BEFORE THE DISCIPLINARY COMMITTEE OF PAKISTAN MEDICAL COMMISSION

In the matter of

Complaint no. PF.8-1716/2018-legal
Begum Shamim Vs. Dr. Muhammad Younis

Mr. Ali Raza	Chairman
Mr. Aamir Ashraf Khawaja	Member
Dr. Asif Loya	Member

Present:

Brig. Prof. Rafique Zafar	Expert
Begum Shameem Zahid	Complainant
Ms. Anum Anjum	Daughter of complaint
Mr. Shamroz Khan	Son of complainant
Dr. Muhammad Younis	Respondent
Dr. Amna	Sister of Respondent

Factual Background

Complaint

1. Begum Shameem Zahid filed a complaint on 17-08-2018 against Dr. Muhammad Younis regarding professional negligence. She has stated that her husband, Mr. Zahid Ali Khan Anjum, suffered with urine problem. Patient visited Dr. Younus at his private clinic Ali

Hospital, Lahore, where Dr. Younus advised an ultrasound of prostate which was clear. But on 09-10-2014 doctor advised and performed an operation of prostate. After that he performed three further operations which led to a cascade of events including severe infection, multi-organ failure and ultimate demise of the patient.

Reply of Respondent Dr. Muhammad Younis

2. Complaint was forwarded to respondent Dr. Younis who replied vide letter dated 21-09-2018 wherein he has stated that:

    i. I have 27 years' experience in medical field and 18 years experience in Urology. I have served as consultant urologist, Assistant Professor Urology at KEMU/Mayo Hospital Lahore 09 years. I was running Ali Ultrasound and Urology Centre during the period of 1993 to 2016. I am supervisor and examiner of FCPS and MS Urology. My 19 students are now consultant urologists. I have done more than 1000 TURP in public and private sector hospitals. I am well known and respected member of my fraternity.

    ii. Mr. Zahid Khan was having severe obstructive symptoms. Ultrasound revealed thick walled urinary bladder, with about 260 ml residual urine. There were multiple reports of USG and consultations from other urologists. Patient came to me multiple times for medical treatment before surgery. All urologists know that obstructive prostate may be small and fibrotic and trans abdominal. USG can give rough estimate of the size of prostate. Diagnosis are always based on clinical acumen with supporting investigations.

    iii. Mr. Zahid Khan was known diabetic, hypertensive and hepatitis-C patient with bladder outflow obstruction. I had a detailed discussion about hepatitis C and BOO with his younger son before operation and I treated him as a hepatitis C positive case. This can be confirmed from his younger son on oath. Now they are not intentionally reproducing his positive reports which we gave them back after operation as this is the property of the patient. About 14 days after surgery patient

developed secondary hematuria which is a known complication worldwide, even in developed world, which was treated with full responsibility and patient was discharged from tertiary care centre, Mayo Hospital Lahore, after full recovery. There is a difference between complication and negligence.

Rejoinder of Complainant

3. Reply of Dr. Younis was shared with the complainant for rejoinder. The complainant commented vide letter dated 31-12-2018 that she is not satisfied with the comments of the respondent doctor. She has requested that the hearing may kindly be ordered to be fixed for an early date and decided on merit to meet the ends of justice.

Proceedings of Disciplinary Committee of Erstwhile PMDC

4. Disciplinary Committee held its meeting in the matter on 27-04-2019 at Lahore. Daughter of the deceased, Ms. Anum Anjum, appeared, however, respondent did not turn up. Ms. Anum Anjum argued that all the relevant record has been provided therefore the matter may be decided ex-party on the basis of available record.

5. The Disciplinary Committee gave findings that when the patient was sent to Mayo hospital, rather than performing a cystoscopy to evacuate clots he was opened up. Surgery was performed in rush for a patient with co-morbid i.e. diabetes. It is not only an element of obstruction but an element of total renal failure. There was no histology done and apparently the sample was lost. Operation notes were also destroyed. Multi organ failure had begun due to hospital acquired infections. The eventual demise was after 7 months. The eventual cause of death, on death certificate signed by Dr. Waqar is written as TBM but there is no evidence of that. The other cause is septic shock but the record doesn't reveal vital charts. Further, there are two identical urine cultures, one month apart meaning thereby there was persistent infection with multi drug resistant bacteria.

6. The Disciplinary Committee recommended to the Council that the license of Dr. Younis may be cancelled till such time when he appears before the Disciplinary Committee, on account of gross professional misconduct for burning the record which was evident in this case. Further, notices to be issued to Sheikh Zayed hospital to provide particulars of Dr. Waqar who signed the death certificate.

7. Second meeting of the Disciplinary Committee in the matter was held on 10-06-2020. Both parties were present. The Respondent, Dr. Younus joined on skype due to current COVID 19 pandemics as he could not travel from Australia. His sister Dr. Aamna was present physically on behalf of respondent Dr. Younis along with power of attorney. Medical Superintendent, Shaikh Zayed Hospital, Lahore sought adjournment through his application dated 09th June, 2020 that he is in isolation due to prevailing condition of pandemic Covid-19.

8. The daughter of complainant, Ms Anam Anjum reiterated the main stance that the ultrasound showed normal prostate. Multiple surgeries were unnecessary and therefore resulted in a cascade of events including hematuria, perforation, multiple organ failure and ultimate demise of the patient.

9. The respondent stated that the case had been heard by Disciplinary Committee in April 2019 and no element of professional negligence found. He had advised alpha blockers on 09-03-2014 and performed trans ureteral resection of the prostate on 09-10-2014 after severe urinary outflow obstruction refractory to medical treatment. Ultrasound showed bladder thickness and lot of residual volume that proved urinary obstruction. Second surgery was for hematuria and third surgery on same day 27-10-2014 was done as high-risk surgery and claimed that consent was also taken.

10. He requested the Disciplinary Committee to issue good standing certificate and review his suspension as he has already suffered suspension of more than a year. He further submitted the he does not have documentary evidence as he is no more a custodian of the Ali Hospital since 2016 and that the case was forwarded to different platforms after much time of the

incidence and also after his departure to Australia in February 2016 which shows *malafide* intentions of the complainant.

11. Brig. Prof. Dr. Rafiq Zafar was appointed as an Expert to assist the Disciplinary Committee in the matter who gave his opinion that Mr. Zahid Ali Anjum was adequately assessed by Dr. Younus for bladder out flow obstruction. There was clear evidence of bladder out flow obstruction which can occur even in the presence of small sized / normal sized prostate. Medical management for bladder outflow obstruction was tried first and after its failure surgery was planned and TURP was performed which was a right decision. Secondary hematuria and clot retention developed in this case which can happen in about 5% of patients after TURP. Frequency of complications can be more in the presence of DM/HTN and Hep-C. Bladder perforation while managing clot retention can happen in about 1.3% of cases. These unfortunate complications were timely identified and adequately managed. Death occurred after seven months of surgery which cannot be attributed to the surgical procedure.

12. The Disciplinary Committee observed that earlier this matter was heard by the Disciplinary Committee in April 2019 and the professional negligence was not evident as LFTs, RFTs etc. all were back to normal. Therefore, death after seven months of the surgery done by the respondent Dr. Younus cannot be attributed to him.

13. Third meeting of the Disciplinary Committee in the matter held on 23-07-2020 at Islamabad. Case was adjourned as parties were not present and Sheikh Zayad Hospital also sought time to find out particulars Dr. Waqas who had signed the death certificate of the patient.

Disciplinary Committee under Pakistan Medical Commission Act 2020

14. Pakistan Medical and Dental Council was dissolved on promulgation of Pakistan Medical Commission Act on 23 September 2020 which repealed Pakistan Medical and Dental Council Ordinance, 1962. Section 32 of the Pakistan and Medical Commission Act, 2020 empowers the Disciplinary Committee consisting of Council Members to initiate disciplinary proceedings on the complaint of any person or on its own motion or on information received against any

full license holder in case of professional negligence or misconduct. The Disciplinary Committee shall hear and decide each such complaint and impose the penalties commensurate with each category of offence.

Hearing on 30-01-2021

15. The Disciplinary Committee held the hearing of pending disciplinary proceedings including complaint of Begum Shamim Zahid on 30-01-2021.

16. Complainant was present with her daughter Ms. Anam Anjum and son Mr Shamroz Khan. They explained that their 56 years old father had difficulty in passing urine and he was shown to Dr. Younus, Associate Professor of Mayo Hospital, in his private clinic. Dr. Younus advised an ultrasound from his private hospital. He was advised surgery for prostate. After surgery, they were not given any biopsy sample stating that it was lost. He subsequently performed three other operations and that is when the patient suffered with severe infection which caused his death.

17. Further adding detail to their complaint, they informed that their father was operated on 09-04-2014. After surgery he developed pyuria and later on hematuria. He had pain abdomen the entire time. On 26-09- 2014, he was shown again to Dr. Younas who reassured and changed medicines. The same day in the evening he was in extreme pain. Upon contacting Dr. Younas he was taken to Mayo Hospital where he agreed to see him. He came to see the patient on 27-09-2014 and took him straight to the theatre where he was operated again and clots from bladder were removed and they were not explained about this second procedure. No consent was taken. They stated that irrigation was done. Due to irrigation his stomach was filled with water. When the doctor was contacted again, he advised that irrigation can't be stopped. At the same time the patient kept complaining and then they were told that bladder had ruptured. He became pale and hypotensive. They were then informed that water will be taken out with the help of suprapubic tubes and a consent was taken for that and a surgery will be done for bladder rupture. They further pointed out that the name of anesthetist is not mentioned on the surgical notes. He was then shifted to ward and suddenly he was shifted to ICU. Multi

organ failure had begun. They were informed that the patient is Hepatitis C positive although nowhere in any investigation it turned out to be positive nor is mentioned by the doctor anywhere in any of his follow up visits.

18. Dr. Younus attended the hearing through zoom. He stated the patient was operated in October 2014 and he died in May 2015. He came to know about the death of the patient after he reached Australia on 10-02-2016 whereas the complainant lodged the complaint in March 2016 against him before Punjab Healthcare Commission.

19. He argued that there is a difference between complication and negligence. Mr. Zahid Khan was having severe obstructive symptoms. His ultrasound revealed thick walled urinary bladder, with about 260 ml residual urine. It is a known fact that obstructive prostate may be small and fibrotic and trans abdominal. Ultrasound gives rough estimate of the size of prostate. Diagnosis are always based on clinical acumen with supporting investigations. Patient was known diabetic, hypertensive and hepatitis-C patient with bladder outflow obstruction. All such details were discussed with the family of patient before operation and he was treated accordingly. They are not intentionally reproducing his positive reports which were given back to them after operation. About 14 days after surgery patient developed secondary hematuria which is a known complication worldwide, even in developed world, which was treated with full responsibility and patient was discharged from tertiary care center, Mayo Hospital Lahore, after full recovery. Patient died after seven months of surgery, therefore, he cannot be held responsible for any professional negligence. He further stated that death of patient was because of Tuberculosis and hepatitis.

Expert Opinion Brig. Professor Doctor Rafique Zafar

20. Brig. Prof. Dr. Rafique Zara was appointed as an Expert in the matter to assist the Disciplinary committee was present in the hearing. He reiterated his earlier opinion provided to the Disciplinary committee in its hearing held on 10-06-2020 at Islamabad. In his earlier opinion he has stated that that Mr. Zahid Ali Anjum was adequately assessed by Dr. Younus for bladder out flow obstruction. There was clear evidence of bladder out flow obstruction which

can occur even in the presence of small sized / normal sized prostate. Medical management for bladder outflow obstruction was tried first and after its failure surgery was planned and TURP was performed which was a right decision. Secondary hematuria and clot retention developed in this case which can happen in about 5% of patients after TURP. Frequency of complications can be more in the presence of DM/HTN and Hep-C. Bladder perforation while managing clot retention can happen in about 1.3% of cases. These unfortunate complications were timely identified and adequately managed. Death occurred after seven months of surgery which cannot be attributed to the surgical procedure.

Findings and Conclusion of Disciplinary Committee

21. The Disciplinary Committee has heard the parties at length. It is observed that the grievance of the complainant is that respondent Dr. Younis advised an ultrasound of prostate of patient which was clear, however, on 09-04-2014 respondent doctor advised and performed an operation of prostate. After surgery, they were not given any biopsy sample stating that it was lost. After surgery he developed pyuria and later on hematuria. On 26-09- 2014, he was shown again to Dr. Younas who reassured and changed medicines. In the evening when patient complained of extreme pain, he was taken to Mayo Hospital as per advice of respondent Dr. Younis. He came to see the patient on 27-09-2014 and took him straight to the operation theatre where he was operated again and clots from bladder were removed, however, family was not explained about this second procedure. No consent was taken. They stated that due to irrigation the stomach of patient was filled with water. When the doctor was contacted again, he advised that irrigation can't be stopped. Later on, patient's bladder ruptured. They were then informed that water will be taken out with the help of suprapubic tubes and a surgery will be done for bladder rupture and for that consent was taken. They further pointed out that the name of anesthetist is not mentioned on the surgical notes. He was then shifted to ward and suddenly he was shifted to ICU. Multi organ failure had begun. They were informed that the patient is Hepatitis C positive although nowhere in any investigation it turned out to be positive nor is mentioned by the doctor anywhere in any of his follow up visits.

22. Dr. Younus was asked about first ultrasound performed by him in his private Clinic and treatment of patient. He informed that in his clinic his wife who is radiologist, did the ultrasound of the patient which was suggestive of obstructive uropathy. He further explained that patient was known/diagnosed diabetic and hypertensive patient. His TURP was in line with his ultrasounds. There was a suspicion of mass found during ultrasound which was done once from the outside and the other was done at our hospital. However, the ultrasound which was done outside our hospital showed some membranous structure. Surgery was uneventful. He was discharged next day. Catheter was removed on 5th day of surgery and patient remained without catheter for about one to two weeks.

23. After surgery, secondary hematuria had occurred. In between patient had come with burning sensation in urethra hesitancy. He was advised to go to Mayo hospital, secondary hematuria is known complication found in 10% of operated patients. He was given catheter wash. Next day he was examined. His bladder was full of clots, when patient was taken to operation theatre, clots were evacuated but bladder neck gave way. After surgery his bladder was distended and since patient was hypertensive he was going in shock. PD catheter was installed so that he may get relief from bladder distention and then we tried to open it in same operation theatre but due to the fact that out operation theatre list was getting over so anesthesia could not be given and he was taken to ER. Same was done at ER and supra pubic catheter was installed. After three to four days, he was discharged. Later patient went to Dr. Nawaz Chughtai, who removed the suprapubic Catheter and pre-urethra Catheter and the patient became quite well. After two months the patient visited him for diabetic abscess in his deltoid region, the abscess was drained through the incision by him.

24. The respondent doctor was inquired about doctor and anesthetist who had attended the doctor in the surgery. Respondent Dr. Younis replied that a Senior Registrar of Mayo Hospital assisted him and he does not remember the name of Anesthetist who assisted him at that time.

25. In view of certain contradictions in the Respondents earlier statements recorded relating to the second and third surgeries as against the first surgery, the Respondent doctor was also inquired about the medical record of the patient at his private hospital which he replied that

he rented out that premises to Dr. Noreen before going to Australia in 2016. He first claimed that record of private practice is not retained for more than a year or so and then claimed claimed that Ali Hospital's record is missing as it was burnt.

26. As for the question of the committee that whether the family of the patient was explained the procedure and their consent was taken before performing the surgery and whether biopsy was carried out and family was provided biopsy sample, the respondent Dr. Younis stated in absence of record it is very difficult to defend himself. In-fact he had no satisfactory answer to the questions raised by the Disciplinary Committee.

27. Respondent Dr. Younis took the stance that patient died because of Tuberculosis and hepatitis, whereas record available with the Disciplinary Committee shows that patient was not Hepatitis C positive. He became Hepatitis C positive after the surgery. Similarly, there is nothing on record to suggest that he was tuberculosis patient.

28. The Disciplinary Committee after considering all evidence and facts concluded that firstly the death of the patient is not connected to the surgeries and treatment done by the Respondent doctor and hence there exists no negligence on that account.

29. However, the Committee has found that the practice of the Respondent doctor in terms of his management of the patient at his private clinic/hospital and thereafter was in violation of numerous provisions of the code of ethic and professional practice. The medical record of the patient was not properly retained and alleged to be destroyed or not produced intentionally. The radiology record and the biopsy record are critical evidence and such record was not retained by the Respondent doctor at his private clinic and in fact admitted to have not been retained or destroyed. Furthermore, the Respondent doctor did not explain the procedure to family properly before performing any of the surgeries and as per record neither obtained their consent at least for the 2nd and/or 3rd surgery. The said actions of the Respondent doctor are patent violations of the code of ethics and professional practice expected of a licensed practitioner.

30. In view of foregoing facts and for reasons recorded, the Disciplinary Committee is of the opinion that respondent Dr. Younis is guilty of professional misconduct in his practice and pertaining to the treatment of the patient in question. Therefore, the Disciplinary Committee recommended a penalty of suspending the license of Dr. Muhammad Younis for two years. The period of suspension shall run from the 27-04-2019 when the license was initially suspended.

31. The subject proceedings stand disposed of in terms of the above directions.

A copy of these proceedings to be shared with present employer of Dr. Muhammad Younis.

Aamir Ashraf Khawaja
Member

Dr. Asif Loya
Member

Ali Raza
Chairman

23rd February, 2021