

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

A meeting of the Disciplinary Committee was held on 30th 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.	Brig. Asif Asghar	Expert
6.	Prof.Dr. Khalid Cheema	Expert
7.	Dr. Ayesha Ghiyas	Expert
8.	Prof. Irshad Hussain Qureshi	Expert
9.	Dr. Faisal Sultan	Expert
10.	Dr. Iftikhar Ijaz	Expert
11.	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.



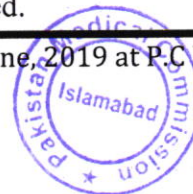
Pakistan Medical & Dental Council, Islamabad
Versus

Dr. Ali Raza Khan, PM&DC Registration number 28212-P

Brief of the Case:

- The Acting Registrar PM&DC has forwarded a copy of web page dated 15th April, 2019 of Doctors Hospital, Lahore, reflecting the name of Dr. Ali Raza Khan as a Consultant Thoracic and Vascular Surgeon at said hospital with his qualifications written as MBBS (KEMU) 1994 and Diplomat American Board.
- Moreover, the official website of Shaukat Khanum Memorial Cancer Hospital and Research Centre, Lahore also shows the name of said doctor with same qualifications and speciality.
- On the contrary, as per PM&DC doctor's registration database only MBBS is written against the name of Dr. Ali Raza Khan under PM&DC Registration number 28212-P.
- A letter was sent to Dr. Ali Raza Khan on 19th April, 2019 for his comments to clarify the same.
- Dr. Ali Raza replied through letter accompanied by a copy of his post graduation degree / experience certificate / employment certificate abroad which was received in R&I Section PM&DC on 15th May, 2019, wherein he has informed that he wishes to come back and practice in Pakistan and Doctors Hospital is known to be prestigious institute in Pakistan and he wishes to work there on his return from abroad. Presently he is working in the Middle East Countries after completion of his postgraduate qualification as consultant, and he further added that he has already applied for his post graduation through his friend in Pakistan.
- On 27th May, 2019 a letter was also written to the Administrator Shaukat Khanum Memorial Cancer Hospital and Research Centre, Lahore and Doctors Hospital & Medical Centre, Lahore for their comments on the matter of Dr. Ali Raza Khan.
- Mr. Masood ur Rehman, Manager Human Resources, Shaukat Khanum Memorial Cancer Hospital and Research Centre, Lahore in his reply dated 28th May, 2019 has apprised that Dr. Ali Raza Khan is working as visiting Consultant Surgeon in the Surgical Oncology Department at said hospital since March 01, 2005 till date.
- On 28th May, 2019, the Medical Superintendent Gulab Devi Hospital, Lahore was sent a letter wherein it was requested to inform as to since when Dr. Ali Raza Khan is working in said hospital and further inform about details about his designation / appointment.
- On 03rd June, 2019 reminders were served to Doctors Hospital & Medical Centre, Lahore and Gulab Devi Hospital, Lahore.
- On 13th June, 2019 two more reminders were sent to both Doctors Hospital & Medical Centre, Lahore and Gulab Devi Hospital, Lahore
- The reply from both the above hospitals has been received.

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- In view of above description, submitted for perusal / consideration please.

PROCEEDING OF DC MEETING 30TH JUNE, 2019 AT P.C HOTEL LAHORE:

Submissions by Parties at the Hearing:

Respondent came with his counsel and he was asked as to why his registration was not valid and why he has been practicing without valid registration status

The committee asked why the reply dated 15/5/2019 states that the respondent is not practicing in Pakistan and the respondent stated that this letter was not written by him.

The respondent stated that the employment certificate states Ali Raza Shaukat whereas respondent name is Ali Raza Khan and the signs are fabricated. Moreover, his father's name is incorrect in the letter as well.

He further added that the registration status has been expired in 2014, and the respondent stated that maintenance of certificate does not mean the degree itself has expired; neither it is mandatory rather voluntary to keep the American board degree updated to work in USA.

The committee clarified that PMDC certification needs updated American board and the respondent stated that his board stands valid till 2024.

The counsel mentioned that recognition is mentioned and not renewal in the rules in USA.

The committee clarified that PMDC rules mention renewal is necessary to ascertain valid registrations to display at HCE and this is in order to prevent quackery.

Representation from Gulab Devi was asked why they did not ensure valid registration as an organization. They stated that first appointment was in 2006 as senior registrar thoraco-surgery with qualification of MBBS as he was working under supervision of thoracic surgeon. The committee mentioned that this is patent misrepresentation.

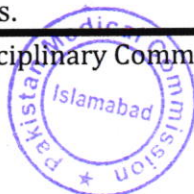
The counsel accepted omission and raised question that why" may be" before registration of PG qualification and the committee clarified that the option lies on discretion of PMDC whether it registers after qualification or not as there are some institutions and degrees that are regretted by PM&DC.

Respondent further added that Section 24 writes "may" apply to counsel and this should be clarified in the regulations

Representative from Shaukat Khanum hospital stated that the respondent is qualified.

The respondent said that it is primarily responsibility of administration to ensure validity and the respondent is working with utmost sincerity to serve humanity and as a clinician he has tried his best to focus on best of qualifications and quality of service. In addition he requested to ensure a notice to all practitioners to ensure valid registrations as doctors mainly focus on quality of service and usually have very hectic schedules and cannot study the status of PMDC themselves.

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In addition he added that he is an active examiner with CPSP and bears an excellent academic and clinical record. He further added that had he been communicated it was easy for him to submit fee and get the registration renewal done. He added that why his fake employment was submitted and this must also be inquired. The committee appreciated the respondent for his efforts and mentioned that this matter will be forwarded to FIA and a copy shall be provided to respondent.

The committee agreed to issue public notice within 7 days to ensure communication and compliance.

The committee further added that the ambiguity in regulations is going to be considered in 1/7/2019 council session as in the past the regulation was not primarily formulated by PMDC. Also institutions will be asked to provide list of full time clinicians with qualification to communicate to PMDC along with the contract/appointment letters to ensure discourage walk in clinicians and to ensure full time pre and post treatment care as per standard measures. The committee also added that it is important for PM&DC to clarify their position on American Board qualifications, given the increasing numbers of American Board qualified doctors returning to the country, since the American Board degree certificate has a date of validity on it, which is confusing, however it does not mean in the United States that the person is only qualified till that date. These issues will also be discussed in further council sessions and clear guidelines made for registration of American Board certification.

A copy of the document of the fake complaint was provided to the respondent on his request.

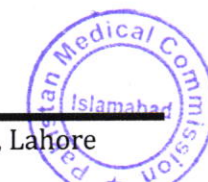
Findings by Expert:

“The case discussed in detail in the presence of supporting counsel and respondents from Doctors Hospital, SKMH and Ghulab Devi Hospital.

1. The American Board Surgery Certificate should be revalidated for first time registration to PMDC.
2. The doctor should be fined for the delay in registration to PMDC which was on his part.”

Recommendations:

1. The respondent will be imposed fine of rupees 5 lacs for practicing without valid post graduate registration status with PMDC.
2. The matter of Shaukat Khanum hospital, Gulab Devi hospital and Doctors Hospitals is referred to PHCC for allowing practitioners without requisite registered qualification.
3. PMDC will Issue a clear public notice to the HCE that they must make it mandatory to ensure valid registration of the health care practitioners working in their facility.



Mr. Javed Iqbal Sial

Versus

THQ Hospital Chowk Azam, District Layyah.

Dr. Abdul Rehman, 23885-P.

Brief of the Case:

The Board has noted from the record that the Complainant got injured during a scuffle with neighbor and was taken to the HCE for MLC by the police under their custody who stitched his wound and performed anti-septic dressing of the wound. Complainant suffered from three injures a lacerated wound 4cmx1/2cm on the left side of the head which He was examined by Respondent No' 1' which was assisted by respondent No'2/Dispenser' A report was –issued MLC report 379/14” dated 1-12-2014 and was handed over to the police on Complainant suffered from three injuries (I) a lacerated 4cm above from the left ear, skin deep, (II) an abrasion 2mx1cm on the back side of the joint of the left shoulder & (III) A bruise 2cm*3cm on the back side below the scapula on the right. The Board has noted with concern that Injury No.3 was not kept under observation by the Respondent No 1 and the X-ray chest was also not advised, on 1/12/2014 which was done later on 22’12-2014 vide MLC X-rav 72114 dated 22/12/2014 vide MLC, X ray 72/14 dated 22/12/2014 when the Complainant himself came’

The Complainant got his X-ray from a private set up which revealed that there was a fracture on his right 10th rib”

The Complainant also applied for re- examination by standing District Medical Board through Court for his re- examination. The actions of Respondent No 1 for not keeping under observation injury no.3, and advising X-ray immediately, proves his negligent and the mala-fide intention on his part.

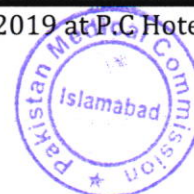
The Board has further noted that the Respondent No.1 approached SHO Police Station, Chowk Azam independently without the concurrence of his MS to produce the “ complainant for X-ray vide his letters dated2-12-2014

Preliminary Findings/Observations

As per expert opinion sought by PHCC

The X-ray chest must have been advised on the very first day on 1/12/2014 of MLC no 379/14 dated 1/12/2014 of the complainant and injury no 3 must have been kept under observation by respondent 1. The initial MLC x-rays were done at HCE on 22/12/2014 and there was fracture in ribs in those xrays, statement of MS teaching hospital, DG khan bearing the signatures of Dr5halid Hussain consultant radiology DHQ teaching hospital DG Khan

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letter no PHC/15354 dated 9/7/2015 but as per need this was not reported and sent to HCE for respondent 1. The information about the CT scan and the new X-ray at teaching hospital should have been conveyed to respondent 1.

CT scan was done on 29/12/2014 and x-ray chest of the injured on 31/12/2014 as per statement of MS HCE vide letter no 1032/THQ dated 10/7/2015. The conduction of x-rays chest on 31/12/2014 after CT scan on 29/12/2014 is not understandable. The report of CT scan was prepared on 15/4/2015 about 3 and half months after the conduction dated 29/12/2014.

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Submissions by Parties at the Hearing:

Complainant was absent. Respondent said that he admits that he had made a wrong MLC due to rush at that time but he had issued corrigendum at earliest.

The committee mentioned that a practitioner of an experience more than 25 years and dealing with a medico-legal document like MLC should be careful and deal with it very intricately.

The expert opined that a board examines the MLC as this is a highly sensitive document of medico-legal importance and it is not possible for MLO to ensure the quality all alone.

The committee noted that the respondent had worked in overly occupied facility with lot of patients to see and he had issued a corrigendum for correction in the MLC later.

Findings by Expert:

“The doctor was overworked taking care of another serious road traffic accident case. He overlooked/missed requesting x-ray chest there on the spot, for which he later sent corrigendum the very next day. As this had an important hearing as MLC case the doctor may be given warning so that he is careful in future.”

RECOMMENDATION:

After hearing the party at length and evaluation of all records the committee recommended that a warning will be issued to the respondent to be more careful in preparing a medico-legal document.



Naseer Ahmad and MoazamamdanaKhurd , Tehsil Kamalia, District Toba Tek Singh. 0340-7870108

Versus

Dr. Altaf Hussain Rathore, (3284-P) Foundation Hospital Rajana ,Disctric Toba Tek Singh

Brief of the Case:

Complainant's 25 years old nephew Akhter Hussain was examined by Prof Dr. Altaf Hussain Rathor (DA, FRCS) at Foundation Hospital Rajana. He was diagnosed with a large MNG (multi-nodular goitre). The doctor recorded diastolic murmur and slightly raised T3 and T4. He advised Tab Neo-Mercazole (Carbimazole) 5 mg 2+2+2 and Tab Inderal (Propranolol) 10 mg 1+1+1. The Laboratory report dated 20-11-2015 revealed T3 = 2.0 (Reference Interval 0.5-1.9 ng/ml) and T4 = 11.9 (Reference Interval 4.6-11.6 ug/dl). Patient was negative for Hepatitis B and C.

The Board has further noted that the patient was again seen by Dr. Altaf Hussain Rathor on 01-12-2015 and admitted him in Foundation Hospital Rajana on 04-12-2015 for the surgery. Two pints of blood were arranged. According to Dr. Altaf Hussain Rathor, the patient and the attendants were explained that it would be a major surgery and they should not hurry but they insisted upon early operation according to Dr. Altaf Hussain Rathor, right portion of the tumour was successfully removed but while removing the left portion, it was found to be cancerous for which more blood was required. The attendants were asked to arrange 5-10 additional bottles of blood but they showed inability to do that and insisted on referral of the patient to some larger hospital. The complainant denied this by stating that had the attendants been asked to arrange 10 bottles of blood they would have arranged those. It was further noted that Dr. Altaf Hussain Rathore did not personally communicate to the attendants for the arrangement of additional blood. As stated by OTA Mumtaz Ahmad, he had asked some attendant in front of the operation theatre to arrange more blood. According to the operation theatre staff, a lot of blood was oozing out, but no major vessel had been cut during the surgery. Histopathology was not done. Assessment by Dr. Altaf Hussain Rathore that the left portion of the tumor was cancerous was based upon his clinical judgment.

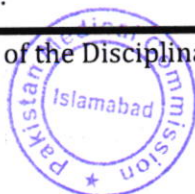
Preliminary Findings/Observations: The case was presented to the expert in the field of surgery who gave the following opinion on 18.01.2017: -

"After having gone through the record of the patient I have found the following facts:

Patient Akhtar Hussain consulted Prof. Altaf Hussain Rathore for a large goiter. He was hyperthyroid for which he was prescribed antithyroid medicines Neo-mercazole 2TDS and Tab Inderal 10 mg TDS.

On 5.12.15 Prof. Altaf Hussain started the thyroidectomy, after the patient was anesthetized by Dr. Qaiser Abbas (MBBS). He was assisted by a staff nurse and an OTA (Mumtaz Ahmed).

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During surgery, blood loss was excessive. The wound was packed and patient was referred to DHQ Faisalabad. Endotracheal tube was still in and patient was put on an Ambu bag, this was operated by dispenser Munir. Ambulance was being driven by driver Sohail Anwar. During his statement, he said that during the journey the patient expired near Pansra; the driver took the ambulance to a local doctor who examined the patient and informed that he has expired; they however took the patient to Faisalabad, where the doctors examined the patient and pronounced him dead on arrival.

This patient had a large hyperthyroid goiter. He was put on anti-thyroid medicines. On 5.12.15, Prof. Altaf Hussain Rathore operated.

Hyperthyroid goiters are very vascular and are known to bleed during surgery. But if adequately controlled, chance of per-operative hemorrhage is less. Left lobe was densely adherent; so the surgeon was not able to dissect it out and control the bleeding. So he packed the wound and referred him to Faisalabad. He died on the way.

Prof Rathore in his statement states that he operated upon the patient on the insistence of his relatives. This should never be done as pre-op FNAC was not done.

When he encountered excessive hemorrhage, the operation could have been stopped at a safe stage. With tight packing and adequate transfusions, the patient had more chances of survival if he had been kept at the Foundation hospital under care of the surgeon instead of referring him to Faisalabad, on a long and hazardous journey.

If the patient was asked to arrange 10 pints of blood, it means excessive amount of bleeding occurred before stopping the operation. "

Case of Dr. Altaf Hussain Rathore is referred to PMDC for: -

- a. Not properly evaluating the patient before planning surgery.
- b. Continuing surgery despite continuous hemorrhage.
- c. Ordering the transfer / shifting of the patient in a critical Condition to another hospital.
- d. Ascertaining the fitness of the 80 years old surgeon to perform surgical procedures.

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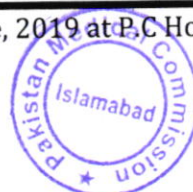
Submissions by Parties at the Hearing:

Complainant is present. The respondent was absent despite notice. When asked whether the respondent was forced by the complainant to perform the surgery, the complainant stated that he had not pressurized the respondent to perform the surgery.

Findings by Expert Opinion:

“Complainant came to present in front of Disciplinary Committee, however the respondent Dr. Altaf Hussain Rathore did not appear before it. He remained absent. However

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the Disciplinary Committee discussed it and agreed to temporarily suspend the PMDC certificate of Dr. Altaf Rathore till further meeting and interaction with him.”

RECOMMENDATION:

The committee recommended that respondent will pay 5000rupees and privileges of his license registration will be suspended till his appearance before Disciplinary Committee.



Mr. Muhammad Sarwar (Complainant)

Versus

Dr. Muhammad Taqi Khan (Sajjad Medical Store) PM&DC Registration No. 27135-P
(Respondent)

Brief of the Case:

Brief facts are that the complainant Mr. Muhammad Sarwar's son Mr. Pervaish Ali brought his mother Shahida Perveen to the medical store named Sajjad Medical Store of Mr. Khadim Hussain Sajjad on 13/08/2015 due to fever and some medicines were prescribed due to which she developed multiple blisters on whole of her body. She used medicines prescribed by the respondent but her condition did not improve. She was shown at Social Security Hospital, Gujranwala on 17-08-2015 early in the morning from where she was referred to DHQ Hospital, Gujranwala. Ultimately she had to be taken to Mayo Hospital, Lahore where she was admitted on the same day i.e. 17-08-2015 as a case of Toxic Epidermal Necrolysis (TEN) and remained admitted in ICU for about 21 days in serious condition. She remained under treatment at ICU under care of Dermatologists of Mayo Hospital, Lahore but finally expired on 07-09-2015 at 8. 1 5 am.

Preliminary Findings/Observations

The case was presented to an expert in the field of Dermatology, who opined the following on 19.05.2016:

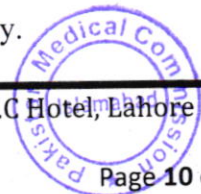
"I have examined the patient treatment file thoroughly. The patient was admitted in Dermatology Department Mayo Hospital, Lahore on 17th August, 2015 as a case of Toxic Epidermal Necrolysis (TEN).

This may be due to multiple drugs including simple NSAID. As there is no prescription available in the record before admission to Mayo Hospital, Lahore, so it is not possible to identify the causative drug. After admission, according to the treatment record, she was well managed. As per Score mentioned in the record it was 5, so there are more chances of mortality. Scorten 5 and above has high mortality rate. Death may be due to Septicemia or cardiopulmonary arrest "

The Board has further noted that the patient had SCORTEN Score 5, carrying mortality rate of 90%. Exhibit C-2 dated 03-03-2016 clearly confirms Mr. Khadim Hussain Sajjad examining the patients and administering injection to a child. Mr. Khalid Mehmood s/o Habibullah works as a salesman at Sajjad Medical Store, being matriculate (Exhibit C-2-dated 03/03/2016). The respondent Mr. Khadim Hussain Sajjad practices under cover of MBBS doctor Muhammad Taqi whom he had employed recently.

Case of Dr. Muhammad Taqi is referred to PMDC for promoting quackery.

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PROCEEDING OF DC MEETING 30TH JUNE, 2019 AT P.C HOTEL LAHORE:

Submissions by Parties at the Hearing:

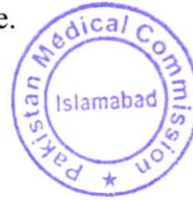
Complainant stated that Khadim Hussain Shah was the primary person who conducted the procedure and the other person Sajjad was also involved. The committee asked whether Dr. Taqi was ever approached by complainant or there was any involvement the complainant replied that Dr. Taqi was never involved in the case. The committee clarified that since there was no involvement of Dr. Taqi as confirmed by complainant's statement. The committee further asked why criminal court or session judge was not approached. The complainant stated that he tried but it was not possible as he could not afford a lawyer.

Findings by Expert Opinion:

“The main case here is not against Dr. Taqi. It is against the medical store where someone only matriculate is practicing medicine.”

RECOMMENDATION:

The respondent Dr. Taqi is exonerated in this case.



Mr. Aqeel Malik Referred through Honourable Supreme Court.

Versus

Executive Director, Doctors Hospital, Lahore.

Dr. Sandeep Kumar (55512-S), Dr. Sabir Dr. Sanaullah, Dr. Mubeen and Dr. Inamullah

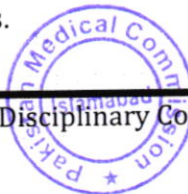
Brief of the Case:

PM&DC received a notice from the Deputy Attorney General. Lahore High Court to appear before the court on 21-06-2010 enclosing orders of the Honorable Supreme Court wherein the Honorable Court has inquired in C.A 736-L / 2009 titled Doctors Hospital (Pvt). Ltd & others V/s Government of Punjab & others as to what action PM&DC has taken against the delinquent doctor and why his registration certificate has not been cancelled. Three inquires in this case have been held in this regard, first by the hospital, second by PM&DC and third by the orders of Chief Minister dated 31- 12-2010.

1. The inquiry conducted by the hospital on 1-12-2009 concluded that the negligence was done by Dr. Sandeep Kumar and he is solely responsible for the death of the child Imane Malik.
2. The inquiry conducted by PM&DC was held on 09-12-2010 and the Committee made following recommendations:-
 - a. The emergency room of Doctors Hospital should be closed immediately till a team of emergency medicine specialist appointed by the PM&DC visits and ensures safe and satisfactory functioning of the emergency room.
 - b. The PM&DC registration certificate of Dr. Sandeep Kumar, Dr. Sabir Dr. Sanaullah. Dr. Mubeen and Dr. Inamullah Khan be suspended immediately and they should be called before disciplinary committee of PM&DC to decide about their fitness to practice in the future.
 - c. The administration of Doctors Hospital must pay fine of Rs.2.5 million as compensation to the family of Imanae Malik.
 - d. Doctors Hospital must make possible arrangements for treatment of the poor patients free of charge especially in their accident & emergency room.

The committee recommended that in order to prevent such incidence following should be implemented.

1. All private and public sector hospital should be governed by the Hospital Regulatory Authority to be established by each Province and PM&DC should facilitate this process.



2. Medical stores and pharmacies should be governed by regulations. Physical presence of pharmacist should be mandatory. Proper storage facilities of medicine should be in place in sale and prescription of dangerous drugs should be duly regulated under the frame work of Ministry of Health.

The third inquiry conducted on the directives of the Chief Minister concluded that;

- 1- Criminal case of manslaughter be registered against Dr. Faiza Asghar Managing Director Doctors hospital for confessing her commissions/omissions in her statement before the Committee, on her hand written note to the committee she stated that hospital has everything in order.
- 2- The committee was keen to recommend that regulations/laws shall be made for private hospitals to avoid such incidences in future.

The reply of PM&DC was submitted before the Honorable Supreme Court of Islamabad and Supreme Court Lahore Bench stating that this case will be placed before the Disciplinary Committee and outcome of the case shall be appraised to the Honorable Court.

PROCEEDING OF THE DISCIPLINARY COMMITTEE HELD ON 04-09-2010:-

On 04-09-2010 the PM&DC notice following respondents were present.

1. Dr. Ghazanfar Ali Shah, CEO, Doctors Hospital,
2. Dr. Sabir,
3. Dr. Inamullah
4. Dr Mubeen.

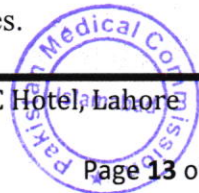
However following did not appear despite of the notices,

1. Dr. Sandeep Kumar
2. Dr. Sanaullah,

Father of Imanae Malik MrAqeel Malik along with MrAzhar Siddique Advocate Supreme Court and Ahmed Naseem Malik the grandfather of Imanae Malik were present. The Advocate MrAzhar Siddique stated that they have come on the notice of PM&DC and they should be provided the material on the basis of which this committee has convened this meeting. They were supplied the material before the committee for his consideration comprising of 76 pages.

Mr. M Azhar Siddique ASC stated that he would like to examine the documents supplied today and file his written response on all the issues including if necessary on the jurisdiction and composition of this committee. An adjournment is therefore requested.

The learned counsel may file his comments/objections within three weeks. As requested copies of objections/comments will be supplied to respondents who may therefore submit their response within two weeks of the documents/comments provided to them. The case to be fixed thereafter on the date after the statutory notice to the parties.



DECISION OF THE DISCIPLINARY COMMITTEE HELD ON 11-02-2012:-

The case was placed before the committee without sending notice to the parties. The committee studied the correspondence with different parties and discussed the case at length.

The committee examined the correspondence in the light of the order of Honorable Supreme Court of Pakistan dated 31-03-2011, which included interalia the following:

“..... On the next date of hearing, representative of PM&DC, shall appear and submit report as to why license of delinquent Doctor has not been cancelled so far and what are the hindrances in doing so.”

It was observed that the case was taken up on 4/09/2010 when the complainant appeared along with his counsel Mr. Azhar Siddique Advocate. The learned counsel sought that the material on the basis of which the committee has convened the meeting be provided to them. This was done and the material comprising 76 pages was provided to the complainant advocate where upon he stated that he would file a written response on all the issues including jurisdiction and composition of the committee. The case was therefore adjourned on the request of the complainant and his counsel.

The complainant through his counsel filed a 1st response on April 6 2011 and objected to the jurisdiction of the PM&DC itself seeking also the composition of this committee and the process of its constitution, and the details of the members of the committee, their academic qualifications with experience/expertise in the medical field and also any interest including any direct or indirect contact or relations with the private hospitals management or close relatives or the family members attached to the private or Government hospital, in any capacity. He further requested to provide a copy of notification for constitution of the committee.

It was also pointed out that the matter is pending in the criminal courts at the insistence of the complainant, as also was subjudice before the Lahore High Court and the Supreme Court of Pakistan. The entire relevant data and information of all complaints taken up by the PM&DC against doctors and hospital management and all actions so far taken under the PM&DC laws were also required to be disclosed including a year wise tabulation of Disciplinary proceedings against doctors undertaken by the PM&DC.

This objection to jurisdiction of the council and the committee alongwith seeking the entire vast and unrelated record was followed by another letter dated 20th April 2011 wherein the demand for the supply of the entire material relating to all cases dealt with in the Council and the Committee was reiterated and further proceeding made conditional on the disclosure/supply of this information.

Another letter dated June 3, 2011 followed, requiring, the credentials/qualification of the legal officer of PM&DC and about his registration as an advocate with the Bar Council.

Objection also taken generally as to the administration of the medical profession by the PM&DC. The objection of jurisdiction was reiterated.

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The Disciplinary Committee was of the view that the orders of the Honorable Supreme Court are of greater importance to the committee, whatever be the objection and demand by complainant or his counsel the case will proceed. The demand of the complainant are like that of seeking to go on a fishing expedition through the entire record, past and present, related and unrelated and the objection on the qualification of the PM&DC officials are also not relevant. All the demands and objections of the complainant, being frivolous and vexatious, are rejected.

As to the observation of the Honorable Supreme Court of Pakistan, the committee is of the view that Dr. Sandeep Kumar has to be heard before coercive action is taken against him. He is absent. Since he belongs to a minority community, the committee feels that greater care and caution should be exercised. The Committee cannot act mechanically on the basis of reports by other inquiry committees/bodies as it has its own statutory function to perform. Notice therefore be issued to Dr. Sandeep Kumar as a last chance, to appear before the committee at the next meeting. The notice should indicate that this will be the last opportunity available to him to appear personally or through an advocate duly authorized and notarized in this specific behalf. Statutory notice be issued at the address provided and the matter will be taken up at the next meeting at Lahore. The remaining doctors be also issued notice to appear on that date. The case is adjourned for next date of hearing.

Statutory notice under Section 35 of the Medical and Dental Council (Amendments) Act 2012 substituting the Section 31 of the PM&DC Ordinance 1962 and under regulation 21 (2) of the Pakistan Regulation of Medical Practitioners 2008 SRO 07 (KE) /2009) have been issued to following:

Complainant:

- i. Aqeel Malik

Respondent:

- i. Dr. Sanaullah Khan
ii. Dr. Sabir Ali Sabir
iii. Dr. Inamullah Khan
iv. Dr. Mobeen Afzal
v. Dr. Sandeep Kumar
vi. Executive Officer, Doctors Hospital and Medical Centre, Lahore.

DECISION OF THE DISCIPLINARY COMMITTEE HELD ON 17-12-2012:-

Dr. Sanaullah Khan, Dr. Inamullah and Dr. JavedAsghar (Chairman Doctor Hospital) present in person. Nabeel Malik brother of complainant present on behalf of the complainant to submit an adjournment application by Aqeel Malik that he has met an accident and is in capacitated for the time being. Dr. Ghazanfar Ali CEO and Administrator of the hospital is present. The administrator informed that Dr. Sanaullah wanted to go on Eid leave therefore in his own personal capacity and without the approval he had planted two doctors to do duty on his behalf namely Dr. Shutr and Dr. Sandeep Kumar, Dr. Sanaullah had changed the typed SOPs roster and hanged his own handwritten fake roster. All this is documented on the internal inquiry held in the hospital, query was asked why the administration of the hospital

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was not aware that an unknown person is treating patient who is not the employ of the hospital. The chairman of the hospital clarified that as it was Eid holidays and administration was on holiday but on call and Dr. Sanaullah informed that Dr. Sandeep had done 2 night duty of 12 hours each wherein he had rounds with consultant Dr. Tariq Rafique who also treated other patients of the hospital.

The Chairman stated that our case pending before magistrate and now the complainant Counsel has changed 6 judges showing dissatisfaction on them. Now a private complaint is pending before Additional Session Judge for transferring the case. Now witness has appeared before those cases.

Dr. Inamullah Khan was found not to have been related to incident. He is discharged of all blames and liability

However he has sent the application through his brother Nabeel Malik. However has been allowed to participate in the proceeding but could not anything for lack of knowledge. The complainant absence is condoned, however it is noted that his earlier application of a diverse nature and several in number have been found to be designed to delay the matter through one such application he sought the entire record of the committee. It was noted that he wanted to go on a fishing expedition and the demands and objection were dismissed as frivolous and vexations he has also challenged the competence of the committee. Therefore his presence is not even relevant despite that indulgence has been shown towards him by allowing messors notices dated 31st August, 2010 and 3rd December, 2012 to remain with the committee with its proceedings today.

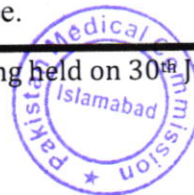
Dr. Sanaullah Khan who is present explained that the unfortunate incident happened during Eid holidays and he was away from duty visiting his home out of Lahore. He admitted that he had not taken permission for his absence and also admitted that in his own place he had introduced Dr. Sandeep Kumar to perform his duty during that period. Dr. Sandeep Kumar's case will be taken up separately. Dr. Sanaullah did not inform the hospital administration. Dr. Sanaullah is not able to produce any record supporting his assertion that he had informed his consultant or the hospital administration. He is found guilty of dilerection from duty.

The hospital administration was represented by Dr. JavedAsghar (Chairman Doctor Hospital) respectively. They explained that the incident happened during the Eid holidays and that the administration was not aware of the absence of Dr. Sanaullah without leave or of the substitution by Dr. Sandeep Kumar. This appears to be a major lapse on the part of the administration and needs corrective measures in further cases. The committee is only competent at the most to make recommendations with regard to hospital administrations while it may take action against individual medical practitioners

It was therefore decided with respect that the registration of Dr. Sanaullah be suspended for one year.

Notice will be issued for the next meeting at Karachi to Dr. Sandeep Kumar to appear and explain his conduct before the committee.

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The hospital is not within the preview of PM&DC however the matter may be taken up with Health Regulatory Authority Punjab.

The committee did take notice of the fact that the conduct of the complainant appears to be vindictive and dilatory it may tell that several forms have been involved in this matter including the judicial magistrate and the session court. Applications have routinely being made for transfer of judicial officers stalling the proceedings initiated by the complainant himself to a point where no witness has been examined so far, but respondents/accused including the hospital and administration are made to appear before the criminal court in person periodically for the last three years or more. The conduct of the complainant qua this committee and the PM&DC has also been wanting although maximum indulgence has been shown to him. This aspect may also be kept in mind before a decision is taken by the appropriate authority in this matter.

The case is closed with respect of all except Dr. Sandeep Kumar who will be required to attend proceeding of committee when held in Karachi.

DECISION OF THE DISCIPLINARY COMMITTEE MEETING HELD ON 26-12-2013:-

Case was fixed on 24th December, 2013 which was declared as Chehlum of Hazrat Imam Hussain hence the hearing of the case was re-fixed for today 26-12-2013. Notice was also issued to the respondent Dr. Sandeep Kumar for this date of hearing. Unfortunately, there is nothing before us that the notice was served or not on the respondent.

We are conscious of the fact that in the past, despite service of notice including the one in print media, the respondent failed to appear on the dates of hearing yet in all fairness as it seems, in order to provide the respondent doctor full opportunity of hearing, be that as it may, since we have no proof of service of notice, for the same reasons we adjourn the case for next date of hearing by the Disciplinary Committee.

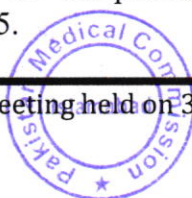
Notice to doctors hospital be issued to subject before the committee on progress on vital issues involved in the same case.

DECISION OF THE DISCIPLINARY COMMITTEE MEETING HELD ON 18-04-2015:-

Aqeel Malik alongwith Ahmed Naseem Malik is present. Ch. Mohammad Qasim Iqbal is present on behalf of Doctor Hospital Lahore.

The committee heard the case at length. The respondent doctor Sandeep Kumar (Reg. No. B-55512-S) is not present despite repeated notices. The Committee recommended to cancel the Registration certificate of Dr. Sandeep Kumar (Reg. No. B-55512-S) as he has willfully absented himself to appear before the Committee. The Disciplinary Committee further decided that the hospital is directed to bring all record of procedures of treatment of patients. The complainant shall also be compensated as decided earlier. The case is **adjourned** for tomorrow i.e. 19-04-2015.

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

Complainant is present. Dr. Zahid (Director Administrator) is present on behalf of the Doctor Hospital Lahore alongwith all the relevant original record containing information of the SOPs of their emergency unit. The committee heard the representative of the hospital in detail. The committee after detailed deliberation recommended that Dr. Sanaullah shall be suspended for **1 year** in continuation of the last Disciplinary Committee meeting dated 2012 in light of Dr. Sanaullah statements. Dr. Sandeep Kumar shall be suspended till his appearance before the committee and also issue public notice. The committee further recommended that the hospital shall be inspected by a team of inspector from outside Punjab province i.e. following is the committee unanimously constituted for this purpose:

1. Dr. Farhat Abbas Agha Khan Hospital, Karachi
2. Dr. Salman Fareedi Liaquat National Hospital Karachi.

The committee has penalized the hospital for a sum of one lac rupees to be paid in the name of the Council.

The case is closed and only taken up to the extent of Dr. Sandeep Kumar.

Dr. Sandeep Kumar has been issued notice for appearing before the Disciplinary Committee.

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

Nemo on behalf of the parties despite notices. The committee observed that the Dr. Sandeep Kumar has never taken PM&DC seriously and never appeared before the committee. The committee recommended that the Registration Certificate of Dr. Sandeep Kumar (55512-S) shall be suspended till his appearance before the Disciplinary Committee. Case is adjourned.

DECISION OF DISCIPLINARY COMMITTEE MEETING HELD ON 23.10.2017 LAHORE:-

Dr. Sandeep Kumar is continuously absent despite notices. The counsel of the Doctors Hospital appeared with the written reply of Prof. Dr. Syed Ghazanfar Ali Shah, CEO of Doctors Hospital and Medical Centre Lahore wherein he has stated that they have been acquitted by the Session Court and subsequently by the high court.

The committee heard the parties at length and perused all available record and decided that registration certificate in respect of Dr. Sandeep Kumar shall remain suspended and Health Department of all provinces will be informed accordingly. Therefore, CEO Doctors Hospitals is directed to submit compliance report of the decision of Disciplinary Committee held on 19.04.2015 at Lahore, failing which PM&DC shall withdraw teaching status of the hospital. The case is closed and will be re-opened to the extent of Dr. Sandeep Kumar after his reply.

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PROCEEDING OF DC MEETING 30TH JUNE, 2019 AT P.C HOTEL LAHORE:

Submissions by Parties at the Hearing:

Complainant was present. Respondent was absent despite notice.

The committee opined that the onus of responsibility lies on Doctors hospital as the patient was brought to Doctors hospital and not specifically in name of the respondent.

When asked if the complainant has approached relevant platform the complainant stated that Supreme Court has passed orders to cancel the license and arrest the respondent.

Findings by Expert Opinion:

“License of Dr. Sandeep Kumar cancelled. No representative from doctor hospital.”

RECOMMENDATION:

The committee recommended canceling the license of the respondent Dr. Sandeep Kumar.



Mr. Pervez Akhtar (Complainant)

Versus

Dr. Muzaffar Ali S/o Muhammad Khan PM&DC No (6802-P)

Muzaffar Clinic & Hospital Sangla Hill, District Nankana Sahib.

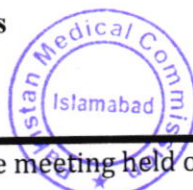
Brief of the Case:

The Board has noted that on 06-06-2015, the complainant's 10 months old nephew Muhammad Hassan had been taken to Al-Muzaffar Clinic & Hospital Sangla Hill with complaint of intermittent fever for one week. According to the respondent Dr. Muzaffar Ali, the patient had been previously treated at the village and in addition to fever 1030 F, he was also having dehydration and vomiting for about 7 days; sponging was advised and the patient was treated for dehydration and septicemia with Injection Oxidil, Injection Ciprofloxacin, Injection Artem (for possibility of malaria) and I/V fluids; the patient improved and the fever subsided. He was advised admission, however on the assurance by the attendants that they could manage the evening dose, Injection Ciprofloxacin was given for home. As per the attendants, patient's condition deteriorated after the treatment.

The Board has further noted that on 07-06-2015, the patient was again brought to Al-Muzaffar Clinic and investigation dated 06-06-2015 from the laboratory of Al-Muzaffar Hospital had revealed Hb 6.1 g/dl and Widal Test for Salmonella Typhi was positive up to 1:160. According to the respondent, antibiotics and IV fluids were repeated. The attendants were advised to arrange blood. Blood group of the patient was A- Negative and attendants could not arrange a donor of the same group, so 175 cc of O-Negative blood was transfused in 3 hours, after cross matching and the patient left at 4:30 pm. After transfusion patients condition deteriorated and although septicemia could lead to similar presentation, but probability of transfusion reaction was high in the presence of unqualified staff, donor of a different blood group and a laboratory with inadequate facilities. Dr. Muzaffar Ali should have explored the cause of anemia or referred the patient to a pediatrician / better hospital, rather than resorting to such blood transfusion, which is usually practiced only in emergency. Writing and describing himself as "Children Specialist" on the basis of one-year house job in the specialty was not justified on part of Dr. Muzaffar Ali.

The Board has also noted that Dr. Muzaffar Ali did not ascertain the cause of anemia.

Preliminary Findings/Observations



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The case was presented to the expert in the field of Pediatrics who gave the following opinion on 30.11.2016:

“I think in the light of available data; the infant was malnourished & marasmic.

He was suffering from septicemia. Because of lack of adequate facilities at Muzaffar Clinic (Diagnostic as well as trained paramedical staff) the attendants were dissatisfied.

Treatment offered was adequate. Due to lack of diagnostic facilities, complications like pleural effusion, renal failure & maybe other organ involvement / failure were not picked up at Muzaffar Hospital. Subsequent course of the ailment suggests that septicemia led to multi organ failure which led to death of the child”.

Case of Dr. Muzaffar Ali is referred to PMDC for portraying himself as “Children Specialist” without possessing any postgraduate qualification.

PROCEEDING OF DC MEETING 30TH JUNE, 2019 AT P.C HOTEL LAHORE:

Submissions by Parties at the Hearing:

The respondent when asked apprised the committee that he has done MBBS and the house job was done in 1985.

The committee asked whether he has ever in his career printed on his prescription as a children specialist and he stated that he had sent the printer in 1987 in urdu that “maahiramraazzacha bacha” should have been written and it was printed as specialist child and gynea by the one who got the prints

The committee asked why same prescription pad with wrong qualifications was used till 2015 and discontinued after the inquiry of PHCC.

The daughter of the respondent who had accompanied the respondent stated that they are working in a place surrounded by quacks and to make the patients understand that the doctor is qualified and experienced they use lay man language.

He owns Al Muzaffar Clinic and Dr. Nafeesa is his wife who is also MBBS

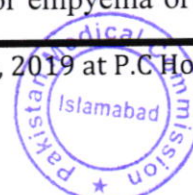
The committee asked why he impersonates himself as child specialist and his wife as gynecologist and how they can perform surgeries.

Dr. Shahid had been a visiting surgeon

The committee asked whether it is an outdoor facility and what facilities are present in the clinic and the respondent stated that there were 5 beds in general ward and 4 rooms as private room and they had an OT till around 2 to 3 years back. When asked they stated that surgeon used to bring anesthetist with him during surgeries.

The committee asked what diagnosis was while he was treating the patient. The respondent stated it was Sepsis. The committee asked what was reason for empyema or any other. The

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respondent had no answer to the question .The committee further asked what was the clinical indicator for sepsis seen and the laboratory indicators to support the diagnosis.

The respondent stated that he found tachycardia as clinical sign and CBC was supposed to have been raised while no labs were done.

The committee asked that why Ciprofloxacin was given for home after giving one dose of anti-malarial

The respondent stated that the patient attendant was advised to admit the child but the attendant refused as they lived close by and if the patient will have any problem they will revisit the facility

The committee asked about the dosage of ciprofloxacin and he stated that it was around 10 kg and he had given 500 gram of ciprofloxacin

The committee asked that why technician without quality control and endorsement by registered pathologist was accepted and who was doing screening of blood

The respondent stated that they do screening on kit. The respondent further stated that he is an old person now and in the past there had been less awareness among public as well as practitioner

The committee asked whether he was still running the in-house lab and he replied that the lab is almost finished

When asked further he stated that his wife has quit her practice due to domestic reasons and now his daughter who is pursuing studies in radiology and daughter in law who is doing FCPS Gynae are practicing in his clinic.

The expert asked that patient was having Septicemia with multi-organ failure and Hb 6 gm/dl though as per the lab technician and whether they think patient with such critical situation should have been treated in their clinic.

The respondent replied that he has forced the attendants to get the child admitted in their facility

The committee asked whether any documentation was done regarding refusal of admission and the respondent stated no.

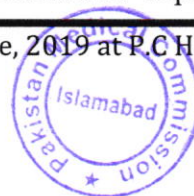
The daughter added that gold standards were to give antibiotics as first line therapy with a patient who had signs of sepsis and it was better to give treatment to the child rather than leaving the child to quacks

The committee noted that peritoneal dialysis was done at children hospital and there are signs for glomerulonephritis which could have occurred after transfusion reaction.

Findings:

During discussion the medicine expert opined that the professional expertise should be

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measured in comparison with the community standards and in his view he could have used layman language and in mid 90's even in UK there were no ideal standards being achieved though he should have then ensured the labs and the pediatric care

The paed's expert opined that documentation was lacking regarding communication of the critical nature of the patient and the referral to any other facility.

He has practiced as pathologist with only MBBS.

Expert Opinion:

“After listening to Dr. Muzaffar Ali thoroughly following facts came to notice:

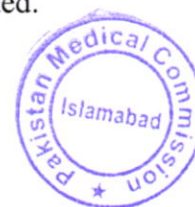
1. He is not qualified child specialist but treated the young child at his clinic who was labelled as having septicaemia.
2. He did an appropriate job by giving first dose of antibiotic but anticipating his illness he did not ask him or refer him to tertiary care hospital. Neither they had any documentation of patient refusal for admission.
3. Clinic did not have appropriate facility for screening of blood / managing blood transfusion. When patient developed blood transfusion reaction, no documentation / resuscitative measures were taken.”

Another Expert Opinion:

“After listening to Dr. Muzaffar Ali thoroughly and cross questioning reached the conclusion that Muzaffar Hospital is not fully equipped to deal with patient of septicemia. Dr. Muzaffar falsely claims himself to be child specialist, he has not referred this critical patient to primary or secondary Care centre. Child developed multi-organ failure so DC is of opinion that his PMDC registration should be suspended for 02 years.”

RECOMMENDATION:

After hearing the respondent in detail a two year suspension is recommended.



Mr. Muddasar Hassan Malik

Versus

Dr. Abdul Aziz Asim PM&DC No (8415-P) Al-Noor Medicare Jhang Hospital.

Brief of the Case:

The Board has noted that the complainant's cousin, Mr. Ghulam Murtaza, 36-39 years of age, an electrician by occupation came home in the evening after whole day's work and complained of palpitation and shortness of breath. The attendants first offered the evening prayers (which took about 10-15 minutes) and then took him to Dr. Abdul Aziz Asim at his clinic; Al- Noor Medicare. There they had to wait for their turn for another 30-45 minutes.

The Board has further noted that the doctor examined the patient and conducted his ECG. Heart rate was about 140/minute and chest was clear. The doctor diagnosed the condition as SVT (supra ventricular Tachycardia) and asked the attendants to bring Inj. Isoptin. The attendants brought the said injection after lapse of about 20 minutes. The doctor asked his dispenser to administer the injection who did so. Soon after that (as per attendants immediately and as per referral slip, after 5-10 minutes), the patient went into shock. The doctor did CPR and referred the patient to the Cardiologist, Dr. Kamran Sohail. At the time of referral, his BP was 150/80 mm Hg (as per referral slip). The Board has also noted that the attendants took the patient to Dr. Kamran Sohail at Nighat Hospital but he was not present there as it was Sunday. The duty doctor Dr. Naeem Rafique, a PGR, came, examined the patient and conducted his ECG. By that time the patient had collapsed and became BP less and Pulse less. Dr. Naeem tried to resuscitate him but could not succeed and the patient died'

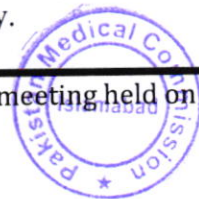
Preliminary Findings/Observations

The Board has noted that as Per Local Inquiry conducted vide orders dated 08-04-2015 by EDO (H), Jhang, the Inquiry Committee consisting of Dr. Sikandar Zulqaman (Cardiologist, DHQ Hospital, Jhang) and Dr. Muhammad Zafar Iqbal Khan (Addl. Medical Superintendent, DHQ Hospital, Jhang) concluded:

"It is concluded that the patient developed cardiac ischemic attack, and it was in evolution towards cardiac shock and ultimate death.

Presentation of the patient was unusual which may occur in cardiac patients, but it is uncommon. As patient did not present with typical symptoms of chest pain, he presented with complaint of tachycardia. Unluckily, first ECG did not show ischemia. It just showed tachycardia. So first doctor (Dr. Abdul Aziz Asim) treated it as case of tachycardia according to standard protocol, as he treated the patient with Tab. Inderal, Tab. Disprin along with Vagal maneuvers & injection Isoptin but it was not a case of simple tachycardia, therefore it did not respond to treatment, condition of the patient did not improve & he referred the patient to the Cardiologist immediately.

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Second physician (Dr. NaeemRafique) received patient in shock and gasping condition. He referred to medical emergency DHQ Hospital, but on the request of attendants of patient, he according to standard protocol, maintained I/V line with N/Saline, gave oxygen therapy and started isotropic support. Within no time, patient went into cardiac arrest, did CPR for 20 minutes but patient expired as he was in cardiogenic shock. Second ECG done at Nighat Hospital made situation clear as it showed extensive infarction leading to cardiogenic shock and ultimate death confirmed on 3rd ECG.

PROCEEDING OF DC MEETING 30TH JUNE, 2019 AT P.C HOTEL LAHORE:

Submissions by Parties at the Hearing:

Complainant was present. Respondent was absent.

Findings byExpert Opinion:

“Listened to complainant. Dr. Abdul Aziz Asimwas absent and committee decided to suspend license of Dr. Abdul Aziz till appearance before DC, adjourned till further hearing. All expense to be paid 5000/- by Dr. Abdul Aziz, notice to doctor.”

R RECOMMENDATION:

The committee decided that respondent will be asked to pay 5000 (five thousand) as the travel expense to the complainant and also decided to suspend practice privileges of the respondent till his appearance before Disciplinary Committee. Immediate notice to the respondent to appear before next hearing.



Muhammad Waqas-ul-hassan s/o Mehandi Hassan, cast Malik Sakin, Street No 10. MohallahAzamAbad, Chak No 279IRB Khurd Faisalabad.0300-8837005

Versus

Tahir Hospital Khurd Ghulamabad, Faisalabad. 0322-627 8572 0412695464

Dr. Muhammad Tahir (4729-P)

Brief of the Case;-

The Board noted that at about 9:00 p.m. on 23-10-2014, the complaint's mother Ms. Niamat Bibi was taken to Tahir Hospital Faisalabad with complaints of loose motions and pain abdomen. She was attended by Dr Muhammad Tahir who advised medicines (Tablet Cefixime 400mg 1 X OD, Tablet Ponstan Forte I X TDS, Tablet Paracetamol I X TDS, Tablet Domperidone, Injection Dicloran and Antacid) and the patient went back to home. The Board also noted that according to Dr. Tahir, the patient was also having nausea and fever on 23-10-2014, but the complainant side denied this. The Board further noted that at about 9:30 p.m. on 24-10-2014, Niamat Bibi again walked into Tahir Hospital. According to Dr. Tahir, her condition had deteriorated, but her son denied this and stated that the patient had told about some improvement. Dr. Tahir advised Injection Ringer's Lactate 1000 ml, Injection Gravinate, Infusion Novidat, Injection Metronidazole and Injection Zantac. The dispenser Mr Muhammad Shafiq administered the injections and the drip. According to the complainant, the medicines were purchased from the pharmacy of Tahir Hospital. On 24-10-2014, Mr. Muhammad Shafiq was the dispenser / medical assistant on duty till 11:00 p.m. and Mr Abdul Khaliq after that temperature was checked by respondent doctor and due to deterioration in condition the patient was referred to National Hospital Faisalabad but due to serious condition the patient was not accepted and brought to emergency of allied hospital Faisalabad where she was managed on the lines of aspiration pneumonia, sepsis and shock and death occurred and declared at 10:20 pm on 25/10/2014. No autopsy done.

Preliminary Findings/Observations

After going through the record thoroughly, Mrs. Niamat Bibi mother of Mr. Waqas-ul-Hassan was brought to Tahir Hospital, Sher Singh Wala Chak No. 279-RB. Faisalabad. She was suffering from vomiting and diarrhea, the drugs prescribed by Dr. Tahir are according to situation i.e. I/V fluids, antibiotic and antiemetic. He did not mention any co-morbid condition of the elderly woman. I don't think that there was any role of broken thermometer in mouth causing death. When patient developed shivering, probably drip reaction, I/V steroid, Provas was justified. Therefore, as far as management is concerned, it was OK. Cause of death may be due to co-morbid cardiac or renal condition, dehydration leading to renal shut down. Two irregularities mentioned by inquiry committee that that unqualified



dispensers were employed by Dr. Tahir and proper referral slip was not given to attendant, which may be considered for minor punishment to Dr. Tahir. "

Case of Dr. Tahir is referred to PMDC for impersonating as specialist / consultant.

PROCEEDING OF DC MEETING 30TH JUNE, 2019 AT P.C HOTEL LAHORE:

Submissions by Parties at the Hearing:

Both parties were present and the respondent appeared with his counsel.

Both parties were heard at length.

The committee noted with concern that respondent is practicing ultrasound without possessing recognized qualification and giving blood transfusions without monitoring facilities.

The respondent stated that he bears approximately 40 years and has been practicing as general practitioner in Dubai and Iran and the patient was 50 years old who came with c/o diarrhea and vomiting and fever and medicines were given

The next day patient came with low BP of 80/50 and pulse more than 100 and resuscitation measures were taken including I/V fluids and was referred when the condition deteriorated.

The committee asked whether electrolytes were not done and the respondent stated that it was not done

The committee asked whether Blood transfusions were done and respondent stated that no transfusions were given. The committee further asked what could be cause of death in a patient with low BP and high pulse. The respondent stated that fluid loss can be the potential cause.

There should have been crash trolley and other facilities

When asked, the respondent stated that he referred the patient to Faisalabad with provisional diagnosis of an infection or a possible reaction to the I/V fluid

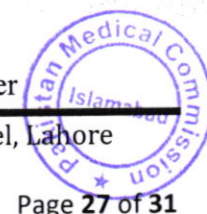
The committee further asked what other procedures have been conducted by him and he stated that he practices SVDs as well while C/S were also conducted in the past when they had a lady doctor at the facility.

The respondent stated that the petition had been suspended by Additional session judge and the committee mentioned that the order is dismissal of the petition.

The committee noted with concern that the respondent has been practicing without possessing additional PG qualification and in absence of required facility

FINDING:

The respondent is running private facility with himself being the sole practitioner
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The respondent admitted the patient and the onus lies with the admitting physician to ensure care and appropriate treatment

The respondent is performing procedures which require specialized qualification and experience.

RECOMMENDATION:

After hearing both parties at length the committee recommended two years suspension for the respondent.



Mr. Nazar Hussain

Versus

Dr. Abdul Rashied Sheikh (17820-P), Noor Hospital Khan Garh Muzaffargarh.

Brief of the Case;-

The facts giving rise to this complaint are that Complainant's 23 years old son Muhammad Zubair had severe pain in his left loin (lumbar region) on 09-5-2014 and was taken to Noor Clinic, a private clinic owned by Dr. Abdul Rasheed Sheikh (MBBS). The said doctor did ultrasound examination of the patient and found a stag horn stone in the left kidney. Surgery was advised by Dr. Abdul Rasheed Sheikh. The operation was carried out on 29-5-2014. Patient remained admitted for 6 days and then discharged. The patient came back after two days of discharge from the hospital with history of bleeding with urination. He was admitted and Dr. Abdul Rasheed tried to manage for two days. Dr Abdul Rasheed decided to refer the case when he thought that he could not handle the case anymore. The patient was referred to Khalid Bin Waleed Hospital, Multan, where Dr Abdul Latif (MS Surgery') operated and removed the diseased/ affected kidney of the patient. Dr Abdul Latif of Khalid Bin Waleed Hospital mentioned in his operation notes that kidney was severely inflamed and foul smelling because of pus mixed with blood, was coming out. He stated that nephrectomy (removal of the kidney) was done after taking the Complainant's consent. Patient was discharged from Khalid Bin Waleed Hospital 10 days after the operation in a very satisfactory condition. Dr Abdul Latif also mentioned that on the request of Dr. Abdul Rasheed Sheikh, all medicines to the patient were provided by the hospital through Zakaat fund and no operation fee and hospital bills were charged from this patient.

The board noted that as per the authorization given by PMDC and note at the bottom of PMDC certificate a registered medical practitioner can practice basic medicine, surgery, Obstetrics and Gynecology, Ophthalmology and Otorhinolaryngology and will be considered a specialist of the level mentioned and in the field of which any additional postgraduate qualification is registered herein. The instant case was of a complicated surgery and special expertise was required to handle such surgeries, as per the expert opinion, Staghorn stone with pyonephrosis (pus in the kidney) is a serious pathology and needs special expertise. Dr Abdul Rasheed is not a qualified surgeon and probably he did not possess required skills to deal with this situation. An experienced Urologist could have dealt with the patient satisfactorily.

Preliminary Findings/Observations

Case of Dr. Abdul Rasheed Sheikh may be referred to PMDC for not having required competence to operate. They have referred to public notice of PMDC vide its PUBLIC NOTICE in the daily THE NEWS dated 28th November 2013, has clearly notified that „The

Minutes of the Disciplinary Committee meeting held on 30th June, 2019 at P.C Hotel, Lahore



registered medical / dental practitioner having only basic medical / dental qualification are not authorized to carry out specialized procedures. Only doctors who have acquired additional medical / dental postgraduate qualifications are authorized to practice as specialist in their respective specialty and render expert opinion.

PROCEEDING OF DC MEETING 30TH JUNE, 2019 AT P.C HOTEL LAHORE:

Submissions by Parties at the Hearing:

Complainant was absent. Respondent appeared and was heard in detail.

The respondent stated that he had done MBBS in 1988 from Nishtar medical college and MS ultrasound from UOL registered with HCE. He had worked in different specialties with different DHQ and RHQ before opening his own clinic. When asked he stated that he had been doing approximately 15 nephrectomies per month in the past.

The committee asked that the patient was operated, stayed admitted for six days and discharged and came back after 2 days with signs of post operative infection and haematuria and pyonephrosis occurred that led to nephrectomy at Khalid bin Waleed hospital. The respondent stated that ultrasound was done and staghorn stone was found and they removed it. When asked he stated that the anesthetist assisting during the procedure was diploma in anesthesia and not a qualified registered anesthetist with PMDC. He further added that he is no more practicing medicine or surgery and he has quit the profession.

Expert Opinion:

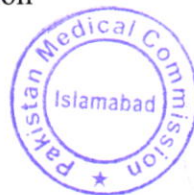
“Dr. Abdul Rashid Sheikh, Noor Hospital, Khan Garh was interviewed by the panel. He reported stopping surgery since the said case. His defense is that in the era and place he started work, he was not aware that formal degree & training was required. He claims about two years of training & subsequent experience equipped him for surgery. There is however no evidence of his training or experience that he can offer.

Suggest:

1. Continued stoppage of surgical work.
2. Suspension of license & re-medical training per chair of committee (which can lead to review of period of suspension)

Finding:

Performed procedure without obtaining or bearing additional PG qualification and without obtaining informed consent and there was lot of communication lapse in taking the attendants into confidence regarding the critical situation



RECOMMENDATION:

After hearing the respondent in detail the committee recommended for two year suspension and attachment with VC KEMU Dr. Gondal for remedial training of 3 months. The punishment will be reviewed after one year when the remedial training certificate is submitted and/or CME or any additional remedial training is submitted by respondent.

