



BEFORE THE DISCIPLINARY COMMITTEE OF PAKISTAN MEDICAL COMMISSION

In the matter of

Complaint No. PF. 8-2093/2022-DC/PMC

Mr. Abdul Qadeer Vs. Dr. Imran Khan Khalil

Professor Dr. Naqib Ullah Achakzai	Chairman
Professor Dr. Noshad Ahmad Sheikh	Member
Mr. Jawad Amin Khan	Member
Barrister Ch. Sultan Mansoor	Secretary
Dr. Marukh Zahoor	Expert (Cardiology)

Present:

Mr. Abdul Qadeer	Complainant
Dr. Imran Khan Khalil (12516-N)	Respondent
Hearing dated	10.10.2022

I. FACTUAL BACKGROUND

1. Mr. Abdul Qadeer (the "Complainant") filed a Complaint on 27.01.2022 against Dr. Imran Khan Khalil (the "Respondent") working at MMC General Hospital, Peshawar (the "Hospital"). Brief facts of the complaint are that:
 - a) *The Complainant's daughter (the "Patient") aged 05 years was suffering from Tetralogy of Fallot (TOF). From 2018 till 2021, the patient remained under consultation of Dr. Abdul Malik Sheikh (38478-P) at Rawalpindi Institute of Cardiology. After Angiography on 29.05.2021 patient was referred to Respondent on the pretext of affordable cost of operation at the Hospital.*

- b) Complainant took patient to Respondent doctor and she was admitted on 21.06.2021. The Complainant alleged that operation was performed on 23.06.2021 by Respondent, negligently, causing the transfusion of 26 units of blood to the patient as the bleeding could not be stopped.
- c) Without Complainant's consent the patient was re-opened and due to negligence of the Respondent, the patient expired on 02.07.2021.
- d) The Complainant requested for disciplinary action against the Respondent.

II. SHOW CAUSE NOTICE TO RESPONDENT, DR. IMRAN KHAN KHALIL

2. In view of the allegations leveled in the Complaint, Show Cause Notice dated 26.05.2022 was issued to the Respondent, Dr. Imran Khan Khalil in the following terms:

“...

4. WHEREAS, in terms of Complaint, it has been alleged that the Complainant visited Rawalpindi Institute of Cardiology, Rawalpindi (RIC) in 2018 for checkup of his daughter namely Ms. Alishba Qadeer (late) (hereinafter referred to as the “Patient”), who was suffering from Tetralogy of Fallot (TOF), wherein she was attended by Dr. Abdul Malik Sheikh and after consultation an operation was recommended. Thereafter, the Patient remained under the consultation of Dr. Abdul Malik Sheikh from 2018 to 2021. However, after angiography on 29.05.2021, the Patient was referred to you on the pretext of comparatively low expenses on the operation in your hospital; and

5. WHEREAS, in terms of Complaint, it has been further alleged that the Patient was admitted to MMC General Hospital, Peshawar on 20.06.2021 and later operated by you on 23.06.2021. It has been alleged that the medical tests of the patient conducted before the operation were normal in both RIC and MMC General hospital. After surgery she spent nine (09) days on ventilator and eventually died on 02.07.2021 due to Multiple Organ Failure (MOF); and

6. WHEREAS, in terms of Complaint it has been alleged that the patient was re-operated during her admission/ stay at the MMC General Hospital from 21.06.2021 to 02.07.2021 without prior consent of the Complainant; and

7. WHEREAS, in terms of Complaint, it has been alleged that the patient expired due to your professional negligence during the surgery and lack of post-surgery care by you. Furthermore, twenty-six (26) pints of blood were transfused to the Patient for the reason of continuous bleeding occurred due to your professional negligence in the operation. Moreover, you performed the operation without considering the findings of angiography; and

8. **WHEREAS**, in terms of the Complaint, after operation on 23.06.2021, you left the hospital and was not present for post-operative follow up and instead the Patient was on the mercy of junior doctors; and
9. **WHEREAS**, in terms of the facts mentioned in the Complaint, it is failure on your part to fulfill your professional responsibilities towards your patient. ...”

III. REPLY OF RESPONDENT, DR. IMRAN KHAN KAHLIL

3. Respondent, Dr. Imran Khan Khalil submitted reply to Show Cause Notice on 23.06.2022 wherein he contended that:

- a) The patient, Ms. Alishba Qadeer was admitted in MMC General Hospital on 21.06.2021, operated on 23.06.2021 and later died on 02.07.2021. Patient was diagnosed of TOF (Tetralogy of Fallot), a cyanotic congenital heart disease. Her pre-operative assessment revealed normal medical tests and she was accepted for surgery and general Anesthesia.
- b) Patient's preoperative diagnostic work up including Echo and Cath/Angio was done by Paeds Cardiologist showing correctable anatomy. Our operation findings were almost the same as reported by Dr Abdul Malik Sheikh (Paeds Cardiologist) in his echo and cardiac cath reports.
Angiography findings: Single large PM VSD, no additional VSD Severe Infundibular Stenosis, good size PAS No PDA, no MAPCA B/L SVC
- c) Operation was done completely in the light of findings revealed in Echo and angio/Cath reports. Aorta, IVC and bilateral SVCs were cannulated to establish cardiopulmonary bypass. VSD was repaired with Gore-Tex patch Infundibular stenosis was relieved and RVOT augmented with trans-annular patch. Nothing was missed during operation and post-operative echo done in ICU showed satisfactory total correction.
- d) In all open-heart surgeries, Heparin is used as blood thinner and bleeding is frequent complication after open heart surgery. In operations for cyanotic congenital heart diseases, the bleeding chances are augmented even further by the deranged clotting capability.
- e) Reopening is not reoperation. Cardiac tamponade leads to emergency collapse of the patient and if not reopened within minutes, the sequels are dreadful to cause patient death. The patient was reopened in emergency because of cardiac tamponade.
- f) During reopening, the collected blood was evacuated, blocked chest tubes were reopened, no active bleeder found, and general ooze noted. Before operation, the complainant was counseled in detail about the disease



- (TOF), the operation (Total correction), and the complications of operation (bleeding, infection, reopening, CVA, respiratory failure, kidney failure). The father consented for the operation plus all necessary procedures as part of the treatment. Reopening for Tamponade was necessary part of the patient treatment.
- g) The patient also needed multiple blood transfusion (8 FFPS + 8 Platelets+ 8 whole bloods, given after grouping and cross match) because of bleeding due to deranged clotting capability that was confirmed on reopening as well, as there was no active bleeder, but all-over general ooze was there. The patient underwent open heart surgery, sustained uncontrolled bleeding, developed tamponade and was reopened for cardiac tamponade, received multiple blood transfusions of blood and blood products, being on ventilator for prolong period, she developed multi organs failure leading to death of the patient.
- h) All the cardiac team actively participated and left no stone unturned to save patient's life but unfortunately the patient was not saved. For this we sympathize with the family for the loss, but this was something beyond our control. Congenital heart disease surgeries have higher mortality not only in Pakistan but worldwide. The complainant's allegation that I left for Bannu after operation on 23.06.2021. I was present throughout the course of her treatment, and I have done operations in the same hospital from 24.06.2021 till 27.06.2021, then 28.06.2021 was off and then on 29.06.2021 and so on.
- i) The Respondent performed this operation free of cost, not receiving any surgeon fee and that the Complainant was non-compliant about the directions for his patient treatment. He was found most of the time absent from the hospital, whenever he was needed. Complainant wanted financial gains from the treatment of patient because he thought that hospital was getting RS 10 Lakh from Stat life while in fact the amount paid to hospital is Rs. 300,000/- (30,000 tax deduction and net amount paid is 270,000).

IV. REJOINDER OF THE COMPLAINANT

4. Reply received from the Respondent doctor was forwarded to Complainant through a letter dated 29.06.2022 for his rejoinder.
5. The Complainant submitted his rejoinder on 18.07.2022 wherein he refuted the replies and allegations of the Respondent. Complainant reiterated his request that strict action be taken in view of gross negligence of the Respondent.

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. Imran Khan Khalil directing them to appear before the Disciplinary Committee on 10.10.2022.
7. On the said date of hearing the Complainant as well as the Respondent appeared in person
8. The Disciplinary Committee asked the Complainant to briefly state his grievance against the Respondent doctor to which the Complainant stated that his daughter was suffering from TOF and was under treatment at Rawalpindi Institute of Cardiology from 2018 to 2021. On 29.05.2021, the patient was referred to Respondent doctor for surgery at MMC General Hospital Peshawar. The patient was admitted at MMC General Hospital on 21.06.2021 and surgery was performed on 23.06.2021. The Complainant further submitted that the Respondent conducted the surgery negligently and about 26 pints of blood were transfused to the patient. He further stated that the Respondent left the hospital after surgery and the patient was treated by juniors. A second surgery was also performed but to no avail and the patient died on 02.07.2021.
9. The Respondent Doctor stated that he has done FCPS Cardiac Surgery in 2013-2014, he has also completed one-year congenital training from Malaysia. Thereafter he worked at Children Hospital Lahore for 6-8 months with senior cardiologist. The patient visited on 12.06.2021 and the disease and procedure required was explained to the Complainant through diagram. Surgery of the Complainant's daughter was performed on 23.06.2021. The surgery was performed in the light of findings revealed in Echo and Angio. Surgery continued for about four hours which is mentioned in notes. IVC and bilateral SVCs were cannulated to establish cardiopulmonary bypass. VSD was repaired with patch. Infundibular stenosis was relieved and RVOT augmented with trans-annular patch. The patient was shifted to ICU where oozing was observed. He further stated that bleeding is the most common complication in TOF patients. FFPs, Platelets and Transamine were given. The patient was reopened next morning i.e. on 24.06.2021 and no active bleeder was found general oozing was observed. Collected blood was evacuated chest tubes were re-opened. I visit operated patients every morning and counsel the attendants in ward. The

allegation that after the operation I left for Bannu is incorrect, I was present in the hospital and performed surgeries of other patients on subsequent days.

VI. EXPERT OPINION

10. Dr. Marukh Zahoor was appointed as expert to assist the Disciplinary Committee in the instant case. The expert after going through the record and asking necessary questions from the parties rendered a detailed opinion. Relevant portion of the opinion is reproduced herein below:

"1. The patient was operated on a working day (Wednesday 23.06.2021). It was a technically challenging surgery requiring prolonged bypass time leading to associated coagulopathy and major bleeding complication for which necessary steps were taken promptly like blood and products transfusion and reopening well in time to prevent life threatening cardiac tamponade under direct supervision and presence of the operating surgeon (defendant) as per record available (Ref: Cardiac ICU flowsheet dated 23/24 June 2021).

2. Furthermore rare and undiagnosed medical causes of major bleeding continuing for more than 48 hours and not responding to conventional treatment; like factor VIII deficiency, hemophilia etc. could not be identified due to lack of or unavailability of advanced diagnostic facilities at the medical Centre for which directions should be issued to the Centre to make these facilities available to the patients.

3. The defendant remained present during the post-operative period with his team daily upon morning rounds along with performing his daily operation list from 24.06.2021 to 02.07.2021. Both complainant and defendant remained committed to the treatment by ordering blood transfusions of extremely rare blood group "O negative" which was immediately arranged and provided by the father of the patient who remained actively involved in the treatment by complying with doctors' orders.

4. The defendant testifies to scheduling daily counselling meetings at 08am in ICU for which complainant could not arrive or remained absent. No written evidence could be produced for these counselling sessions therefore generating misunderstandings between both defendant and complainant regarding treatment of the patient.

5. The Consent Form used in this case is neither designed nor powered to address the needs of the cardiac surgery both adult and pediatric procedures. It must be changed immediately to address the required needs for better understanding of both doctors and patients."



VII. FINDINGS AND CONCLUSION

11. The Disciplinary Committee after going through the record, submissions of parties and expert opinion has noted that the daughter of the Complainant was suffering from Tetralogy of Fallot. She initially remained under treatment at Rawalpindi Institute of Cardiology. On 12.06.2021, the patient was taken to Respondent Dr. Imran Khalil who after seeing reports explained to the attendants the disease and advised immediate surgery. The patient was later admitted at MMC Hospital Peshawar under care of Dr. Imran Khalil and surgery was performed on 23.06.2021.
12. The Disciplinary Committee has noted that it was a complicated surgery and it carries many complications including profuse bleeding, infection, respiratory failure, kidney failure. The allegation of the Complainant that the Respondent left after the surgery and did not come back is not tenable. The record reveals that the Respondent was available in the hospital and he performed other surgeries on 24.06.2021 to 02.07.2021. Furthermore, the allegation of the patient that second surgery of the patient was performed by Respondent doctor on 28.06.2021 without informing the attendants is also misconceived. As per record and statement of the Respondent the patient was oozy after the surgery and the next day i.e. on 24.06.2021 morning the patient was re-opened to rule out bleeder and to treat cardiac tamponade. Furthermore, re-opening is very common in open heart surgeries.
13. The expert of cardiology has also given a detailed opinion and as per the opinion it was a technically challenging surgery requiring prolonged bypass time leading to associated coagulopathy and major bleeding complication for which necessary steps were taken promptly like blood and products transfusion and reopening well in time to prevent life threatening cardiac tamponade under direct supervision and presence of the operating surgeon.
14. The Disciplinary Committee further observes that as highlighted by the expert the consent form used by the Respondent doctor needs to be amended and it should be detailed and specific to serve the purpose. Furthermore, the Respondent as a matter of practice should enter his notes on patient/attendant counselling.





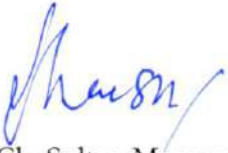
15. The Disciplinary Committee after thorough deliberation and minutely going through medical record, submission of parties and the expert opinion concludes that there is no professional/ medical negligence in this case. The Respondent however is directed to amend the consent form used by him and also to take notes of patient/attendant counselling.


Prof. Dr. Noshad Ahmad Shaikh

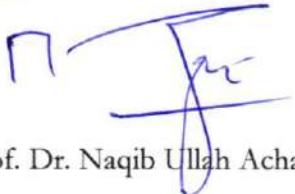
Member


Mr. Jawad Amin Khan

Member


Barrister Ch. Sultan Mansoor

Secretary


Prof. Dr. Naqib Ullah Achakzai

Chairman

27th October, 2022

