



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

In the matter of

Complaint No. PF.8-1891/2020-DC/PMC

Mr. Muhammad Yaqoob Vs. Dr. Abida Yasmeen (12964-P) & others

Professor Dr. Naqib Ullah Achakzai	Chairman
Professor Dr. Noshad Ahmad Shaikh	Member
Mr. Jawad Amin Khan	Member
Barrister Ch. Sultan Mansoor	Member
Dr. Humera Noreen	Expert (Gynecology)

*Present:*

Mr. Muhammad Yaqoob	Complainant
Dr. Sadia Maqsoom (67438-P)	Respondent No. 2
Dr. Samia Rasheed (65273-P)	Respondent No. 3
Hearing dated	10.10.2022

**I. FACTUAL BACKGROUND**

1. Mr. Muhammad Yaqoob (herein referred to as the "Complainant") filed a complaint on 22.06.2021 against Dr. Abida Yasmeen (the "Respondent No. 1"); working as a Gynecologist at DHQ Hospital, Chakwal (the "Hospital"). Brief facts of the complaint are that:

- a) *The complainant took his pregnant wife (the "Patient") to the private clinic of Respondent No. 1 on 05.04.2020, who informed the complainant that the delivery would be conducted the same day. The delivery was successful and a baby boy was born.*
  - b) *The doctor at the Hospital asked the complainant to arrange blood, for which partial arrangement was made however, they referred the patient to Rawalpindi. During transportation (almost 5 Kms), the patient expired.*
  - c) *The Complainant requested that strict action be taken against Respondent doctor for her misconduct.*
2. The Complainant had initially filed a complaint to the Deputy Commissioner, Chakwal, who had constituted an enquiry and thereafter found the respondent as guilty, and further referred the matter to Punjab Healthcare Commission (PHC) for an in-depth inquiry.
  3. The PHC subsequently made an investigation and gave a decision. Decision of PHC was assailed before District & Sessions Judge, Chakwal who set aside decision to extent of punishment, remanded the decision and directed that punitive action should be in conformity with the gross negligence. Punjab Healthcare Commission re-heard the case and vide order dated 15.11.2021, enhanced the penalty and also referred the case of Dr. Abida Yasmeen to the PMC for appropriate action. Alongside, the Complainant filed a formal complainant with afore-mentioned details.

## II. SHOW CAUSE NOTICE TO RESPONDENT # 1

4. In view of the allegations leveled in the complaint, Show Cause Notice dated 07.07.2021 was served to Dr. Abida Yasmeen in the following terms:

“...

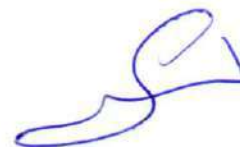
4. *WHEREAS, in terms of the facts mentioned and document appended with the complaint, it has been alleged that on 05.04.2020 the Complainant brought his wife to your private clinic where you recommended that the delivery would be carried out on the same day, while it is alleged that the Complainant's wife had no symptoms and labor pains; and*
5. *WHEREAS, in terms of the facts mentioned and documents appended with the compliant, it is also alleged that immediately after the delivery of the baby you referred the patient to DHQ Hospital, Chakwal without explaining to the family the complication involved and providing them any intimation, referral slip or document; and*



6. WHEREAS, in terms of the fact mentioned and the documents appended with the complaint, it is alleged that in the DHQ Hospital, Chakwal, the mother was profusely bleeding therefore she was referred to Holy Family Hospital, Rawalpindi. However, the patient expired in the ambulance on her way to Rawalpindi; and
7. WHEREAS, in terms of the facts mentioned and the documents appended with the complaint, it has been found that the Deputy Commissioner, Chakwal on 13-04-2020 held an inquiry into the matter by constituting inquiry committee which gave findings on your negligence, giving reasons that the patient/mother was profusely bleeding and was in critical condition and she was referred to DHQ Hospital, Chakwal from your private clinic without any history or relevant record and the same later resulted in the patient's death; and
8. WHEREAS, in terms of the facts mentioned and documents appended with the Complaint it is failure on your part to fulfill your professional responsibilities towards your patient. Such conduct is breach of code of ethics and amounts to professional Negligence/Misconduct. ...”

### III. REPLY OF RESPONDENT, DR. ABIDA YASMEEN

5. Respondent, Dr. Abida Yasmeen submitted reply to Show Cause Notice on 04.08.2021 wherein she contended that:
  - a) The patient came with term pregnancy labor pains on 05.04.2020. She never sought regular medical check-ups. The complainant insistent that the patient be treated by the respondent No. 1 at the clinic which was closed on Sunday morning and she had previous normal deliveries.
  - b) The patient was provided every possible care and she delivered a healthy alive baby boy. Prompt treatment was given to control post-partum bleeding and transfer of the patient to DHQ Hospital, Chakwal was suggested. The Complainant resorted the help of DHQ Hospital, Chakwal and the patient was referred to Holy Family Hospital, Rawalpindi afterwards by the duty doctor.
  - c) In response to an earlier application by the Complainant, the Deputy Commissioner, Chakwal also constituted an inquiry committee which investigated this matter thoroughly. The report of this inquiry committee clearly manifests that no absolute responsibility has been attributed to her. Initially, the Deputy Commissioner of Chakwal perhaps to assuage the anguish of the Complainant directed the matter to the Secretary, Primary and Secondary Health Care Department, however, after affording opportunity of personal hearing to me, withdrew his directions.



- d) *The matter has already been disposed of by the Punjab Healthcare Commission and according to the law of double jeopardy, a person cannot be punished twice for the same matter.*

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

6. Reply received from Respondent, Dr. Abida Yasmeen was forwarded to Complainant through a letter dated 16.8.2021 for rejoinder.
7. The Complainant submitted rejoinder on 12.10.2021, wherein he reiterated his allegations and previously held stance as mentioned in his complaint. Complainant categorically denied the facts shared by the Respondent, Dr. Abida and further raised certain questions regarding management of the patient at DHQ Hospital, Chakwal.

#### **V. HEARING DATED 03.06.2022**

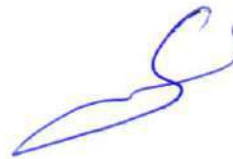
8. The matter was fixed for hearing before the Disciplinary Committee on 03.06.2022. On the date of said hearing, the Complainant appeared whereas the Respondent remained absent. The Disciplinary Committee directed as under:

*“... Patient was treated by Dr. Sadia and Dr. Samia at DHQ Hospital in critical condition in absence of any senior doctor and gynecologist and apparently no proper management of patient was done at the DHQ Hospital. Later, the patient was referred to Holy Family Hospital, Rawalpindi, however, she died on the way. ... Therefore, keeping in view the sudden death of the patient and allegations levelled by the Complainant against the doctors of DHQ Hospital, the Disciplinary Committee directs to issue Show Cause Notices to Dr. Sadia and Dr. Samia at DHQ Hospital, Chakwal as their evidence and the record of treatment will be relevant for doing complete justice. ...”*

#### **VI. SHOW CAUSE NOTICE TO RESPONDENT NO. 2, DR. SADIA MAQSOOM**

9. In view of the directions of the Disciplinary Committee dated 03.06.2022, Show Cause Notice dated 22.08.2022 was served to Respondent, Dr. Sadia Maqsoom, in the following terms:

“... ”



4. WHEREAS, in terms of the facts mentioned in the Complaint it is alleged that, on 05.04.2020, the Complainant brought his wife Mst. Maryam Shaheen (27yrs) to private clinic of Dr. Abida Yasmeen (working as Gynecologist at DHQ Hospital, Chakwal) for the purpose of delivery. Delivery was carried out on the same day and a baby boy was delivered; and


5. WHEREAS, in terms of the facts and record available, it is further alleged that after the delivery at private clinic of Dr. Abida, the patient was referred to DHQ Hospital Chakwal on 05:04 2020, where you were the treating doctor. It is further alleged that you asked the attendants for arrangement of blood, which was arranged by the attendants. Subsequently, you referred the patient to Holy Family Hospital, Rawalpindi without completing the referral procedure i.e., transfusion of blood and management of critical patient. The patient passed away in ambulance while on her way to Rawalpindi, and

6. WHEREAS, in terms of the facts and available record, it is observed that the Deputy Commissioner, Chakwal on 13.04.2020 held an inquiry into the matter by constituting inquiry committee who also gave findings that "at DHQ hospital the behavior of the duty doctor and staff towards the patient's attendant was not courteous and they referred the critical patient to Rawalpindi without completing the procedure of blood transfusion"; and

7. WHEREAS, on 07.07.2021, Show Cause Notice was issued to Dr. Abida Yasmeen in the matter of Complaint and hearing was held on 03.06.2022 before the Disciplinary Committee of Pakistan Medical Commission. The Disciplinary Committee after hearing the parties observed that apparently you as treating doctor of the patient at DHQ Hospital, Chakwal failed to fulfill your professional responsibilities. It was further observed during the bearing that referral of the patient was made by you without completing referral formalities. Prima facie you failed to perform your obligation of duty of care towards patient which led to severe complications and further death of the patient. Such conduct is, prima facie, in violation of the Code of Ethics of Practice for medical and dental practitioners, Regulations, 2011 in general and Regulation 4, 21 (1), 49 (a) & 50 in particular, and ..."

## VII. SHOW CAUSE NOTICE TO RESPONDENT NO.3 , DR. SAMIA RASHEED

10. In view of the directions of the Disciplinary Committee dated 03.06.2022, Show Cause Notice dated 22.08.2022 was served to Respondent, Dr. Samia Rasheed, in the following terms:



“ ...

4. WHEREAS, in terms of the facts mentioned in the Complaint and available record, it is alleged that on 05.04.2020, the Complainant brought his wife Mst. Maryam Shaheen (27yrs) to private clinic of Dr. Abida Yasmeen (working as Gynecologist at DHQ Hospital, Chakwal) for the purpose of delivery. Delivery was carried out on the same day and a baby boy was delivered; and

5. WHEREAS, in terms of the facts and available record, it is further alleged that after the delivery at private clinic of Dr. Abida, the patient was referred to DHQ Hospital Chakwal on 05.04.2020, where you were the treating doctor. It is further alleged that you asked the attendants for arrangement of blood, which was arranged by the attendants Subsequently, you referred the patient to Holy Family Hospital, Rawalpindi without completing the referral procedure Le transfusion of blood and management of critical patient. The patient passed away in ambulance while on her way to Rawalpindi, and

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7. WHEREAS, on 07.07.2021, Show Cause Notice was issued to Dr. Abida Yasmeen in the matter of Complaint and hearing was held on 03.06.2022 before the Disciplinary Committee of Pakistan Medical Commission. The Disciplinary Committee after hearing the parties observed that apparently you as treating doctor of the patient at DHQ Hospital, Chakwal failed to fulfill your professional responsibilities. It was further observed during the hearing that referral of the patient was made by you without completing referral formalities. Prima fane you failed to perform your obligation of duty of care towards patient which led to severe complications and further death of the patient. Such conduct is, prima facie, in violation of the Code of Ethics of Practice for medical and dental practitioners, Regulations, 2011 in general and Regulation 4, 21 (1), 49 (a) & 50 in particular, and ...”

#### VIII. REPLY OF RESPONDENT NO. 2, DR. SADIA MAQSOOM

11. Respondent, Dr. Sadia Maqsoom submitted her reply on 20.09.2022, wherein she stated that:

a) She is a fully qualified doctor having requisite qualifications and dignified work experience to her credit.



- b) *The Prime Minister of Pakistan through Notification No. 1563(1)/2022 dated 19.8.2022 has withdrawn the nominations of the members of the Medical and Dental Council. Thus, there is no Council empowered to look after the affairs, hence, the instant show cause notice of your good office is liable to be dropped on this score alone.*
- c) *Nothing has been found against me in any of the proceedings/litigation mentioned hereinabove. Therefore, this complaint is just an attempt to harass and blackmail me.*
- d) *The Patient was received by me in a state of shock at labour room of the DHQ, Chakwal on 05.04.2020 at 04:15pm. Patient delivered at and was referred from private clinic of Respondent No. 1 with referral slip or any medical record. Patient was in shock (BP: 90-60) with very heavy post-partum hemorrhage (PPH). Assessment and initial management of patient was done and samples and blood grouping were sent to the labs.*
- e) *Respondent No. 3, Dr. Samia, being on call Consultant for Sunday, was informed on phone regarding serious condition of patient who reached at 05:30pm. Double IV lines were passed, fluid resuscitation was done, catheter was passed and patient was further explored. Stitches were taken, vaginal packing was done and initial medical and surgical management for PPH was done.*
- f) *High risk condition of the patient was conveyed to the attendants and accordingly consent was taken as patient was in grade-III shock with PPH and in DIC.*
- g) *Blood bank was called up for availability of 'A-ve' blood which was unavailable. Arranged blood, nearly a pint, was transfused on 06:30pm, however, no further blood could be arranged. Accordingly, at around 06:45pm, patient was referred to tertiary care Hospital, Rawalpindi for further management and the attendants were duly informed.*
- b) *1122 Ambulance was called for at around 07:00pm, which arrived at DHQ Hospital, Chakwal at 07:50pm. However, during the transportation of the patient, she expired.*

#### **IX. REPLY OF RESPONDENT NO. 3, DR. SAMIA RASHEED**

12. Respondent, Dr. Samia Rasheed submitted identical response to that of the Respondent, Dr. Sadia Maqsoom on 20.09.2022, in response to the Show Cause Notice, wherein she stated that:

- a) *She is a fully qualified doctor having requisite qualifications and dignified work experience to her credit.*
- b) *The Prime Minister of Pakistan through Notification No. 1563(1)/2022 dated 19.8.2022 has withdrawn the nominations of the members of the Medical and Dental Council. Thus, there is no*



*Council empowered to look after the affairs, hence, the instant show cause notice of your good office is liable to be dropped on this score alone.*

- c) Nothing has been found against me in any of the proceedings/litigation mentioned hereinabove. Therefore, this complaint is just an attempt to harass and blackmail me.*
- d) The Patient was received by me in a state of shock at labour room of the DHQ, Chakwal on 05.04.2020 at 04:15pm. Patient delivered at and was referred from private clinic of Respondent No. 1 with referral slip or any medical record. Patient was in shock (BP: 90-60) with very heavy post-partum hemorrhage (PPH). Assessment and initial management of patient was done and samples and blood grouping were sent to the labs.*
- e) Respondent No. 3, Dr. Samia, being on call Consultant for Sunday, was informed on phone regarding serious condition of patient who reached at 05:30pm. Double IV lines were passed, fluid resuscitation was done, catheter was passed and patient was further explored. Stitches were taken, vaginal packing was done and initial medical and surgical management for PPH was done.*
- f) High risk condition of the patient was conveyed to the attendants and accordingly consent was taken as patient was in grade-III shock with PPH and in DIC.*
- g) Blood bank was called up for availability of 'A-ive' blood which was unavailable. Arranged blood, nearly a pint, was transfused on 06:30pm, however, no further blood could be arranged. Accordingly, at around 06:45pm, patient was referred to tertiary care Hospital, Rawalpindi for further management and the attendants were duly informed.*
- b) 1122 Ambulance was called for at around 07:00pm, which arrived at DHQ Hospital, Chakwal at 07:50pm. However, during the transportation of the patient, she expired.*

#### **X. HEARING dated 10.10.2022**

13. After receipt of replies to Show Cause Notices from Respondent No. 2 and No. 3, 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 doctors, directing them to appear before the Disciplinary Committee on 10.10.2022.
14. On the date of hearing, the Respondent No.2 and No. 3 were present in person, as well as the Complainant who was also physically present. The Respondent No.1 however remained absent.



15. The complainant while reiterating the facts of the presented complaint submitted that patient was not bleeding when presented at the DHQ Hospital, Chakwal and owing to the negligence of the Respondent doctors No. 2 and No. 3 in treating the patient, the patient died. The Complainant maintained his assertion that the patient was negligently managed at the DHQ Hospital, wasting the precious time of treatment. He argued that instead of provision of appropriate treatment to the patient, the Respondent doctors, i.e., Sadia Maqsood and Samia Rasheed, referred the patient to a tertiary Hospital, relieving their responsibility.
16. The Respondent No. 2 explained herself in terms that she received the patient, without any record, in bleeding condition at the DHQ Hospital. She contended that condition of the patient was informed to the attendants, consent was taken and patient was managed by taking immediate measures including exploration, taking samples etc. for lab work. Further, she informed her on-call colleague and informed her about the condition of the patient and took all necessary steps to provide care to the patient as per medical protocols. She contended that the bleeding of the patient subsided after management and the condition of the uterus relaxed.
17. Respondent No. 3 contended that she arrived within 45 minutes of being informed that the patient has been brought to the DHQ Hospital, however, two very important 'golden hours' for management of patient had already been lost since time of delivery. She explored the patient in the delivery room, as she was bleeding, witnessed cervical tears and managed the patient by packing through gauze piece. No anesthetic was available immediately at the DHQ Hospital and the patient was not taken to the Operation Theatre due to unavailable facilities, blood bank or anesthetist. However, she provided the best possible care to the patient and upon seeing the condition of the patient referred her to tertiary care Hospital in Rawalpindi.
18. The Respondent doctors maintained that they provided the initial management to the patient, and post the transfusion of the blood after receipt of a pack of blood, proper measures were taken, thus based on the lack of appropriate facilities at the Hospital and comparatively better condition, the patient was referred to the tertiary Hospital.

## **XI. EXPERT OPINION**

19. Dr. Humera Noreen was appointed as an Expert to assist the Disciplinary Committee in this matter. The Expert opined as under:

**“Expert opinion**

- The unfortunate death of young patient reflects the deficient antenatal care, unsatisfactory intrapartum, and poor postpartum monitoring and inadequate facilities at DHQ hospital to deal with obstetrical emergencies like PPH which is major reason of maternal mortality in our country. So, there is need of correction of system including good antenatal care, appropriate nutrition to avoid anemia, up gradation of blood bank with availability of rare 'Negative' blood groups, availability of on floor anesthetist, and training of doctors to deal with critical emergencies, good ICU back up, provision of essential items like abdominal sponges.
- As the Respondent 1: Dr Abida Yasmeen failed to appear before disciplinary committee so the expert opinion is inconclusive.”

**XII. FINDINGS AND CONCLUSION**

20. The Disciplinary Committee has perused the relevant record, submissions of the parties and the expert opinion in the instant complaint. The patient (Complainant's wife) was taken to the Respondent No. 1 at her private clinic for her delivery. Post-delivery, the patient was taken to DHQ Hospital, Chakwal where she was admitted under bleeding condition, cited as PPH. Patient was initially attended and managed by the duty doctor, Respondent No. 2 who contacted her on-call consultant, Respondent No. 3, who also arrived at the Hospital after approximately 45 mins. The patient was later referred to tertiary care Hospital, in Rawalpindi. Unfortunately, the patient expired en-route to the tertiary care Hospital.
21. After giving due consideration, we are of the opinion that Respondent No.1 Dr. Abida Yasmeen is the primary physician in this case who failed to appear before the Disciplinary Committee. The expert gynecologist has also in her opinion mentioned that the expert opinion is inconclusive due to absence of primary doctor i.e. Dr. Abida Yasmeen. It is noteworthy that management of this patient was initially done by Respondent No.1 Dr. Abida Yasmeen and later by Respondent No.2 Dr. Sadia and Respondent No. 3 Dr. Samia. Since Respondent No.1 Dr. Abida Yasmeen has





failed to appear before the Committee, therefore, the Disciplinary Committee decides to grant one last opportunity to Dr. Abida Yasmeen to appear for personal hearing whenever and wherever the next meeting/hearing is scheduled, failing which the matter shall be decided ex-parte on the basis of available record. Fresh Notices of hearing shall be issued to the Complainant and all the Respondents for hearing before the Disciplinary Committee in due course. Adjourned.

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