BEFORE THE DISCIPLINARY COMMITTEE OF PAKISTAN MEDICAL & DENTAL COUNCIL

In the matter of
Complaint No. PF.8-1957/2021-DC/PMC
Mr. Muhammad Tahir against Dr. Asim (7887-N)

Prof. Dr. Muhammad Zubair Khan	Chairman
Barrister Ch. Sultan Mansoor	Secretary
Prof. Dr. Mahmud Aurangzeb	Member (online)
Mr. Jawad Amin Khan	Member (online)
Expert of Medicine	

Present:

Mr. Muhammad Tahir	Complainant
Dr. Muhammad Asim (7887-N)	Respondent
Hearing dated	12.12.2024

I. FACTUAL BACKGROUND

1. Mr. Muhammad Tahir (the "Complainant)" filed a Complaint on 08.03.2021 against Dr. Mohammad Asim, General Physician & Surgeon (the "Respondent") working at Northwest General Hospital & Research Center Peshawar (the "Hospital"). Brief facts of the Complaint are:

   a. *Complainant's father, Mr. Sucha Gul (the "Patient", since deceased) died due to the professional negligence / misconduct of the Respondent after he was admitted at the Hospital due to Covid-19.*
   b. *The patient was brought to the Hospital on 19.01.2021, where after initial examinations, patient was diagnosed with COVID-19 and was admitted to corona ward. Patient had history of Diabetes, Hypertension, Hypothyroidism and depression. However, this information was*

disregarded and the patient and complainant were not informed about the treatment being given to the patient at all.

c. *On 6th February, complainant was informed that the patient had expired due to COVID-19, however, medical record which was only shared after death of the patient revealed that patient died due to hyperkalemia.*

II. SHOW CAUSE NOTICE ISSUED TO RESPONDENT

2. In view of the allegations leveled in the Complaint, a Show Because Notice dated 24.10.2022 was issued to the Respondent doctor, in the following terms:

"...

3. ***WHEREAS,*** *a Complaint has been filed by Mr. Muhammad Tahir (the "Complainant") before the Disciplinary Committee of Pakistan Medical Commission (the "Complaint") which is enclosed along with its annexures and shall be read as an integral part of this notice, and*
4. ***WHEREAS,*** *in terms of the complaint, it has been alleged that Mr. Sucha Gul (the "Patient") who had medical history of Diabetes, Hypertension, Hypothyroidism, and Depression; a COVID-positive patient, and got admitted at the Hospital. You negligently treated the patient, failing to maintain a transparent treatment mechanism of the patient. Your gross negligence and carelessness caused the patient's condition to worsen and ultimately led to his death; and ..."*

III. REPLY OF RESPONDENT

3. The Respondent submitted his response on 18.11.2022, wherein he stated that the complainant also moved similar complaint of the criminal procedure code before the Session Judge Peshawar, the application was not only dismissed by session judge but also by the Peshawar High Court, Peshawar. The response of the Respondent, in terms, is as under:

a. *"...The father of the Complainant namely Mr. Sucha Gul, a 63-year-old gentleman with MR No. 041502121 was received in ER on 19th Jan, 2021 in extremely critical state with oxygen saturations of only 66% having symptoms of breathlessness and cough. Initial diagnosis of COVID pneumonia was made on basis of positive COVID antigen. He was subsequently transferred to COVID ward in Northwest Teaching Hospital. The attendants of Mr. Sucha Gul gave history of diabetes mellitus, hypertension, hypothyroidism and his home medications were noted by the Medical Officer of the COVID ward. Mr. Sucha Gul had already received azithromycin, ivermectin, steroids,*

multivitamins and aspirin at home for the last 5 days. He was started on Oxygen (Initial requirements 8L/m) and other standard therapy including steroids, anticoagulants, PPI and other supportive therapy. I have seen this patient from admission till 24th Jan 2021 and then 1st Feb till his death. It is reiterated that Mr. Sucha Gul was provided with the best medical care and assistance in the Northwest General Hospital and the complaint under reply has been filed with malice and ill will.

b. Since the patient was suffering from COVID-19, therefore he was put on continuous monitoring via vitals monitor and regular RBS record was made. His chronic conditions including diabetes, hypertension, hypothyroidism and depression were well controlled with Insulin, losartan, thyroxine, quetiapine and divalproex sodium respectively right from the first day.

c. It is also relevant to mention during the relevant days the hospital policy had restricted visitors to only when the consultant was doing round on a particular patient in order to restrict spread of COVID. A single attendant was only allowed at round time where he/she was able to meet the patient, attend the morning ward round and talk to the covid team. This was made clear at the time of admission with a written informed consent as per hospital policy which was signed by the family at the time of as p admission. Mr. Sucha Gul's family/ attendants were counselled in detail multiple times during these rounds, the record of which has been clearly documented in medical records attached herewith.

d. The Patient's family was counselled on daily basis and was updated about his management and clinical condition as documented in his clinical notes clearly. Patient's sons (including the complainant) were constantly interfering in the medical management of the patient and demanding for various treatments to be included in his management which were not part of our hospital COVID policy or any national or international guidelines. This was clearly documented in patient's medical record. Family of the patient also demanded starting him on Pirfenidone (which is a fairly toxic drug with significant side effects as shown in attached sheet). A doctor named Dr. Ayesha who claimed to be a family friend and not an employee of Northwest General Hospital demanded other drugs to be included. They were told clearly multiple times as documented in notes that if they are not satisfied with management of the Hospital, they can shift their patient to another hospital. Despite this there was constant interference in management by family and they were taking their own risks against the wishes of the consultant in charge. In order to stop this interference, a call was made to the next of kin of the patient as provided at the time of admission.

e. It is also pertinent to mention that the Ventilator settings are set according to ideal body weight rather than the actual body weight and hence the patient was put on adequate ventilator settings as required.

f. Appropriate calls were made to the required departments including nephrology and psychiatry and their advice and input was documented and incorporated into his medical management. Due to deteriorating renal functions and hyperkalemia, Nephrologist was consulted; who advised against dialysis because of his hemodynamic instability. However, hyperkalemia was managed with appropriate drugs as needed. It is emphasized that Mr. Sucha Gul received maximum medical management including mechanical ventilation, pruning, inotropic support and adequate anticoagulation. Unfortunately, Mr. Sucha Gul died of severe pneumonia and other complications caused by COVID-19 which was a global pandemic resulting in millions of deaths worldwide. However, despite the best efforts of the hospital staff, the patient Mr. Sucha Gul unfortunately passed away on the 6 February, 2021.Thereafter, the complainant has been provided with the documents pertaining to his father's treatment at the Northwest General Hospital.

g. In order to maintain confidentiality and dignity of its patients, the Northwest General Hospital prohibits the use of cameras and camera-phones in the consultation rooms, wards and other medical units. The allegation regarding the display of the false SRO in the Northwest General Hospital is fabricated and false. The complainant was politely warned during ward rounds to refrain from taking pictures and making videos on two different occasions in a chamber where three more patients were present for purpose of patient confidentiality and dignity of patients and staff. In spite of this he kept on doing so. …"

IV. REJOINDER OF COMPLAINANT

4. A letter dated 24.11.2022 was written to the Complainant enclosing the comments received from the Respondent doctor, directing him to submit his rejoinder.

5. Complainant submitted his rejoinder on 08.12.2022 wherein he conveyed that reply of the Respondent is based on conjectures and is rejected on facts and merit. The Complainant reiterated his stance as contained in his Complained with additional details.

V. HEARING

6. The matter was fixed for hearing before the Disciplinary Committee on 12.12.2024. Notices dated 04.12.2024 were issued to the Complainant and Respondent doctors directing them to appear
before the Disciplinary Committee on 12.12.2024.

7. On the date of hearing, the Complainant and the Respondent were both present before the Disciplinary Committee, in person.

8. The Complainant was provided an opportunity to present his view, where he narrated the facts of the initial complaint and reiterated that his patient was not properly treated at the Hospital and was harassed by death threats by the doctor. During admission at the Hospital (19.01.2021), no knowledge was shared with him regarding the treatment of medical care which was provided to the patient. He took the mobile pictures of the treatment sheet of the patient, having being diagnosed with COVID-19, to which he was verbally abused and threatened of dire consequences by the staff and respondent. The patient expired on 06.02.2021 and the Respondent remained ever negligence to properly treat or counsel the patient.

9. Conversely, the Respondent submitted before the Disciplinary Committee re-stating the written reply submitted to the Disciplinary Committee. He stated that the patient had severe pre-existing conditions and was found to be COVID-19 positive, hence he was provided with all the due care as per the existing conditions and circumstances at the time. The relatives of the patient were counselled and even written consent was taken from the relatives, indicating that the treatment provided was explained and the relatives were duly counselled as well. However, the complainant was having different doctors from others Hospitals, call the staff at the Hospital, with multiple medicinal advices, which was unprofessional and refrained from. Patient was a sick man and complainant was explained that, if unsatisfied with the treatment, he is entitled to shift the patient. Regarding the medical record, the Hospital record is digital and cannot be changed by any individual staff or doctor.

VI. EXPERT OPINION

10. An Expert of Medicine was appointed to assist the Disciplinary Committee in this matter. The Expert has opined as under:

> *"... He presented with an oxygen saturation of just over sixty percent. The condition of the patient was explained to the relatives. Management of the patient was done on proper lines as determined by examining the written record and testimony to verbal statements. While tensions ran high during the COVID years ... treating patient with a sympathetic attitude by the treating physicians and a tolerant behavior by the relatives is required. In view of the above, no medical negligence is determined."*

VII. FINDINGS AND CONCLUSION

11. The Disciplinary Committee has perused the relevant record, heard the submissions of the parties at length and considered the opinion of the specialty expert.

12. The Disciplinary Committee notes that patient was suffering from hypertension, diabetes, hypothyroidism and depression. Further, the patient was tested positive for COVID-19 and had oxygen saturation of just 60%. However, later the patient expired due to these pre-existing conditions and the complications created by COVID-19.

13. The Disciplinary Committee is of the considered view, having perused the medical record, that the patient's delicate health was further complicated by COVID-19, despite the medical team adhering to established protocols for COVID-19 management, including administering appropriate medications and treatments as per standard guidelines. The combination of these chronic illnesses and the complications arising from COVID-19 resulted in a rapid decline in the patient's health. Tragically, despite all efforts to stabilize and treat the patient, he succumbed to the combined effects of their pre-existing medical conditions and the severity of the COVID-19 infection. We believe that the medical team's efforts, along with the Respondent doctor, were in accordance with the best practices available, as documented in the records.

14. For what has been said above, the Disciplinary Committee is of the unanimous view that the instant complaint does not constitute medical negligence on the part of the Respondent while treating the patient. The Respondent, Dr. Muhammad Asim (7887-N) was not negligent and complied with expected standards of practice in the instant facts and complaint. Accordingly, Dr. Muhammad Asim (7887-N) is recommended by the Disciplinary Committee to be exonerated in the instant complaint.

15. This instant Complaint is disposed of in the above terms.

Prof. Dr. Muhammad Zubair Khan
Chairman

____ January, 2025