DECISIONS AND RECOMMEDATONS OF THE DISCIPLINARY COMMITTEE OF PAKISTAN MEDICAL AND DENTAL COUNCIL ISLAMABAD

A meeting of the Disciplinary Committee was held on 29th 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.	Prof. Dr. Wasif Ali Shah	Expert
6.	Prof.Dr. Muhammad Imran Anwar	Expert
7.	Prof. Dr. Arif Rasheed Maik	Expert
8.	Dr. Shahid Malik	Expert
9.	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. 2

File No: 12-Comp-189/2018-Legal

Mr. Farrukh Bukhari

Versus

National Orthopaedic Hospital, Bahawalpur,

Dr. Tehseen Cheema, 12782-P

Salient features of the case:

Complainant had pain in his left knee due to an old injury. MRI dated 10.09.2012, had revealed injury to Anterior Cruciate Ligament, and tear of the posterior horns of Medial Meniscus of the left knee. He had consulted Dr. Tahseen Cheema of National Orthopedic Hospital, Bahawalpur for the said problem and who had advised operation of left knee (Medical Meniscectomy) which had been conducted on 25.12.2015. Faultily, Dr. Tahseen Cheema had also operated upon the Complainant's right knee, at the same time, without his consent. The MRI report dated 05.04.2016, of the right knee of the Complainant had revealed "Tear both horns of medial meniscus" and "joint effusion".

Preliminary Findings/Observations:

The Board further noted that as per statements of the Complainant and his witnesses, the plan was only to operate the left knee and fee had been charged only for that. After the operation, when it was observed that right knee of the complainant had also been operated, they had complained to Dr. Tahseen Cheema for that. He initially said that the right knee of the complainant was also diseased; therefore, he had operated upon that knee also. When they had argued how the doctor could diagnose the disease in right knee without MRI and other investigations, and also showed their intention to call the media people, then the doctor had sought apology from them, requested them not to defame him and had paid back the fee charged from them. The Complainant, when consulted Dr. Khalil Ahmed Gill, at Multan, on 31.05.2016, the doctor after seeing the x-ray of the right knee had told him that Dr. Tahseen Cheema had not performed any procedure on that knee, instead he had just opened the knee and then closed that.

After thorough deliberations and taking into consideration the record and the above noted findings/observations, the Board unanimously decided that:

a. The case of Dr. Tahseen Cheema is referred to PMDC for operating both knees of the complainant without consent as consent had been taken for surgery of left knee only.

PROCEEDING OF DC MEETING 29TH JUNE, 2019 AT P.C HOTEL LAHORE:

Submissions by Parties at the Hearing:

The respondent has submitted application for adjournment as he is out of country.

The complainant was heard as he had requested to be heard.

Findings by Expert:

"The respondent is physically not present and authorized doctor in replacement of him was not able to answer."

RECOMMENDATION:

The committee recommended for interim suspension of registration status of the respondent till he appears before the DC meeting.

The committee also directed the respondent to pay the cost of travel or other miscellaneous expenses that have been incurred by the complainant during his travel from Faisalabad to Lahore.

Furthermore respondent is directed to send his availability to Registrar office PMDC Secretariat for consideration by committee for his next date of hearing.

CASE NO. 3

File No: 12-Comp-108/2016-Legal

Mr. Muhammad Rafiq Ahmed

Versus

Dr. Saghir Hussain Shah PM&DC Registration No. 30571-p

Hayat Hospital Mandi Bahuddin.

Salient features of the case:

The board noted that the complainant's son Hassan Rafiq aged four and half year got displaced fracture of left humerus on 15-09-2014 for which the respondent Dr. Saghir Hussain only applied POP but he told the complainant that he has operated the child and charged a handsome amount from him.

He told that surgery was required. He took the child to the operation theatre and after some time came out and told that the operation has been successful and that the plaster would be removed after three weeks. They all were satisfied but when the plaster was removed, the bone was not aligned to which Dr' Saghir told that after carrying out massage it would be alright. After continuous massage of fifteen days the bone could not be placed at his place. So the patient was taken to Gujrat on 31.10.2014 where Dr. Wazahat Hussain told after checking that no surgery has been carried out'

Preliminary Findings/Observations

The respondent told that the bone of the patient was fractured which has been re-fixed successfully and the plaster would be removed after three weeks and consoled all of them. When the plaster was removed after 03 weeks, the bone was still displaced and the respondent told, to carry out massage daily. He told that the arm would be alright but despite carrying out massage for continuous fifteen days the condition was not improved' Then the child was taken to Gujrat Hospital on 31.10.2014 where it came into their knowledge that no operation was conducted.

PROCEEDING OF DC MEETING 29TH JUNE, 2019 AT P.C HOTEL LAHORE:

Submissions by Parties at the Hearing:

The respondent was absent despite notice

The complainant mentioned that PHCC has already decided against respondents and the committee apprised that PHCC has the authority to decide regarding HCE while the doctors come under domain of PMDC and the committee will decide the matter after hearing the respondent however complainant can record his statement for the day

The complainant presented the x ray done with Children Hospital

Findings by Expert:

Fracture lateral condyle of left humerus needed fixation but child was given Post-operated later in Mayo hospital. Now ROM is ok with healed scar. Distal is ok.

RECOMMENDATION:

The registration of the respondent will be cancelled till his appearance and an inquiry be initiated against verification done at PM&DC for the registration of the qualification of the respondent.

CASE NO. 5

File No: 12-Comp-168/2017-Legal

Mr. Muhammad ShahidAnjum

Versus

District Headquarter Hospital Okara etc

Dr. Amjad Ali Kazmi, 24746-P

Salient features of the case:

At 7:37 a.m. on 28-09-2015, Rescue 1122 Okara had received an emergency call from Mr. Usman (0324-6210725), about a motorbike accident at Sahiwal side of Okara Bypass. Ambulance of Rescue 1122 reached the scene in 4 minutes. There were two victims (a male and a female) with severe head injuries, the first (male) with pulse 6O/minute and BP 100/80 mmHg was unconscious, whereas the second (female) had died. According to Rescue 1122 staff, people at the scene had told that both the victims were riding on a motorcycle, when an unknown car had hit them and fled. The staff had administered Ringer's Lactate drip to the male and had applied dressing to his head. Both the victims had been evacuated to DHQ City Hospital Okara.

The Board has also noted that according to Rescue 1122 staff, CPR (cardiopulmonary resuscitation) of both the patients had been done, while they were being shifted to the hospital. The Board has further noted that the casualties had been received at DHQ Hospital Okara at 7:55 a.m. on 28-09- 2015. The female had been received dead, whereas the male had been received gasping. CMO Dr. Amjad Ali Kazmi had provided emergency treatment (Injection Haemocel, Injection Ringer's Lactate, Injection Normal Saline, Injection Atropine, Injection Adrenaline, Injection Transamine and Injection Dexa) to the injured male, but the patient had not survived and had expired at 8:10 a.m. on 28-09-2015.

The Board has also noted that in the meantime, the relatives of the victims had arrived and identified the deceased as Tahir Ali (complainant's 20 years old brother) and Mrs. Shumaila Musarrat (complainant's 25 years old sister). The relatives had informed that Mrs. Shumaila Musarrat was about 8 months pregnant, and had insisted upon saving the baby. Dr. Amjad Ali Kazmi had explained to them that the baby could not have survived after a lapse of so much time.

Preliminary Findings/Observations

They were told that police would prepare the legal document, cause of death would be ascertained by post-mortem and then the dead bodies would be handed over, but, before the arrival of police, the relatives started quarrelling and forcefully had taken away both the dead bodies. The Board has also noted that according to the complainant, no one had asked to get the post-mortem done. They (hospital staff) themselves had called the ambulance and

shifted the bodies in it but death certificates had not been provided. The Board has further noted that as per Dr. Amjad Ali Kazmi, death certificates had been prepared on the same day, but the attendants were non-cooperative.

Case of Dr. Amjad Ali Kazmi is referred to PMDC for his failure toExamine the wounds of the injured Tahir Ali.

Ensure the clinical examination of the deceased ShumailaMusarrat.

Legal Aspects

Post-mortem of Mr. Tahir Ali had revealed punctured skin Y, x Y, cm2 left eyebrow, missing eye ball, orbit fractured from above (wound of entry), and a hole measuring I x 1 cm2 in left temporal region, fractured left temporal bone, cracked parietal bone up to right temporal region (wound of exit). The Medico-legal Examiner opined that the injuries were ante mortem and had been caused by firearm weapon.

The Board has also noted that on 10-11-2015, FIR No. 959/15 was registered at Police Station Sadar Okara, against two unknown persons. Husband of Mrs. Shumaila Musarrat (Mr. Kashif Ali) is a police constable. After the hearing at PH on 23-02-2016, Ms. Ayesha Sohail (Rescue & Safety Officer Rescue 1122) presented a press clipping, mentioning with reference to Acting RPO Okara Mr. Faisal Rana that the constable had illegitimate relations with a girl, he had planned the murder in connivance with his girlfriend and had got the victims murdered by hiring ail assassin forRs.200000/-.

PROCEEDING OF DC MEETING 29TH JUNE, 2019 AT P.C HOTEL LAHORE:

Submissions by Parties at the Hearing:

Both parties were heard at length.

The complainant stated that the death of the injured occurred after gunshot injury by 30 bore pistol and MLO prepared death certificate showing cause of death as RTA while autopsy report which was received after 28-29 days of the incidence mentioned gunshot injury as the cause of death.

The respondent stated that rescue received call at 7:35 am on 28/9/2015 regarding incidence and reached the place of incidence at around 7:40 am where they found the female had died and the male was gasping.

The two were brought to DHQ City hospital Okara at 7:55 am when the respondent was on duty. The committee asked why the baby was not saved. The respondent stated that at that time saving the male was the priority as he was gasping and keeping in view that the baby dies within 10 minutes after death of mother and they knew that more than 15 minutes had already elapsed after the death of the mother.

The male died after 15 minutes despite all measures taken.

The respondent added that relatives got annoyed on knowing the deaths and had asked to handover the dead bodies. They were told that police would prepare the legal documents and

cause of death would be ascertained by post mortem and then dead bodies would be handed over but the attendants took the bodies by force.

When asked by committee why death certificate mentioned the names as unknown and why modified as Shumaila later when a MLO was not allowed to make amendments in such a document of legal importance. The respondent replied that he added the name when he came to know the same through attendants when they arrived.

The committee further asked why cause of death was written as head injury due to RTA

The respondent replied that he wrote the reasons he was told the same by rescue.

The committee further asked that why gunshot wound requiring post-mortem report for further evaluation was not mentioned. The respondent could not give any appropriate answer.

When asked which injured was observed first and the respondent replied that the one who came first.

The committee further asked what was the cause of death that came in his mind after examining the patient he replied gunshot injury.

The expert asked that in either case it was unnatural death. The expert further asked if police was contacted he said yes

The expert asked if the police chawki is inside hospital he said yes and added that it came after around 1 hour

The committee noted that the name of injured/demised when received should have been written as unknown if it was unknown at that time and should have mentioned that name was found as Shumaila and Tahir Ali when attendants arrived. Furthermore he should have called police and should not have let unknown people take the dead bodies who were not identified as attendants by them. The respondent replied that he had no work force with him to prevent the attendants who were aggressive and he was alone and could not prevent it.

The committee showed displeasure on falsified death certificate and asked when the death certificate prepared was. The committee noted that time of receiving the injured and the demised was documented as 7:55 am and 8:10 am was the time of death for the male injured. The respondent when asked replied that death certificate was prepared at around 830 am and attendants came after half hour and police after 1 hour of the incidence.

The committee then raised following questions and asked the respondent to answer as yes or no.

Q) Did you see the bullet injury?

A) Yes

Q) Did you document the bullet injury?

A) No

The complainant was asked by the committee why they had taken the bodies themselves and they replied that they were told by a dispenser that their brother had died and they should come immediately and they were asked to carry the dead bodies with them. When asked they stated that they were not contacted by police neither they were conveyed that they should not carry the bodies with them

FINDING

The male had head injury and therefore could not have been received gasping and the female was received with chest injury and she could have been alive with the baby alive. There is another inquiry in process against rescue at their head quarters.

The time documented for receiving the patient is before rescue reported to the head quarter which is 7:55 am

There is great disparity in documentations by respondent

There is criminal negligence involved on part of the respondent

Expert opinion:

"On scrutiny of record, listening to complainant and respondent and cross questioning to both complainant and respondent, I am of following opinion:

1. That respondent Dr. AmjadKazmi on admitting himself that he examined both injured victims (one Shumaila received dead and other Tahir Ali alive) and found bullet injuries, negligent in informing police and not preparing and issuing Medico-Legal certificate for Tahir Ali who died after about 15 minutes receiving in emergency of DHQ Okara.
2. Death certificate prepared by him, prima facia are ambiguous."

RECOMMENDATION:

After hearing both parties at length the committee decided as follows. The respondent registration will be cancelled permanently and criminal proceedings against the respondent be initiated

Pakistan Medical Commission
Islamabad

CASE NO.8

PF.12-Comp-175/2017-Legal

Muhammad TufailKotFatukay, Post Office Kanganpur, Tehsil Chunian, District Kasur.0302-4755850

Versus

Dr. Ashfaq (9768-P) Hospital Ellah Abad, District Kasur.

Brief of the Case;-

The complainant's 52 years old mother Mst. Fatima Bibi, a case of prolapsed uterus had reported to Dr. Ashfaq Hospital Ellah Abad. According to Dr. Muhammad Ashfaq, the patient had first reported to him on 27-07-2015, when as per respondent dr. Ashfaq uterus was prolapsed totally. The complainant had denied that the patient drank or ate anything after the surgery and according to him, the uterus had been forcefully pulled out, which had damaged the urinary tract, causing accumulation of fluid inside the abdomen. The patient had expired at about 05:45 p.m. on 29-07-2015. The attendants had protested. Glass door had been broken. Dr. Ashfaq had fled from the scene. Histopathology and autopsy were not done.

Case of Dr. Muhammad Ashfaq is referred to PMDC and Health Department for: -

i) Conducting major surgeries without having the requisite post graduate qualification.

ii) Performing surgery at his private setup during official duty hours.

iii) Performing surgical procedures at a premises with inadequate facilities

Preliminary Findings/Observations

The case was presented to the expert in the field of Gynecology & Obstetrics who gave the following opinion on 03.04.2017: -

"Mrs. Fatima Bibi diagnosed as a case of uterine prolapse by Dr- Ashfaq operated by him.

In view of available record & statements, patient became serious after surgery & died. In my opinion vaginal hysterectomy is a major surgery & should always be done by a trained gynecological surgeon. Uterine prolapse is not an emergency & patient's general condition should be optimized before operation. After major surgery, a qualified health person is needed for postoperative follow up.

In present case all the above mentioned standard requirements were not fulfilled."

PROCEEDING OF DC MEETING 29TH JUNE, 2019 AT P.C HOTEL LAHORE:

Submissions by Parties at the Hearing:

Both parties were heard in detail.

The patient came with a prolapsed uterus. The operation was done in a private facility which had 5 beds and 1 OT. The doctor who performed surgery was an MBBS only. He was in Government service at the time and was performing surgery in the private clinic at 7:30 a.m. He gave spinal anesthesia himself. Mohammed hanif was the OT technician. There were no other doctors in the facility. There were no resuscitation facilities. There was no crash trolley.

When asked why the respondent performed gynecological surgery and gave anesthesia without any additional PG qualification the respondent could not give appropriate answer.

RECOMMENDATION:

After hearing both parties at length the committee recommended for permanent cancellation of license.

CASE NO.14

PF.12-Comp-153/2017-Legal

Mr. Fiaz Ahmed

Versus

Dr. Maj Muhammad Aslam (8300-P) Hanan Hospital Chakralla Sialkot.

Brief of the Case:-

Complainant is a barber by profession and he underwent a second operation at the HCE, which is owned by the Respondent who is actually a homeopathic doctor.

The Board further noted that the patient had been examined by a qualified FCPS doctor (Dr. Major Aslam) at his clinic but the Complainant/patient was operated at the HCE for a fee of Rs. 30, 000/-. The referred FCPS doctor observed the leakage of anastomosis and referred the Complainant/patient to Mayo Hospital through a properly prepared referral slip. The leakage of anastomosis though one of the known complications of the procedure was likely under the said circumstances

The Board noted with concern that the staff at Mayo Hospital performed colostomy of the patient and attached a plastic bag externally. The case was also reviewed by an expert in the field of Surgery.

Preliminary Findings/Observations

"A major abdominal surgery was carried out in a facility which was not equipped to deal with the referred cases. The HCE lacks requisite qualified staff, documentation and other resuscitative equipment. Moreover, primary anastomoses of ileum were 2 inches proximal to ileocaecal junction undertaken by the surgeon (Dr. Major Aslam) in such circumstances was highly likely to break down and therefore ill advised. It is recommended that surgeries should not be allowed in the HCE under the mentioned circumstances The operating surgeon Dr. Major Muhammad Aslam (Retired) is warned to refrain from performing surgeries at Hanan Hospital in future until the availability of adequate facilities at this hospital.

c. Case of Dr. Major Muhammad Aslam (Retired) is referred to PMDC for operating at a substandard HCE.

PROCEEDING OF DC MEETING 29TH JUNE, 2019 AT P.C HOTEL LAHORE:

Submissions by Parties at the Hearing:

The complainant was absent. The respondent was heard in detail.

The respondent told that the Shifa hospital where appendicectomy was done had been closed and patient had persistent abdominal pain and the respondent found adhesions in posterior abdominal wall and it was re-sected and anasotomosed

The expert asked whether it was sent for histopathology and the respondent replied that it was fibrosed adhesions and no stricture so there was no need of a histopathology sample.

No free fluid and albumin level was normal as per respondent but when re-asked the respondent said he does not remember.

When further asked about the anesthetist he said Col. Maqsood was the anesthetist and monitoring facilities like pulse oxi-meter were available in the HCE

The committee asked what were the mandatory monitoring facilities that are required in OT when doing major surgery and particularly an abdominal laparotomy being done in GA. The respondent requested to clarify the question.

The committee clarified that how would a surgeon know that the patient is doing well and what were the four parameters.

The respondent said that HCE was having pulse oxi-meter and the case was first and last case at Hannan hospital and the respondent had already suggested to get the case done in Fauji foundation where he was already working and where he knew all mandatory facilities were available however he was asked by Dr. Nisar who insisted for him to perform the surgery at Hannan hospital. (He said he gets paid more at Fauji Foundation.) He said that the patient had already been to Civil Hospital and already diagnosed case of sub-acute intestinal obstruction. Case had undergone prior abdominal surgery of appendix at Shifa Hospital. In present surgery, he had found adhesions, fibrosis and proximal dilation.

He had worked for 5 year as full time and part time contract for further 9 years at Fauji foundation. The registration status with PMDC was found valid

The respondent added that primary consultant where appendectomy was done was never inquired.

The committee mentioned that Primary end-to-end anastomosis and resection was done close to ileo-cecal valve therefore -indication was iatrogenic injury and not primary surgery.

When asked respondent replied that gut wall thickening was not much

The expert opined that when gut was mobilized and the viability was compromised and so resection was done and disparity in gut wall thickness was not significant, the decision of anastomosis is acceptable as far as surgeon is comfortable at performing anastomosis but when performing close to valve, the chances of leakage are high

RECOMMENDATION:

After hearing the respondent the committee recommended that warning will be issued to the respondent to not operate in sub-optimal facility.

The committee asked the complainant that during shifting in ambulance whether oxygen facility was available in the ambulance and whether any qualified staff had accompanied the patient and the complainant's answer was no for both questions. The patient subsequently died.

When complainants were asked about existence of any co-morbidity in the patient at time of surgery they replied that the patient had no history of co-morbidities.

The respondent stated that he is working in THQ and at time of the incidence he was medical officer in THQ hospital Bhagtanwala.

When asked about who was the anesthetist the respondent stated that he himself had administered spinal anesthesia.

When asked about the Parameters of monitoring the respondent replied that it included pulse oxi-meter, cardiac parameter blood pressure. Respondent said that patient had an MI. That ECG showed an MI. He said that patient was entirely normal but 1 and half hour after surgery became breathless.

The committee asked about the difference between ECG and ECG Trace the respondent could not give appropriate answer

The committee further asked about Oxygen saturation and the ECG signs and the respondent failed to answer both questions.

The committee further asked who was giving oxygen during procedure and the respondent stated that the OTA was doing it.

The committee showed displeasure on administration of anesthesia by a non qualified staff.

The committee asked about definition ventricular tachycardia and what is given in such case

The respondent stated that in case of VT the heart rate increases and beta blocker are given

The committee asked why the patient was shifted, the respondent stated that when he thought the patient might be having some cardiac signs he gave instructions to shift the patient in ambulance

When asked the respondent replied that neither he nor his OTA have received any training in BLS or ACLS. The doctor is just an MBBS, not surgeon, but does hernia and appendectomies in private setting. He portrays himself as MRCS.

RECOMMENDATION:

After hearing both the parties the committee recommended permanent cancellation of the registration status of the respondent Dr. Khalid Dad.

The PMDC shall communicate to PHCC to shut down the facility on treating patients without mandatory facilities.

CASE NO.15

PF.12-Comp-107/2016-Legal

Mr. Khalid Mehmood

Versus

Dr. Munir Hussain 26556-P ,DarulBarkat Hospital, Sheikhpura

Brief of the Case;-

The Board noted that Muhammad Boota had a planned right submandibular duct sialolithotomy under GA on 25.04.2014 at DarulBarkat Hospital by Dr. Muhammad Aslam, ENT consultant. Prior to his surgery, the patient was properly investigated and assessed from anesthetic point of view and after getting fitness from the anesthetist, Dr. Munir Hussain and proper consent, he was operated.

The Board noted that surgery was uneventful but the patient did not respond to vocal commands during recovery period from anesthesia for which advice was sought from senior consultants in anesthesia by Dr. Munir Hussain and the patient was shifted to Hussain Memorial Hospital, Lahore on the same day at 10:30 pm where ICU facility with ventilator was available. Patient regained consciousness after 48 hours and was off the ventilator. But he developed generalized tonic and colonic fits with Status epileptics during his stay which were managed accordingly. Again the patient had to be switched to the ventilator. Later on the patient was referred to Sheikh Zayed Hospital, Lahore on 05.05.2014 where he remained under care of multi-specialty team but expired on 16.05.2016 at 11:00 am.

Preliminary Findings/Observations

As per expert opinion sought by PHCC.

The case was straightforward and simple that is removal of stone from right submandibular duct which was performed under GA. Apparently, the procedure went very smooth and was finished in half an hour by Dr. Muhammad Aslam on 25.04.2014.

Post-operatively, patient did not respond to vocal commands whereupon, the anesthetist Dr. Munir Ahmed asked for opinion from senior anesthetist in Lahore. Later patient was shifted to Hussain Memorial Hospital on the day of surgery that is 25th April 2014. Patient did not recover in 10 days after which he was shifted to Sheikh Zayed hospital Lahore where he finally died of sepsis and cardiopulmonary arrest.

During entire stay at Hussain Memorial Hospital and Sheikh Zayed Hospital patient kept on having seizures In his opinion as per medical records Dr Muhammad Aslam ENT surgeon is not at fault. Regarding post-operative recovery, anesthetist can give better opinion.

The Commission also obtained expert opinion on 09.04.2015 from anesthetist which reads as under:

"It was simple, short ENT procedure. Relative intra-operative record produced before me is un-remarkable. Patient did not recover post- operatively and started having fits-post-operatively which lasted till his death.

It is difficult to tell exact cause of it which may be due to Cerebral Edema / brain damage"

PROCEEDING OF DC MEETING 29TH JUNE, 2019 AT P.C HOTEL LAHORE:

Submissions by Parties at the Hearing:

Both parties were heard at length.

When asked the respondent Dr. Munir, who is MBBS and DA, replied it was categorized as ASA 1

When asked about pre-op measures he replied he advised blood sugar BTCT etc

When asked if investigations for Echo, ECG or pulmonary functions were done before giving general anesthesia the respondent stated that the tests were not done.

The committee noted that X-ray chest was also not done

The committee asked what is practice for administering GA and whether an X-ray is required for GA fitness. The respondent stated X-ray chest is required for GA fitness but he had not advised it in the subject case.

The committee asked what is the first check to see whether patient was on route to recovery from a GA. The respondent stated that a response to vocal command is indicator of recovery from GA.

The committee further asked that whether patient was responding to vocal commands in the subject case and the respondent said no.

The committee asked why patient was shifted from OT without recovery of consciousness and without recovery from anesthesia. The respondent failed to give appropriate answer.

The committee added that as per record vitals were maintained so the possible cause could be a cerebral event

When the respondent asked said that Pentozocine and succinyl choline were the anesthetic agents and when asked about the side effects he said he did not know the adverse effects of these agents.

When asked about dissociation anesthesia agent the respondent replied it was ketamine.

Expert asked whether there was any history of epilepsy with patient the complainant replied no history with patient and no family history of same

The expert further asked regarding duration of the surgery and the respondent replied it was approximately half hour. He said that patient recovered partially from anesthesia but was not fully conscious but responded to vocal commands. Oxygen saturation was 96-97%.

When asked by committee which tube was intubated the respondent said orotracheal tube and the committee asked the OTT might have been dislocated and that could have potentially led to cerebral event.

When the respondent asked replied that Blood pressure and saturation and ECG are among the four parameters for cardiac monitoring

The committee further asked whether laryngoscope was covered and the cover was changed before using in another patient the respondent said he ensures this for Hep. C positive patients.

The committee asked the complainant that did the patient talk to them after surgery and the complainant said no and the committee asked respondent that why the patient was shifted from recovery without gaining consciousness.

Finding:

General Anesthesia was given without advising and examining X-ray chest .

Patient was shifted from recovery without ensuring recovery of consciousness and without appropriate measures.

Cerebral insult occurred due to insecure intubation or any other possible reasons.

The anesthetist was unaware of the side effects of the agents he is routinely using. He did his DA in 2010 and acknowledged that he has not engaged in continuing medical education.

RECOMMENDATION:

The committee recommended that the registration of the respondent will be suspended for two year and also recommended for remedial training.

CASE NO.17

PF.12-Comp-163/2017-Legal

Mr. Muhammad Saleem

Versus

Dr. Muhammad Attique (2337P), S/o Muhammad Siddique

Brief of the Case:-

Patient Khadija aged 17 years was admitted at the HCE on 5-6-2015 with a history of moderate abdominal pain in right iliac fossa since the previous day. There was tenderness in the right iliac fossa and her temperature was about 101" F and she had vomited once or twice. The patient had gone a day earlier to Wafa surgical on 4-6-2015, where Capt. Retired Dr. Rana Muhammad Aslam had carried out ultrasound and diagnosed the pain to be related to acute appendicitis.

The Respondent had placed a drain in the abdomen after the operation and had closed the wound primarily which is against the standards of care for perforated appendix. This was also observed by the expert who pointed out that if (and as per the Respondent) the wound was full of pus the wound should have been left open. Moreover, the administration of general anesthesia by the surgeon himself was also taken note of and considered dangerous and unlawful.

The Board noted with concern that this may have contributed to iatrogenic injury leading to fecal fistula

The case of Dr. Muhammad Attique, Administrator Ravi Hospital, Samundri is referred to Pakistan Medical & Dental Council for action at their end for the following reasons:

i. Conducting major surgery without having requisite competence.

ii. Claiming to be DGO & Ultrasound specialist without any proper qualification.

iii. Administrating anesthesia himself in the instant case.

iv. Not maintaining proper medical record of the patient (pre & post-operative notes).

v. Not taking the informed consent of the patient before surgery'

vi. Transfusing blood without consent of the patient.

Preliminary Findings/Observations

"The Respondent claims to be a DGO and Ultrasound Specialist without evidence of either of these degrees. His diploma from the Skill Development Council appears dubious. His credentials may be verified from PMDC. The Respondent claimed that the patient had perforated appendix with abdomen full of pus at the time of operation. Still he closed the wound primarily which is against the standard of care as such wounds should be left open. A case of perforated appendix under self-administered Ketamine is dangerous and without proper relaxation adequate surgery and peritoneal lavage cannot be ensured. This may be contributed to iatrogenic injury leading to fecal fistula. The Respondent failed to recognize impending fecal fistula and delayed proper treatment of this dreaded complication. The visit of the inspection team clearly showed the poor condition of the OT, sterilization and waste disposal. There is no evidence of proper documentation before and after the operation. Consent does not appear informed and there is no consent visible for blood transfixion as well. The Respondents appear guilty of falsification of his credentials, incompetent to deal with major abdominal condition endangering life of a young girl.

PROCEEDING OF DC MEETING 29TH JUNE, 2019 AT P.C HOTEL LAHORE:

Submissions by Parties at the Hearing:

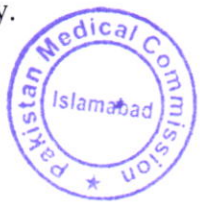
Dr. M. Attique is MBBS and does not have PG qualifications. He says his private facility has 5 beds and 1 OT. His wife is an MBBS and he has 6 nurses, half of whom are registered. He said he does 4-5 surgeries per month. Though he is an MBBS, he gives anesthesia himself and does not have an anesthetist. The committee showed displeasure on the practice of procedures requiring specialized skills and training without having additional relevant PG qualifications by the respondent. He is running a private facility where he is performing beyond the scope of his training, giving anesthesia, performing surgery, in an inadequately staffed facility. Respondent was unaware of parameters to monitor patients who are under general anesthesia. He did not have a crash/resuscitation trolley in the OT.

When asked the sterilization techniques in the OT the respondent could not give appropriate answer and said that he uses a boiler.

RECOMMENDATION:

The committee after both parties at length and decided for permanent cancellation of the registration status of the respondent.

Also to suggest to PHCC to shut down facility.



CASE NO.18

PF.12-Comp-194/2018-Legal

Mr. Muhammad Ramzan Khan

Versus

Dr. Rafique A. Malik 6131-P , Al-Hameed Medical & Surgical Complex Hospital , Bhakkar

Brief of the Case;-

The complainant's wife Haseena Bibi was diagnosed as a case of Cholelithiasis (gallbladder stones) on ultrasonography dated 22-04-2014, by Dr. Nauman Ahmed (DMRD) who reported, "multiple stones largest 1.4 cm ". On 26-04-2014, Dr. Aijaz Ahmed did ultrasonography and reported, "Multiple small stones ". On 19-03-2015, Haseena Bibi was taken to AI-Hameed (AI-Asri) Medical & Surgical Complex Hospital.

Case is referred to PHCC for false representation i.e. portraying to possess MS degree, performing major surgical procedure without the requisite qualification, lying to attendants that GB had been removed.

Preliminary Findings/Observations

The surgery expert made following observations:

"Patient, Haseena Bibi, age 45 years, had Cholelithiasis on USG. Her open Cholecystectomy was claimed to be done by Dr. Rafiq A Malik at AI-Hameed Medical and Surgical Complex Bhakkar.

The operating doctor stated that the gallbladder was gangrenous and operation was difficult. He removed the gallbladder up to its neck along with the stones and left the rest inside. No histopathological report is available. Patient's complaints continued and she reported to Dr. Zahid Iqbal at Mian Muhammad Trust Hospital, Faisalabad. Her USG and MRCP showed that a complete gallbladder containing stones is still inside the patient.

On 19-09-2015 Dr. Zahid Iqbal did a laparoscopic cholecystectomy. He found an inflamed gallbladder with adhesions. Lap chole was difficult (evidence of inflamed, past or present). An apparently complete gallbladder containing multiple stones was removed. And a tube drain left in. She was discharged on 21/9/15.

As evidenced from the USG and MRCP done before the second operation, the operative findings and histopathological report, cholecystectomy was done during the second operation only.

Apparently cholecystectomy (partial or complete) was not done during the first operation done on 19/3/15

In the meantime, the Commission obtained opinion of the expert in the field of Radiology on 10.3.2016. The expert made following observations:

"Having gone through the available record and the statement of the parties, Dr. Rafiq A. Malik claims that he did partial Cholecystectomy and removed Gallbladder up to the neck (as mentioned in his prescription slip dated 19.03.2015) along-with removal of stones. While patient claims that the surgeon did not perform the said surgery. Patient has provided Radiologyreports of ultrasound report dated 15.09.2015 done at Sheikh Mian Muhammad Trust Hospital, Faisalabad and MRCP report dated 17.09.2015 at Punjab Medical College, Radiology department. Both these reports mention intact Gallbladder and stones. Later on Lapchole performed by Dr. Zahid Iqbal on 19.09.2015. He sent the specimen to SKMT Lab for Histopathology. The report dated 22.09.2015 confirms Gallbladder and the stones were present.

In my opinion, Dr. Rafiq A. Malik's claim appears to be weak because he had not sent the specimen for Histopathology then.

PROCEEDING OF DC MEETING 29TH JUNE, 2019 AT P.C HOTEL LAHORE:

Submissions by Parties at the Hearing:

Both parties were heard in detail

The respondent had been called to a private facility to perform surgery. He said that he has performed 50-60 cholecystectomies. He has no post-graduate qualifications. Not registered as a surgeon. He is based 150 miles from the private facility. His friend, who called him for the surgery, is a friend of the owner of the hospital. The owner had 4-5 surgeries waiting for him that day which included 2 cesarean sections and 1 cholecysectomy.

The committee noted with great concern that the procedures of surgery and Gynecology were being performed by respondent without having additional qualification while these procedures require specialized skills and qualification. Moreover, these were all elective surgeries, and not life saving emergency procedures and could have been referred to a trained qualified specialist.

When asked about oxygen saturation and sterilization techniques in OT the respondent failed to answer. Furthermore when asked the respondent replied that the anesthesia was administered by a staff who was Bachelor in Arts.

RECOMMENDATION:

After hearing both the parties the committee recommended permanent cancellation of the registration status of the respondent.

CASE NO. 19

File No: 12-Comp-164/2017-Legal

Mr. Imran Khan (Complainant)

Versus

Dr. Khaliq Dad, (36208-P), Dr. Zubaida Siddique Zubaida Siddique Hospital Bhagtanwala District Sargodha Respondent.

Salient features of the case: -

Patient aged 55 years was suffering from Right Inguinal Hernia. And after operation patient did not regain consciousness. The HCE staff informed the attendants that Respondent No.l had left the HCE when the patient needed treatment. The HCE was not equipped with the requisite facilities; therefore the patient was referred to Ibn-e-Sina Hospital, Sargodha. It was observed that the application submitted by the Complainant to the Secretary Health, Government of the Punjab suggested that the patient had died during the surgery due to overdose of anesthesia but the attendants had been kept in dark.

Case of Dr. Khaliq Dad, Medical Officer, THQ Hospital, Bhagtanwala is also referred to Pakistan Medical & Dental Council for fraudulently displaying himself as MRCS England and for giving anesthesia without having required qualification and expertise.

Preliminary Findings/Observations

The Board also noted with concern that the Respondent No.1 had denied that he had left early. He stated that he had left at about 3:30 pm andjust before he had left the HCE, a staff person had informed him about the condition of the patient and Dr. Saima had informed Respondent No.l that the patient had suffered from Myocardial infarction and the decision of shifting/referring the patient to Ibn-e-Sina had been taken

PROCEEDING OF DC MEETING 29TH JUNE, 2019 AT P.C HOTEL LAHORE:

Submissions by Parties at the Hearing:

Both parties were heard in detail. The respondent appeared along with his counsel.

The complainant mentioned that the patient had visited Zubaida Siddique hospital on 11/9/2014, and he had himself driven over on his motorbike, at around 10 am and operated at 12 noon same day by respondent. He did not regain consciousness, and was told that maybe "he got heart attack".

The committee asked whether patient had taken breakfast on the day before the surgery. The complainant replied that patient had taken tea only

After the surgery when attendant saw the patient, the patient was still unconscious and around 2 pm 11/9/2014 the patient was shifted in ambulance.

CASE NO. 20

File No: 12-Comp-181/2017-Legal

Mr. Waseem Iqbal

Versus

Dr. Malik Habib Qadir (22143-P), Ch.Fazal Din Welfare Hospital Okara.

Salient features of the case: -

The complainant, Waseem Iqbal was suffering from ailment of bladder for which he consulted the Respondent at the Respondent HCE. The Complainant alleges that he was negligently operated by the Respondent in the year 2012.

The Board further noted that all the medical record presented by the complainant before the commission pertains to late 2013, 2014 and 2015 which consistently shows urinary tract infection. It further shows that Cystoscopy was done on 06-03-2014 at Sharif Surgimed Hospital, Okara.

Moreover, it shows Granulation tissue on left lateral wall of the urinary Bladder. However, the Complainant miserably failed to produce any cogent, confidence inspiring and independent evidence to the effect that the alleged surgical procedure was even conducted by the Respondent at the Respondent HCE.

Preliminary Findings/Observations

Case of the Respondent i.e. Dr. Malik Habib Qadir is referred to PM&DC for practicing without having valid PM&DC registration'

PROCEEDING OF DC MEETING 29TH JUNE, 2019 AT P.C HOTEL LAHORE:

Submissions by Parties at the Hearing:

Both parties were present and heard at length

The committee asked about qualification of respondent and he said he has done FCPS surgery and at time of incidence the registration status had expired

The respondent further stated that he did not operate the patient while complainant stated that the patient was operated at Fazal Deen hospital by respondent

The complainant further stated that he had pain in urinary bladder and he went to another hospital where swab was recovered

He further mentioned he had ultrasound including one from Prof Riaz Tasneem mentioning the word "may be swab" for possible presence of swab

The complainant showed ultrasound from Zainab maternity and Chudry Welfare Hospital both owned by the respondent which showed UTI

The committee noted that FRCS was mentioned on ultrasound report while it was not registered with PMDC

The respondent apprised the committee that he has done FRCS in 2001 and when asked he added that his FCPS 1999 is registered with PMDC

RECOMMENDATION:

The respondent was asked to change the name of his clinic and to register his FRCS Edin.

He was imposed a fine of 50,000 (fifty thousand) for not registering his FRCS while showing it on reports.