



**BEFORE THE DISCIPLINARY COMMITTEE OF PAKISTAN MEDICAL COMMISSION**

In the matter of

Complaint No. PF. 8-2099/2022-DC/PMC

Mr. Tufail Hassan Vs. Dr. Sayed Zafar Hassan

Professor Dr. Naqib Ullah Achakzai	Chairman
Professor Dr. Noshad Ahmad Shaikh	Member
Mr. Jawad Amin Khan	Member
Barrister Ch. Sultan Mansoor	Secretary
Dr. Ahmed Hassan	Expert (ENT surgeon)

*Present:*

Mr. Tufail Hassan	Complainant
Dr. Sayed Zafar Hassan (8960-N)	Respondent along with Counsel
Date of hearing	10.10.2022

**I. FACTUAL BACKGROUND**

1. Mr. Tufail Hassan (the "Complainant") filed a Complaint on 15.02.2022 against Dr. Sayed Zafar Hassan (the "Respondent") working at his private clinic i.e. Frontier Medical Centre, Kohat. Brief facts of the complaint are that:

*a) The complainant's 6-year-old son (the "Patient") was brought to ENT Surgeon; the Respondent, on 03.04.2021, for the purpose of tonsil operation which was proposed by the Respondent.*

- b) Operation was performed by the respondent and the patient was brought to the rest room instead of recovery room, after the operation. At rest room, the nurse gave the patient 'Acuron inj.' and patient collapsed, expiring shortly thereafter.
- c) The Complainant requested that strict disciplinary and legal action be taken against the Respondent.

## II. SHOW CAUSE NOTICE TO RESPONDENT, DR. SAYED ZAFAR HASSAN

2. In view of the allegations leveled in the Complaint, Show Cause Notice dated 24.02.2022 was issued to the Respondent, Dr. Sayed Zafar Hasan in the following terms:

“... ”

**4. WHEREAS**, in terms of Complaint, it has been alleged that you performed tonsils surgery of the Complainant's son (the patient) on 03.04.2021 at Frontier Medical Centre, Kohat. Immediately after the surgery the patient collapsed and expired; and

**5. WHEREAS**, in terms of Complaint, on 03.04.2021, the patient was taken into operation theatre at 03:30 pm whereafter you operated him for twenty-five (25) minutes till 03:55 pm. Furthermore, it has been alleged that there was no anesthesia specialist present at the time of the operation and instead the anesthesia was administered by an operation theatre (OT) technician; and

**6. WHEREAS**, in terms of Complaint, it has been alleged that after the operation, the patient was immediately shifted to the rest room instead of recovery room. Patient was accompanied to the rest room by a maid and remained under the care of that maid. The maid administered Acuron injection without having any knowledge of injection; and

**7. WHEREAS**, in terms of Complaint, soon after the injection was administered, the patient was shifted back to operation theatre but he did not survive. Furthermore, as per the Forensic Toxicology Analysis Report dated 03.05.2021 issued by Punjab Forensic Science Agency, break down product of Atracurim were detected in blood and urine of the deceased; and

**8. WHEREAS**, in terms of the Complaint, an inquiry on the basis of the allegations put forward by the Complainant, was conducted by Inquiry Committee consisting of Additional Deputy Commissioner, Kohat; District Health Officer, Kohat and Inspector HCC, Kohat, which pointed out that there was no nurse present at the time of operation to perform post operation duties. Instead, a maid was performing the duties of a nurse. It was also found that a wrong injection was administered to the patient by the said maid. Furthermore, it was found that an OT Technician administered anesthesia to the patient. Moreover, it was found that an OT





technician administered anesthesia to the patient. Moreover, during the inspection of the hospital, expired injections were found in the operation theatre; and

**9. WHEREAS**, in terms of the facts mentioned in the Complaint, you have prima facie failed to fulfill responsibilities of duty of care towards the patient and follow the post-surgery protocol and supervise the treatment of patient. ...”

### III. REPLY OF RESPONDENT, DR. SAYED ZAFAR HASSAN

3. Respondent, Dr. Sayed Zafar Hassan submitted reply to Show Cause Notice on 18.05.2022 wherein he contended that:

- a) He is working in Health Department, Govt. of KPK since September 2002. Moreover, he is a classified (FCPS) ENT Surgeon, working as District Specialist ENT in DHQ Teaching Hospital KDA Kohat since 02.12.2013 upto date. During the said period he has performed thousands of surgical operations successfully.
- b) It is incorrect to suggest that the patient immediately collapsed and expired, after the surgical operation, rather the patient was shifted to private room after proper assessment. Patient was recovered from general anesthesia i.e he was conscious, alert and hemodynamically stable prior to shifting. He was responding to commands such as open your mouth, protrude your tongue etc.
- c) Reportedly the Aya administered a wrong injection in patient's private room, which she was neither allowed to nor she had been ordered to. Aya was deputed for shifting the patient to private room and his general cleanliness.
- d) The anesthesia was administered by a senior anesthesia technician Nade Ali, who is working in the Department of Health, KPK's category A&B Public Hospital since 08.08.1995 and is presently working as Senior Clinical Technician Anesthesia at DHQ Hospital Kohat w.e.f 11.11.2010 till date.
- e) It is practice in vogue that all over the province that general anesthesia is administered by Anesthesia Technicians due to non-availability of Anesthetists in most of Public and Private Hospitals.
- f) The enquiry report was indeed conducted by the Enquiry Committee constituted in response to the complaint filed in the office of Additional Deputy Commissioner, Kohat.
- g) Contrary to the observations of the Enquiry Committee, a qualified nurse was present in the operation theater, as it is an established fact that surgical operation is a team work, every member of the team having a definite role as per job description and SOP's Nurse, OT Technician, Anesthesia Technician and Aya





- were present in the operation theatre and thereafter, for assistance of the surgeon and patient's care even in private room.*
- b) *The OT In-charge, staff and Pharmacist of the Medical Centre, working under the immediate control of Administrator/ Owner of the Centre, are responsible for daily upkeep and checking of the Emergency Tray and Medicines stored (in OT) and used therein (OT/Private rooms).*
- i) *Frontier Medical Centre, Kobat is a registered Medical Centre with KPK Healthcare Commission. Anything found contrary to the rules and regulations of Healthcare Commission and law, can be taken notice of and dealt with accordingly.*
- j) *The unfortunate patient has lost life as a consequence of an act or phenomenon occurred outside the operation theatre (and out of ambient of surgeon's control and advice).*
- k) *The enquiry committee has already exonerated me from the charge of "alleged negligence".*
- l) *Keeping in view the para/point wise reply of the Show Cause Notice, the factual position, circumstantial evidence and sequence of events; the Disciplinary Committee is humbly requested to kindly withdraw the "Show Cause Notice" and the charges contained therein, in consonance with the rules and spirit of justice.*

#### **IV. REJOINDER OF THE COMPLAINANT**

4. Reply received from the Respondent doctor was forwarded to Complainant, for his Rejoinder, through a letter dated 19.05.2022.
5. The Complainant submitted his rejoinder on 31.05.2022, and conveying his dissatisfaction to the reply submitted by Respondent, Dr. Sayed Zafar Hassan. Moreover, Complainant reiterated his earlier stance that the death of the patient occurred due to the wrong injection 'Acuron' being given and requested for stern action against Respondent, considering his negligence.

#### **V. HEARING**

6. The matter was fixed for hearing before the Disciplinary Committee on 10.10.2022. Notices dated 27.09.2022 were issued to the Complainant and Respondent, Dr. Sayed Zafar Hasan directing them to appear before the Disciplinary Committee on 10.10.2022.



7. On the said date of hearing the Complainant and the Respondent appeared in person. Mr. Adnan Iqbal Advocate (Counsel of the Respondent) was also present in the hearing.
8. The Disciplinary Committee asked the Complainant to briefly state his grievance against the Respondent to which he stated that operation of the patient was done in a haste manner he was rushed to the OT at 03:35 PM. The Respondent doctor came to OT and operation was performed in 20 to 25 minutes. The patient was brought out of OT by Aya and was shifted directly to room. The said Aya subsequently administered injection Acuron to the patient. The injection Acuron was given to the Aya by the Anesthesia Technician Nad-e-Ali in the presence of Respondent Dr. Zafar Hassan. The Complainant further stated that the Aya is an illiterate lady. After the administration of injection, the patient collapsed and he was shifted to OT. The Respondent arrived in OT after twenty minutes of shifting the patient to OT as he was busy in his OPD.
9. The Complainant questioned the availability of injection Acuron in the OT and stated that injection Acuron was administered instead of injection transamine which is gross negligence. The Complainant further stated that in the inquiry conducted by DC Kohat it has been established that Aya was performing duties as a nurse. The Khyber Pakhtunkhwa Healthcare Commission sealed the hospital but the Respondent de-sealed the hospital after three days without any order of the competent authority and is practicing there.
10. The Committee asked Respondent Dr. Zafar Hassan to explain the management of the patient to which the Respondent stated that an uneventful surgery of the patient was performed. It took about 20 minutes. Post-op he received a call to visit OT. He reached OT immediately and started resuscitation but the patient did not revive and was declared dead. The Committee asked the Respondent about the condition of the patient at the time of shifting from OT to room and his operation notes, the Respondent stated that the patient was stable but he neither recorded operation notes nor the notes after the surgery. He further stated that injection Acuron was administered by Khala (Aya).

## VI. EXPERT OPINION

11. Dr. Ahmed Hassan was appointed as expert to assist the Disciplinary Committee in the instant case. The expert after hearing the parties and perusing the record opined as under:

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*Decision of the Disciplinary Committee in the matter of Complaint No. PF. 8-2099/2022-DC/PMC*

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*“After listening to both the parties, I am of the opinion that the main responsibility lies with the hospital as they were not having a qualified nurse and anesthetist and both the anesthetist and postoperative care was provided by non-qualified persons that ultimately lead to the incident.*

*The doctor as a surgeon has no fault with his surgical skill or decision of surgery but he should not have operated the patient at a substandard hospital lacking nursing staff and should not have operated the patient when the anesthesia was being given by a technician”*

## VII. FINDINGS AND CONCLUSION

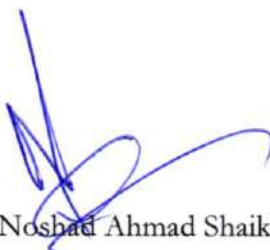
12. The Disciplinary Committee after perusing the record statements of parties and opinion of the expert has noted that the Complainant's six (6) year old son was operated for tonsillitis by Respondent Dr. Zafar Hassan at Frontier Medical Centre, Kohat on 03.04.2021. After the surgery the patient was administered injection Accuron due to which he collapsed and ultimately died.
13. The Respondent in his written reply has admitted that injection Accuron was administered to the patient post-surgery by the Aya. The Respondent during the hearing further admitted that he did not write any operation notes or post-operative notes/findings regarding condition of the patient. It has been noted that record maintenance on part of Respondent doctor is very poor.
14. The expert ENT surgeon in his opinion has also mentioned that Dr. Zafar being the primary doctor should not have operated the patient at a sub-standard facility where an Aya was working as nurse and admittedly she administered injection accuron to the patient which ultimately led to the patient's death. Furthermore, anesthesia was administered by an anesthesia technician rather than a qualified anesthetist.
15. The Disciplinary Committee has taken notice of casual approach of Dr. Zafar Hassan as he himself admitted that he did not enter any notes of surgery. Furthermore, it was an elective surgery and Dr. Zafar being a qualified surgeon should have avoided performing this surgery at a sub-standard facility. It is important to note here that a physician should always bear in mind the obligation of preserving human life. The patient physician relationship constitutes a fiduciary

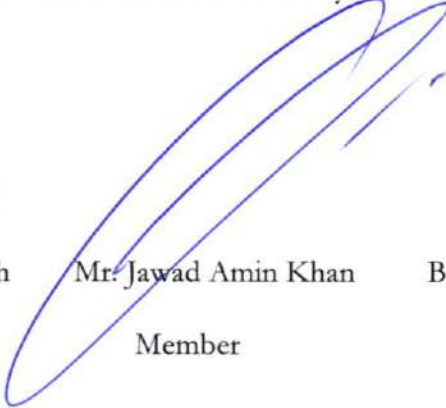


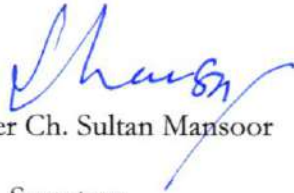


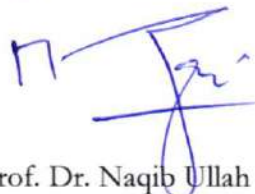
obligation, requiring physician to be responsible to serve the interest of patients above their own financial or other interest. Performing elective surgery at a private sub-standard facility where even the basic facilities were not available is a practice which should be condemned. For the forgoing reason the Disciplinary Committee decides to suspend the license of Dr. Zafar Hassan (8960-N) for a period of six months. The Disciplinary Committee further decides to impose a fine of PKR 500,000/ (Rupees five hundred thousand only) upon Respondent Dr. Zafar Hassan.

16. The affairs of Frontier Medical Centre, Kohat are also highly objectionable where a maid (Aya) admittedly administered a dangerous drug (injection Accuron) to the patient. Further, as per available record and statements of parties there was no medical officer available for post-op care of patients. Surgical Procedure either minor or major are always critical and proper post-op care is necessary for surgical patients. The matter of Frontier Medical Centre is therefore referred to Khyber Pakhtunkhwa Healthcare Commission for necessary action in accordance with law.

  
Prof. Dr. Noshad Ahmad Shaikh  
Member

  
Mr. Jawad Amin Khan  
Member

  
Barrister Ch. Sultan Mansoor  
Secretary

  
Prof. Dr. Naqib Ullah Achakzai  
Chairman

27<sup>th</sup> October, 2022

