaqat Aftab (27061-P)

Salient features of the Case:-

"According to record, patient Mrs. Sadia d/o Ghulam Gul was admitted on 5.1 1.14 with Dr. SadaqatAftab (Gynecologist). Her blood group was (B negative). Her labor was induced respecting patient's desire for normal delivery. During 2nd stage of labor, she had hemorrhage and failure to progress. Her emergency C-section was done. Her blood was not available at that specific moment as it was already asked by the doctor to cross match but specific person was not available in the town, According to the record, patient was shifted in ambulance, arranged by the doctor, in stable condition because of non-availability of B negative blood group.

Preliminary Findings/Observations

The Board noted that no autopsy of the deceased was performed. Many of the statements of the complainant proved incorrect during investigation and proceedings. Moreover, there were obvious discrepancies in the statements of the complainant and his witnesses. The respondent could only produce the medical record regarding the surgery and immediate post op period. There was no signed consent form for surgery, no record of pre-op investigations, no documentation of progression of labor, fetal monitoring and vitals of the patient during pre-op period. She however mentioned the details during her oral evidence dated 15-10-2015. Dr. Sadaqat Aftab is an FCPS (Obstetrics & Gynaecology-2004) and Head of the Department of Obstetrics & Gynecology, THQ Hospital Gujar Khan.

PROCEEDING OF DC MEETING 28TH JUNE, 2019 AT P.C HOTEL LAHORE:

Submissions by Parties at the Hearing:

Complainant was absent. The respondent Dr. Sadaqat appeared in hearing. Diagnosis of obstructed labor was made with no documentation for failure to progress. The committee asked whether the facility had monitoring facility and the respondent replied yes.

Findings by Expert:

Dr. Sadaqat Aftab is FCPS Gynecologist. She induced patient Mrs Sadia d/o Ghulam Gul G2P1 who was B-Negative blood group. According to Dr. Sadaqat patient progressed well in labor butduring second stageof labor she got bleeding plus obstructed labor for which she was operated by Dr. Sadaqat who was qualified Gynecologist. She also called surgeon to take opinion before closing the abdomen of patient. According to Dr. Sadaqat there was about 1500 CC blood loss intra-operatively. Patient was ok following surgery but after sometime she got restless and referred to Rawalpindi. During her way to Rawalpindi patient died. Dr. Sadaqat had no crossed matched blood prior to induction of patient. She had not produced the monitoring document regarding patient care.

RECOMMENDATION:

One year (01) suspension for the respondent is recommended.

CASE NO.8

PF.12-Comp-191/2018-Legal

Sajjad Yasir Raza House No. 4, Street No. 13, Goru Mangat Road, Gulberg-lll, Lahore. 0321-7 510257

Versus

Wasifa Clinic & Maternity Services, Johar Town, Lahore
1. Dr. WasifaShammim (3213-S) (referred by PHCC)

Salient features of the Case:-

The patient, Hira Yasir was a regular antenatal patient of Dr. Wasifa & she had visited Wasifa Shamim Maternity clinic on 14-03-2016 and gave birth to a dead baby in the same clinic at about 9.30 pm. Dr. Wasifa did not have facility for caesarean section in her clinic which had been conveyed to the patient's attendants. The patient had left the labor room after delivery and had walked by foot with the support of attendants.

Discharge slip issued by SGRH depicts that Hira Yasir had presented with PV bleeding and passage of clots after delivery. A diagnosis of retained products of conception (RPOC) had been made. Evacuation & Curettage (E & C) had been performed and sample sent for histopathology.

Birth certificate of baby has been issued by Dr. Wasifa as male (dead), dated 14-03-2016, weight: 3.5 kg, without mentioning serial # and baby's length. Dr. Wasifa letter pad shows her postgraduate qualification as DGO, whereas same has not been registered with PMDC. The attendants of the patient had misbehaved with and abused Dr. Wasifa and threw items of labor room & had threatened the respondent in her clinic.

Preliminary Findings/Observations

In discharge slip the time of baby's death has been mentioned as 18 hours after delivery while operationnotes show the death as IUD (Intrauterine death).

It was evident from the available patient record that the baby had expired in early neonatal period (ENND). Dr.Wasifa Shamim could not monitor fetal cardiac activity as she had not used CTG monitor. There was no pediatrician to cover the delivery under consideration. Chances of hypothermia could also not be ruled out as being the cause of baby's death.

There was poor record keeping of the patient by Dr.Wasifa Shamim. The element of proper counseling had been lacking by Dr.Wasifa Shamim. There seems to be an element of inadvertent professional incompetency on the part of the respondent.

There had been a lot of agitation by the attendants of the patient at death of their baby, which they had confessed in their statements.

The case of Dr.Wasifa Shamim is referred to PM&DC for pretending to be a qualified postgraduate Gynecologist (DGO) whereas she is only M.B.B.S.

PROCEEDING OF DC MEETING 28TH JUNE, 2019 AT P.C HOTEL LAHORE:

Submissions by Parties at the Hearing:

Both parties were heard at length

Dr. Wasifa stated that she is only MBBS and did not perform any procedure beyond her qualification.

Complainant stated that the respondent had committed to provide necessary treatment and at 3 pm on 14/3/2016 conveyed that there still is some time left for delivery. And at 7 pm they were told that the patient has given birth to dead male baby. He added that the attendants were told at nick of time that if they want to shift the patient the responsibility will lie on attendants as now head is down and delivery will occur at any time. Therefore the complainants were not left with any option other than to stay and watch.
The respondent confessed that she is only MBBS and upon query regarding her display of additional PG qualification she had no appropriate answer.
The committee further asked about the dose of syntocinon in units and rate of infusion and she replied that was 10 unit and 10 drops per 15 minutes. When she was asked about how she calculated the rate she replied she used her watch. When further asked about the dosage calculation per kg, she failed to give a satisfactory answer.
The committee asked whether there was meconium and the respondent answered it was clear liquor. Then committee asked what is number of deliveries conducted per month and what is the mortality rate and the respondent replied that the deliveries conducted are approximately 40/ month and she is not sure about mortality rate. She was also not sure about the APGAR score when asked. She also stated that the attendants had misbehaved.

FINDING

The respondent had been negligent in providing care for the mother and arranging paediatric referral that resulted in death of both mother and the baby
She also misrepresented herself as DGO by adding STD as claimed by respondent herself that she writes the degree STD to signify that she had studied in a DGO training program. Committee noted that this misrepresentation as DGO was to attract patients.
The pediatric expert opined that the baby was not born dead by the was born to mother who died and the baby took some breaths and the respondent failed to arrange paediatrician facility as this was ENND.

Finding by Expert:

"Dr. Wasifa Shamim is only MBBS plus she writes STD (student of DGO) on letter head pad which is illegal. She delivered the patient by NVD at 9 pm. Baby delivered with poor Apgar score and died after short time. She was lacking in neonatal resuscitation. The Committee decided to suspend her license for 1 year and Gynae /Obstetrical practice till she passed DGO and also course."

RECOMMENDATION:

The committee recommended One year (01) suspension and she can not undertake any gynae/obs cases till she passes DGO and also recommended to do Advanced Life Support in Obstertrics (ALSO).

Pakistan Medical Commission
Islamabad

CASE NO.10

PF.12-Comp-204/2018-Legal

Yasir Bilal, Officers Colony, District Complex, House No. 25-A, Tehsil & District Layyah. 0300-6768045

Versus

Al Khidmat FOF Matemity Hospital Employees Colony, Layyah.
0606-41 131 1
Dr. Misha Majeed (89827-P) (referred by PHCC)

Salient features of the Case:-

The wife of complainant 30 years od G4P3 presented in the opd of Al-Khidmat Maternity Hospital Layyah on 23/5/2016 and was examined by Dr. Humaira and was treated as a case of missed abortion 13 weeks on 24/5/2016 patient revisited for Termination of pregnancy and after the procedure ultrasound was done at night after complaint of abdominal pain revealing POCs

On 25/5/16 3 am patient was referred to DHQ hospital Layyah where peritionitis was diagnosed and exploratory laparotomy was performed on 26/5/2016

Per-operative findings included about 300 ml of foul smelling blood in the peritioneal cavity, perforation of the uterus with POCs and one foot gangrene of the ileum. Resection and anastomosis was done. After aggressive treatment, the patient recovered and was discharged on 3/6/2016

Preliminary Findings/Observations

Uterine perforation is a known complication of D and C and timely intervention can improve patient's outcome. The respondent Dr Meesha has pleaded that she had referred the patient in time for further management

PROCEEDING OF DC MEETING 28TH JUNE, 2019 AT P.C HOTEL LAHORE:

Submissions by Parties at the Hearing:

Both parties were heard at length

The respondent told that she is pursuing MD pediatrics and she is not willing to carry on in field of gynecology as her main interest lies in paeds.

Findingsby Expert:

"Dr. Meesha Majeed is MBBS and performed D&C after expulsion of fetus during which uterus perforation occurred which is a known complication of D&C can occur even in expert's hands. She had diagnosed this complication in time andshe took advice from her senior gynecologist and referred the patient to DHQ hospital in time".

RECOMMENDATION:

Respondent be given suspended sentence for one year.
She cannot practice gynea/obs until she clears DGO.
Case will be forwarded to PHCC regarding the HCE which is recommended for closure.

CASE NO.11

PF.12-Comp-182/2017-Legal

Muhammad Aslam Klus Gama Post Office Kanganpur, TeshilChunian, District Kasur. 0301-4632809

Versus

Zain Hospital, Kanganpur, Kasur.
Dr. Fayaz Ahmed (51936-S) (referred by PHCC)

Salient features of the Case:-

That complainant who is a labourerby occupation took his daughter-in-law Nazia Bibi to Zain Hospital on 28.06.2016 at 3:00 p.m. Nazia Bibi was having labor pains and it was her first pregnancy. The C- section was performed by Dr. Fayyaz on the same day and a baby girl was born. Patient remained admitted for three days and she was discharged on 30.06.2016. Dr.Fayyaz himself gave spinal anaesthesia to the patient. That because of continuous pain in the abdomen, Nazia Bibi was again taken to Zain Hospital on the 4 post-op day. Dr. Fayyazhad gone on leave for 4 to 5 days. The wound ofthe patient had gotinfected and when Dr. Fayyaz came back from leave he examined the patient and found out that there was a lot ofpus in the wound and stitches had got opened because of the pressure.

That on 18.07.2016, seeing the condition of the wound Dr. Fayyaz referred the patient to Sheikh Zayed Hospital Lahore on the request of the complainant and the doctors there after seeing the patient had refused to admit her. Thereafter, patient was taken to Mayo Hospital Lahore where she was admitted on21.07.2016.

Her laparotomy was done in which pus was drained from a sack, sub-phrenic collection was also drained and serosal tear repaired with prolene. A mesenteric cyst of 7x7 cm was also excised. The culture of peritoneal fluid showed no growth after 48 hours of incubation. CBC of Nazia Bibi done on 27.07.2016 showed Hb level of 9.5, WBC count of 7.7 and platelet count of 307000/-. Her blood urea was 18.6 and creatinine was 0.5. The biochemical analysis of the peritoneal fluid showed glucose value of 148 mg/dl and Protein value of 8.6 g/dl. The patient was discharged from Mayo Hospital on 30.07.2016. Dr. Fayyaz is a graduate of Liaqat Medical College Jamshoro having passed in 2007. He has not done any post-graduation.

The Board has also noted that Dr. Fayyaz the owner of Zain Hospital Kanganpur, is a government employee looking after two BHUs.

Preliminary Findings/Observations

As per PHCC expert opinion at time of inquiry:

"The available evidence shows that Mrs. Nazia Shahbaz had an emergency C/Section at a private set-up and developed wound infection and intraperitoneal pus collection. Wound infection is a known complication of any abdominal surgery due to various predisposing factors like low immunity, anemia, diabetes and faulty aseptic measures etc. and if not treated promptly can lead to septicemia and other complications.

The PHC team pointed out number of deficiencies at that healthcare facility which seems very unsafe for the human lives. Moreover, statement of doctor that he simultaneously was anesthetists and surgeon is very unsafe for the patients. C/section is a major surgery where qualified obstetrician/surgeon, anesthetist and neonatologist should be present.

PROCEEDING OF DC MEETING 28TH JUNE, 2019 AT P.C HOTEL LAHORE:

Submissions by Parties at the Hearing:

The respondent appeared for hearing. Complainant was absent. The committee asked who gives spinal anesthesia and the respondent answered that no qualified anesthetist practices in the HCE. The respondent when asked mentioned that the pulse was 70/min . The committee asked what is first sign of concealed sign of concealed hemorrhage and perforation and the respondent failed to answer.

The committee asked why patient was not referred to THQ which was 20 min away from his HCE at Kanganpur and the respondent said it was 40 km away. The committee further asked about sterilization techniques and the respondent failed to reply appropriately

Findings by Expert:

"Dr. Fayyaz Ahmad is simple MBBS who gave spinal anesthesia and performed C-Section of patient himself. The patient came to him in labor with bleeding P/V according to Dr. Fayyaz he did all this to save patient life. But Dr. Fayyaz is only MBBSand he is not supposed to do LSCS and give spinal anesthesia which is ethically wrong. The Committee decided cancellation of Registration for life time."

RECOMMENDATION:

Permanent cancellation of registration of the respondent is recommended.

Pakistan Medical Commission Islamabad

CASE NO.13

PF.12-Comp-140/2017-Legal

Mr. Mazhar Iqbal, S/o Mr. Manzoor Hussain, R/o House No.727, Mohalla Islarf Pura, KhanqahDogran, Distt Sheikhupura .0301-4050608

Versus

Khan Hospital, Sargodha Road, Shikhupura
Dr. Muhammad Javed Shakir (28153-P)
(referred by PHCC)

Salient features of the Case:-

Mst Shahnaz Munawar, aged 40 years was having menorrhagia for the last two years. She consulted Lady Dr. Mahtab Qayyum at Sheikhupura and Dr. Rubina at Gujranwala. Dr. Foqia Asif Khan, Khan Hospital, Sheikhupura mentioned in her reply that she was shown prescription of Lady Dr.Mahtab and Dr. Rubina wherein hysterectomy was advised by these doctors. The Commission examined the available prescription slip of Lady Dr. Mahtab and there was no advice for the patient to undergo surgery.
The Board has further noted that patient developed DIC possibly due to multiple transfusions, electrolyte imbalance consequent to administration of I/V fluids, and septicemia due to repeated surgeries at short interval and inadequate sterilization in the OT.
Board has also noted that Dr. Foqia Asif Khan and Dr. JavaidShakir failed to provide post-operative care as per the standards and by causing delay in referral of the patient to tertiary care hospital. Inadequate medical documentation on pre-operative, operative and post-operative plan of care by Dr. Foqia Asif Khan and Dr. Javaid Shakir

Preliminary Findings/Observations
The case of Dr. Muhammad Javaid Shakir is referred to PMDC for doing malpractice leading to the death of the patient.

PROCEEDING OF DC MEETING 28TH JUNE, 2019 AT P.C HOTEL LAHORE:

Submissions by Parties at the Hearing:
Both parties were heard at length.
The complainant stated that Dr. Foqia should be inquired as well as she was the primary consultant.
Respondent admitted that there was lack of documentation and he would improve documentation and he will avoid practicing at HCE with lack of facility.
He was working without a written contract.
The respondent stated that he got the patient after referral from Dr. Foqia, who was the owner of the Clinic, for hysterectomy and the committee asked about qualification of Dr. Foqia he replied that she was simply MBBS and the respondent performed hysterectomy on recommendation of the doctor. The committee showed displeasure that a doctor with basic qualification of MBBS had no right to refer for hysterectomy. They felt that Dr. Javed had crossed several ethical lines. He was a surgeon who agreed to do a hysterectomy for dysfunctional uterine bleeding on the request of an MBBS doctor at her private clinic. The

patient's own or any other qualified gynecologist had not recommended for hysterectomy. In addition informed consent was not obtained and the patient was less than 40 years.
The respondent replied that he did not obtain informed consent directly as it was obtained by HCE. Moreover, there was no written contract and the facility was sub-optimal for surgery.
The committee further observed that routine hysterectomy with no history of adhesion and no previous surgeries would not be difficult for a trained FCPS gynecologist.
The respondent when asked replied that he is currently working with Fatima Memorial Hospital as general surgeon.
The respondent when asked replied that he did not find active bleeding at the time.
The committee directed him to stay careful and work after written documentation.

Findings by Expert:
Dr. Muhammad Javed Shakir is FCPS General Surgeon working as Associate Professor at FMH Lahore. He did TAH on call and request of Dr. Foqia (MBBS). The patient Mrs. Munawar was 40 years old with diagnosis of DUB. Following hysterectomy next day patient became serious because of internal bleeding possibly because of slip of some ligature and he reopened the patient and plus secured homeostasis and referred to HLH next day. Dr. Javed is General Surgeon and not gynecologist. Dr. Foqia is also MBBS doctor, Dr. Javed should not call Dr. Foqia to do Gynae Surgery. The Committee decided that his license is suspended for one year. Faculty Registration is cancelled for whole life.

RECOMMENDATION:

Dr. Foqia will be issued notice for appearance.
Dr. Javed Shakir recommended for one year suspension with faculty registration cancelled permanently.

CASE NO.14

PF.12-Comp-97/2016-Legal

Mr. Naveed Younas House 29, St; 3, New Chaudhary Colony Okara.03007959643

Versus

Nosheen Memorial Welfare Trust Hospital, Okara.
Dr. Samina Anwar (17482-P) (referred by PHCC)

Salient features of the Case:-

The facts germane to the decision of this case are that the complainant took patient Allah Rakhi to Nosheen Memorial welfare Trust Hospital, Okara for Pyometra (pus in the uterus). He was apprised that the operation of the patient would be conducted by Dr. Jamil at 09:30 pm. The investigations of the patient were done by Meditest Lab and Ultrasound by Dr. Khaiil. The task was accomplished and the reports were handed over to owner of the HCE. Later it was informed to the complainant that Dr. Jamil was not coming and the operation would be conducted on 15.05.2014. On 15.05.2014 at about 12:00 pm an unknown doctor came in the hospital alongwith Mr. & Mrs. Shahid and directed them to arrange two pints of blood which was arranged. The patient was then shifted to the operation theatre at about 09:00 pm. At 1l: 00 pm', the complainant received a telephonic call that the patient was very serious, so he came back immediately in the hospital. On his arrival one more pint of blood was demanded which was provided too. Dr. Samina Anwar performed thesurgery under spinal anesthesia and total abdominal hysterectomy was done. Dr. Samina was assisted by Dr. Attique but later, during the operation, she called her own OTA, Wazir Muhammad, as she felt that Dr. Attique was not giving her real operating field. The bleeding could not be controlled. There were a lot of adhesions due to chronic cervicitis. When the cervix was removed there was profuse bleeding from vault of the vagina. She applied ligature over the bleeding points, but failed to stop the bleeding because tissues were very friable as when the needle or stich would pass through the tissue, it would start bleeding. Packing was done and blood was transfused immediately. Hemostatins were injected, drain tube passed and abdomen closed in layers.

The Board noted that Dr. Samina Anwar left the hospital at 01:00 am, without writing post-operating notes with the promise to write on next day and complete the file work. The patient was left under care of Dr. Attique from 0l:00 am to 03:00 am who continuously monitored her BP and pulse, transfused one pint of blood and injected Hemocele, Ringers lactate and oxygen but she failed to recover and later at night the patient's condition started to deteriorate and she finally died.

The board noted with serious concerns that surgery of such serious nature was conducted in the late evening, with no qualified anesthetist, no primary doctor on hand, no vital operative and post-op information documented. PMDC registration of Dr. Attique-ur-Rehman expired on31.12.2013. Mr. Wazir Muhammad Khan, OTA is not registered with Pakistan Medical Faculty. No postmortem was performed of the deceased. Surgeon Dr. Samina Anwar with her qualification and experience in several hospitals should have performed her job satisfactorily as is the established protocol of any surgery. Dr. Samina Anwar should not have performed this major surgery without a qualified anesthetist and facilities of an ICU. The primary surgeon should have performed surgery only after having a team of her liking assisting her and definitely not when she was physically and mentally exhausted- Dr. Samina

Anwar should not only have made post-op notes immediately after surgery but also should have documented medical events during and after surgery such as amount and source of bleeding, drain inserted or not, vital sign monitoring, consciouslevel etc.

Preliminary Findings/Observations

The patient was a known case of Hepatitis-C with other multiple problems, therefore, before operation sufficient pre-operative measures were required to be taken but no one in the HCE felt the responsibility to deal with the case in a proper way. There was no anesthetist. Dr. Jamil did not visit the hospital. It was irresponsible to operate the patient. Dr. Samina Anwar without her team performed the major surgery therefore matter referred to PMDC for gross negligence

PROCEEDING OF DC MEETING 28TH JUNE, 2019 AT P.C HOTEL LAHORE:

Submissions by Parties at the Hearing:

Both parties were present. The complainant mentioned that he wants to withdraw the case.
The respondent was heard in length. The respondent submitted that she has done DGO and clinical attachment as observer in UK.
Anesthetist was Dr. Tariq Lashari when asked by committee but when further asked whether the doctor administering anesthesia was a qualified anesthetist, the respondent replied that the doctor was not qualified anesthetist
When asked was respondent aware that patient was Hepatitis C positive she said yes
When the respondent asked replied that anesthetist was not available at the time of surgery. The committee showed displeasure.
The time of surgery as stated by respondent was 9 pm and she had arrived at the facility at 4 pm and examined the patient and arranged 2 pint of blood and she was told by HCE that Dr. Lashari would join for administering anesthesia.
When asked whether post operative notes were documented on file the respondent answered that she had asked Dr. Lashari to document post operative notes as she was not feeling well at all and faced accident on way to home.
It was her first experience with the HCE and her staff nurse who had been assisting her before in other HCE was not there that day which caused further difficulty for her to manage the day.
When asked about the owner of HCE she replied that the owner impersonated as doctor as qualification was written on his name plate and she could not confirm whether the degree was genuine or impersonated.
The committee showed displeasure on not checking antenatal record of the patient and operating the patient while the patient was admitted by the owner of the HCE who was husband of her staff nurse and the staff nurse and the respondent had no examination or active role and she just operated.
The committee further opined that the case could not be withdrawn as the case has been forwarded by PHCC and not lodged as a direct complaint and neither any other legal proceedings are in process nor the case was withdrawn from HCE.

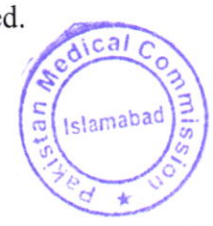
Findings by Expert:

"Dr. Samina Anwar did TAH on patient who was not admitted by herself. Patient was a case of hepatitis-C but had normal LFT. Bleeding following hysterectomy is known complication

and can happen in expert hands but she did malpractice in sense that she did not do pre-op & post-op care of patient by herself.The Committee decided to suspend her license for 02 years."
The Committee had also taken seriously that the doctor had not documented her operative notes. Moreover, she had no written contract with the healthcare facility.

RECOMMENDATION:

Two year suspension for the respondent is recommended.



CASE NO.15

PF.12-Comp-150/2017-Legal

Mr. Muhammad Abbas, Tibaa Masood Pur, Tehsil and Distt Bahawalnagar. 0334-7271896

Versus

Atta Muhammad Medical Complex, Bahawalnagar.
Dr. Saba Khalid (59507-P) (referred by PHCC)

Salient features of the Case:-

Due to prolonged labor as a result of mishandling of the case of patient Najma Abbas by Staff Nurse Rose Javed at her home, she developed intrauterine death of her baby and rupture uterus which was repaired by Dr. Saba Khalid. Later on the patient developed Left Hydronephrosis and Incision Hemia for which she remained admitted at DHQ Hospital, Bahawalnagar, Jinnah Hospital, Lahore and Sheikh Zayed Hospital, Rahim Yar Khan a number of times and her DJ Stenting and Left Ureteroscopy was done and finally Right Nephrectomy was done at Sheikh Zayed Hospital, Rahim Yar Khan.

Preliminary Findings/Observations

Dr. Saba Khalid being simple MBBS should not have performed this operation being high risk case and she should have referred the case to a tertiary care hospital.

PROCEEDING OF DC MEETING 28TH JUNE, 2019 AT P.C HOTEL LAHORE:

Submissions by Parties at the Hearing:

Both parties were heard at length.
The committee asked if the respondent is still with the Atta-Ullah hospital and the respondent replied that the HCE was closed and the respondent has quit her government job as well for personal reasons however running private clinic near the Atta-Ullah hospital.

Findings byExpert:

"Dr. Saba Khalid is an MBBS doctor. She had done life saving procedure by repairing the ruptured uterus. But as simple MBBS doctor she is not allowed to perform major surgeries. Therefore Committee decided to suspend her license for 6 months and asked to avoid doing major Gynae &Obs procedure till she get enrolled in some postgraduate course to do that."

RECOMMENDATION:

6 months suspension of license and after 6 months she will be allowed to perform procedures as allowed by PMDC
No surgery is allowed unless she completes training for minimum DGO or MCPS/FCPS.

Pakistan Medical Commission Islamabad

CASE NO.16

PF.12-Comp-152/2017-Legal

Mr. Riasat Ali, Chak No 93/6-R Tehsil Haroon Abad, District Bahwalnagar. 0346-535224.

Versus

Doctors Hospital, Chishtian
Dr. Muhammad Idress (26781-P) (referred by PHCC)

Salient features of the Case:-

The patient Mrs. Alia Bibi was operated in his hospital on22.05.2015 at 10:00 pm. The patient came with labor pains and she was thoroughly investigated. Spontaneous Vaginal Delivery (SVD) was not possible due to obstructed labor, thus C-Section was performed and a live female baby delivered. Patient successfully came out of anesthesia. There was no PV bleeding up to 11:00 pm on 22.05.2015. At 03:00 am on 23.05.2015 paramedics (Dai) on duty called him that there was PV bleeding. She checked the patient in his presence as there was mild soakage of V-pad. At this time patient was fully conscious and her vitals were normal. At 06:00 am on 23.05.2015 the attendant again complained of pv bleeding, at this time there was pv bleeding which was treated with injection syntocinon infusion.

The patient was referred to BV Hospital, Bahawalpur when the management of patient was out of control considering PPH or bleeding due to some other unknown reasons. Patient was referred to BV Hospital for expert management.

Preliminary Findings/Observations

The case was presented to the expert in the field of Gynae and obstetrics. The expert made the following observations on 28.10.2015:

"I have received the case file of the complainant Mr. Riasat Ali against Doctors Hospital, Christian (Dr. Muhammad Idrees). I have the following observations:

Patient Miss. Alia Bibi was operated due to obstructed labor. In supervised labor, it should not be obstructed labor as it leads to complications.

According to the record, she had PPH after 8 hours and then she was shifted to BVH, Bahawalpur. There she had obstetrical Hysterectomy but had developed DIC/Multi Organ Failure.

The patient was received at BVH, Bahawalpur in serious condition and was unable to recover. Primary reason lies for the obstructed labor.

No documented policies and procedures for administration of Anesthesia and Surgical procedures were available. Dr.Idrees himself administers spinal anesthesia and GA. On asking it was told that the same untrained OTA supervises that GA during operation. The condition of the so called Operation Theatre and Sterilization Room was very poor. The OT lacked the requisite electro medical equipment and resuscitation drugs. Instead, some dirty linen and cartons were present in the OT cupboard reportedly reserved for emergency resuscitation of patients.

PROCEEDING OF DC MEETING 28TH JUNE, 2019 AT P.C HOTEL LAHORE:

Submissions by Parties at the Hearing:

The registration has been expired and the respondent had applied for registration renewal and as per his statement his registration has been renewed.
The committee noted with concern that respondent performed C/S and administered anesthesia without having relevant qualification. In addition he practiced for 9 year since 2008 till 2017 without valid registration status

Findings byExpert
Dr. Idrees is simple MBBS and he is running his private hospital. He did LSCS and Anesthesia of patient, Miss Alia Bibi by himself. Moreover his PM&DC registration was also expired that was gross negligence on his side. The Committee has cancelled his PM&DC registration for life time.

RECOMMENDATION:

The respondent is recommended for permanent cancellation of registration with PMDC.
Fine will also be imposed on the respondent.

CASE NO.17

PF.12-Comp-166/2017-Legal

Mr. Saifullah KhanCaste Sheikh, R/O ThathaKharlan, Tehsil Laalian, District Chiniot. 03427686788

Versus

Dr. Qalab Hussain (3628-N) , ShawaizShairazi Surgical Hospital Lallian Chiniot Dr. Muhammad Idress (26781-P) (referred by PHCC)

Salient features of the Case:-

The Board(PHCC) has noted that the complainant's wife Kausar Bibi was taken to BHU Khanewal, received by LHV Sehrish and Midwife told the complainant and his wife Kausar that the baby had died in the mother's womb and it was more appropriate for them to go to hospital ShawaizSherazi Surgical Hospital .

Preliminary Findings/Observations

The Respondent named Dr.Qalab Hussain submitted his reply on 15-11- 2015 wherein he described that no surgical treatment of the patient was ever carried out at their Healthcare establishment as per the record available. He further explained that his Hospital is a welfare Hospital in partnership with Dr. Nosheen Akbar Zaidi (FCPS Gynae& obstetrics) since 13-2-2015 where the ultra sound, consultation, laboratory tests and necessary medications were all carried out free of cost. He replied that Dr.Nosheen Akbar had left this Healthcare center on 17-09-2015 due to some dornestic commitments

- During the course of hearing Dr.Qalab Hussain presented an affidavit of withdrawal of complaint signed by the complainant. The complainant admitted that the affidavit had been signed by him but Mr. Saifullah had got it signed from him on a blank stamp paper. He claimed that the statement had been written afterwards on the stamp paper.

Dr. Qalab bears expired PMDC registration and though wound infection is a common complication of C-section but the performer of the surgery should be confirmed whether Dr. Nnosheen had performed it or the midwife. In addition Dr. Nosheen seems to be lacking required qualifications.

PROCEEDING OF DC MEETING 28TH JUNE, 2019 AT P.C HOTEL LAHORE:

Submissions by Parties at the Hearing:

Complainant was absent. The respondent appeared before the committee and was heard at length.

The committee noted with concern that registration status expired in 1991 and for 25 years he had been practicing without valid registration with PMDC. The respondent further told that Dr. Nousheen who was the owner had left the country.

Findings by Expert:

"Dr. Qalab Hussain is MBBS after which he did an incomplete Masters in hospital management from NUST. His PM&DC registration expired in 1991, which he renewed in

2016. He was administrator of Shawaiz Shirazi Surgical Hospital Lallian Chiniot. Committee decided fine of Rs. 10000/- for first 5 years and then Rs. 5000/- per year."

RECOMMENDATION:

Committee decided fine of Rs. 10000/- for first 5 years and then Rs. 5000/- per year."

CASE NO. 18

File No: 12-Comp-128/2016-Legal

Mr. Ghulam Haider , sakingangapur Tehsil & Distt Nankana Sahib.
0304-7671980

Versus

Dr. Muhammad Javed Mahmood PM&DC No (11845-P) Javed Hospital, Khunda Tehsil & District Nankana Sahib.

Salient features of the Case:-

The complainant's pregnant wife (Bushra Bibi) was taken to the HCE on 20-5-2014 where her LSCS was performed under spinal anesthesia by the Respondent. The patient remained admitted in the hospital for two days and was discharged on 22-5-2014. The patient was readmitted to the HCE on 23-5-2014 in altered state of consciousness. The Respondent advised LFTs which were deranged so he referred the patient to Jinnah Hospital.
Board noted from the record that the patient's HB was 5.7gm/gl post-operatively on23-5-2014 vide lab No: 6923. No record of monitoring of vital signs of the patient was available with the Respondent in his HCE. The initial ultrasound at Jinnah Hospital revealed RPOCs and the patient went into DIC and Acute Renal Shutdown as well as Multi Organ Failure. The patient had continuous oozing of blood from the wound site of C-section performed by the Respondent as was submitted by the Jinnah Hospital from its record. This suggests that the Respondent carried out the surgery negligently as continuous oozing from the wound site is most likely to be the surgeons fault.

Preliminary Findings/Observations

The Case of Dr. Muhammad Javed is referred to PMDC for initiating action against him for doing medical practice without a duly renewed PMDC registration and for performing surgeries without the requisite post-graduate qualification.

PROCEEDING OF DC MEETING 28TH JUNE, 2019 AT P.C HOTEL LAHORE:

Submissions by Parties at the Hearing:

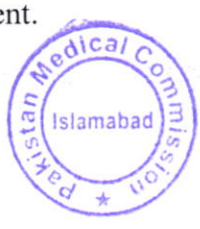
Complainant was absent. Respondent appeared before the committee. The committee noted with concern that the respondent had been practicing without additional PG qualification and the registration was recently renewed after lapse of many years and he had been practicing without valid registration for many years
The committee asked why C/S was performed and the respondent replied that the patient was not in condition to be referred.
The respondent further added that he has staff of around 25 persons working with him
The committee asked whether he has any doctors in the team and the respondent replied that he has no doctors in the team.
The committee noted with concern that surgery was performed and anesthesia was administered by himself.
The committee asked whether any compensation was offered and the respondent apprised that he has paid one lac after the decision of panchayat.

The respondent apprised the committee that the case is subjudice before High Court.
The committee recommended for permanent cancellation of the respondent.

Findings by Expert
"Dr. Muhammad Javed Mahmood is simple MBBS, he himself given spinal anesthesia to patient and did her emergency LSCS for fetal distress which is negligence. Committee decided to cancel his PM&DC registration for lift time."

RECOMMENDATION:

The committee recommended for permanent cancellation of the respondent.



CASE NO. 19

File No: 12-Comp-155/2017-Legal

Mr. Riasat Ali , Chal No. 200G8, Tehsil Samundri District Faisalabad. 03068018860
Versus
Dr. Tahir Javed S/o Abdul Shakoor PM&DC No (10142-P) Respondent Ali Medical Centre Faisalabad.

Salient features of the Case:-
On l3-5-2015 the patient was taken to the HCE where her Cesarean Section was performed by Respondent No. 2 (Dr. Farooq). After three days of the operation the patient felt that her abdomen started to swell due to a cut that was inflicted upon the intestines of the patient and due to which blood had accumulated in the abdomen of the patient.

The patient was then taken to CMH Okara in a serious condition and second operation had to be done there. The patient was still in a serious condition and was obtaining medical treatment at the time of filing of this complaint

Preliminary Findings/Observations
The respondent submitted that the patient was examined on 13 May 2015 and he had performed C section however post operative follow up was uneventful. The complainant has allegedly pressurized the respondent through some doctors of CMH Okara to compensate the complainant monetarily for withdrawal of the case and black mail him.
The Board has concluded that as far as the surgical procedure and the performance of C-section in this case is concerned, the performance of C Section was the correct choice as even pointed out by the Expert. In addition to this it must be noted that hemoperitoneum is a known complication which was taken care of by CMH Okara. It must also be noted that Respondent No. 3 is the main person who manages the administration and affairs of the HCE therefore the lapses and the maladministration is on part of him, his staff and the HCE could not be ignored.

PROCEEDING OF DC MEETING 28TH JUNE, 2019 AT P.C HOTEL LAHORE:

Submissions by Parties at the Hearing:
Complainant was absent. Dr. Tahir appeared before the committee. The committee noted with concern that anesthesia was given by technician. The committee further noted with concern that the registration expired in 1994 and renewed in 2018 as per respondent statement.
The committee further observed that the respondent had been practicing in government sector as well and retired now. The respondent apprised that he is doing private practice nowadays and when asked he apprised that he used to perform C/S in the past with the non qualified team.

Pakistan Medical Commission Islamabad

Findings by Expert:

"Dr. Tahir Javed is an MBBS doctor. He performed C-Section of patient who came in emergency after taking trial of labor by some LHV. He did emergency LSCS. Later patient got complications inform of hemoperitonium for which he was referred to CMH Okara where she was re-operated and patient survived. The Committee decided fine and license cancellation."

RECOMMENDATION:

The respondent will be imposed a fine of Rs.100,000 and permanent cancellation of license of the respondent.

CASE NO. 22

File No: PF.12-comp-212/2018-Legal

Mr. Muhammad Arshad, 126/15-1, Ahataa No.2, lrianChannu, District Khanewal. 0301 - 7676126

Versus

Fatima Polyclinic & Maternity Home Chichawatni District Sahiwal Dr. Muhammad Hanif Dogar PM&DC No (9212-P) Dr. Musarat Parveen PM&DC No. 8713-S and Dr. Kazim Hayat.

Salient features of the Case:-

The complainant's 27 years old primigravida niece Mrs. Tanzeela Bibi, was reporting to Fatima Polyclinic &Matenity Home for antenatal check-ups. The attendants were told that surgery would be required. As per the respondents, there was cephalopelvic disproportion, but no ultrasound report to this effect was provided by any party. On 19-05-2016, hemoglobin level of the lady was 7.3 gm/dl (Normal l2-16 g/dl); one pint of blood was transfused. The patientwas admitted to Fatima Polyclinic & Maternity Home at 9:00 a.m. on 20-05-2016. Her hemoglobin level was 7.81 g/dl. Consent was signed by the patient and her husband. At about ll;00 a.m. C-section was done by Dr. Muhammad Hanif Dogar and Dr. Mussarat Hanif Dogar. A baby boy was delivered. The surgery was performed under spinal anesthesia by SMO THQ Hospital Chichawatni Dr. Kazim Hayat, who was on short-leave for domestic affair. Dr. Kazim did not write any note on the patient file. Second pint of blood was started during the operation and transfusion was completed after the patient was brought out of the operation theatre. After 15 minutes of the surgery the patient developed signs of multi-organ failure(possibly because of transfusion reaction) for which nephrologists was consulted but the patient left Fatima Polyclinic & Maternity Home at 2:00 p.m. on 21-05-2016. With some support, she walked into the ambulance. Vital signs were not mentioned on the referral document.

Preliminary Findings/Observations

According to the patient's husband, the doctor at Sir Ganga Ram Hospital Lahore had told that the patient required dialysis but the dialysis machine was out of order, so she should be taken to Jinnah Hospital. MS Sir Ganga Ram Hospital Lahore was specifically asked to comment on the functionality of the dialysis machine, but he did not address the issue in his reply; whereas the attending doctor (Dr. Sadaf Ibrahim) stated, "The attendants were repeatedly counseled that their patient was highly critical due to severe infection and that her lungs, liver and kidneys were not working (multi-organ failure). However the attendants failed to understand and left against medical advice."

PROCEEDING OF DC MEETING 28TH JUNE, 2019 AT P.C HOTEL LAHORE:

Submissions by Parties at the Hearing:

The complainant and respondent Dr. Hanif Dogar and Dr. Musarrat appeared before the committee for hearing.

The complainant has submitted his withdrawal of complaint on affidavit

Pakistan Medical Commission Islamabad

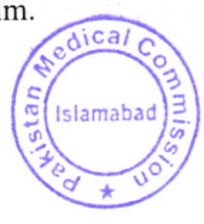
The committee asked that the practioners giving anesthesia, one doing C/S and the other assisting in procedures are all general practioners with no additional post graduate qualifications and offering private care.
The committee asked whether cross matching is done for minor groups and what are the minor groups. The respondents failed to answer. In addition committee asked about who owns the lab and the respondents informed that it was owned by lab technician.
Respondents were further asked about how they sterilize the instruments and another question was that they know what a genome of hepatitis C. The respondent answered that steam autoclave is used and that they have no idea about genome of hepatitis C.
The respondents mentioned that they do 4-10 surgeries/month.

Findings by Expert:

"Dr. Musarrat Perveen is simple MBBS doctor running her own hospital and is doing surgeries which is malpractice on her part. Patients got uneventful LSCS but she got Blood transfusion following that she got blood transfusion reaction which is known complication of blood transfusion leading to multi-organ failure and patient later expired. The Committee recommended cancellation of her license for lift time."

RECOMMENDATION:

The committee after hearing both parties in detail recommended for permanent cancellation of registration for both of the respondents and notice for Dr. Kazim.



CASE NO. 23

PF.12-comp-102/2016-Legal

Muhammad Farooq Street No. 1, House No. 31, Chowk Hassan Park Near Tyre Factory, Dars Road, Baghban Pura, Lahore. 0321-4883003

Versus

Al Raheem Hospital Shalamar Town, Lahore.
Dr. Lubna Bashir, 27208-P

Salient features of the Case:-

As per medical record at Omar Hospital, the patient was presented with primary PPH (post-Partum Hemorrhage). She was in shock and very pale with her Hb at 7. 9 gm. Two pints of blood were transfused to her and Hb was raised to l0.7 gm pelvic ultrasound reports suggest that RPOCs (retained products of conception) measuring 9.7 x 5.0 x 7.5cm were present. It is noted that the doctor had the plan to treat the patient conservatively and remove RPOCs through vaginal route and their team was ready but the patient and his relatives were notsatisfied and wanted to shift the patient to another hospital thereby the patient was discharged on request on the night of 18-5-2014. Subsequently, the patient was shifted to OMC Hospital, Jail Road, Lahore where she was admitted and a re-open surgery was performed at 3:00 am on 19-5-2014 by Dr. Samina Sindhu (Gynecologist). The patient was discharged on20-5-2014.

Preliminary Findings/Observations

The Board has also noted that there is no denial of the fact that during cross examination of the Complainant and the patient by the Respondent and other doctors, who were member of the team of Respondents, all the allegations as leveled in the complaint have been washed out. The stance and explanation of the Respondents was found correct, but at the same time the Board has noted the following:

There remains no case of medical negligence against the Respondents and the Board is of the opinion that:

The baby had severe congenital anomalies and dimorphic features thus had very poor prognosis. RPOCs are a well-known complication therefore the allegations of medical negligence against the HCE are not proved.

PROCEEDING OF DC MEETING 28TH JUNE, 2019 AT P.C HOTEL LAHORE:

Submissions by Parties at the Hearing:

Complainant was not present

The respondent was heard at length.

When the respondent asked answered that PPH occurred after 6 hours of the procedure

The patient was under care of two consultants while respondent being senior one and the committee observed that arrangement was perfectly acceptable but documentation should have been done properly.

Findings by Expert:
"Dr. Lubna Bashir is qualified FCPS who informed well before time to patient regarding her visit abroad. She did elective LSCS of patient by herself and PPH is known complication following delivery or LSCS. So Dr. Lubna has done her best along with her team to take care of patient. So Committee decided to issue warning to Dr. Lubna."

RECOMMENDATION:

The committee observed that arrangement was perfectly acceptable but documentation should have been done properly.