SUMMARY

DR. SAIF ULLAH (CPSO# 92580)

1. Disposition

On June 20, 2018, the Inquiries, Complaints and Reports Committee (the Committee) required Dr. Ullah (Respirology and Internal Medicine) to appear before a panel of the Committee to be cautioned with respect to considering the use of not only a bleeding risk-scoring system when considering whether or not to start empiric anticoagulation, but also the use of a thromboembolic risk-scoring system.

The Committee also requested Dr. Ullah to provide a written report focused on guidelines about the use of anticoagulation prior to testing, the decision to allow the intravenous (IV) access issue to be left until the morning in this case, and changes he will make to incorporate the relevant guidelines.

2. Introduction

A patient attended a hospital Emergency Room (ER) with shortness of breath. Dr. Ullah provided care to the patient in the ER, including he ordered an ultrasound to rule out a blood clot in the patient's leg. The radiologist who reviewed the ultrasound images initially reported there was no evidence of a blood clot. The patient died early the next morning; the cause of death was a blood clot that travelled from the right leg to the lung.

A family member of the deceased patient complained to the College that Dr. Ullah:

- failed to recognize the signs and symptoms of a blood clot in the patient's leg
- failed to start the patient on blood thinners to treat a possible blood clot despite the patient's past medical history
- failed to order any follow-up investigation after the ultrasound was reported as negative

- failed to establish IV access after many failed attempts over many hours by the nursing staff

Dr. Ullah responded that he did recognize signs and symptoms of a blood clot in the patient's leg and undertook investigations to confirm this. He outlined his reasons for not starting the patient on blood thinners. Dr. Ullah indicated he ordered a CT with contrast and a transthoracic echocardiogram, and he explained why a ventilation-perfusion (V/Q) lung scan was not indicated. Dr. Ullah agreed the patient needed IV access for fluid resuscitation, but explained why he was confident the patient could tolerate oral fluids as a method of hydration overnight (after a previous IV line had gone interstitial).

3. Committee Process

As part of this investigation, the Committee retained an Independent Opinion (IO) provider who is a respirologist and intensivist. The IO provider reviewed the entire written investigative record and submitted a written report to the Committee.

A General Panel of the Committee, consisting of public and physician members, met to review the relevant records and documents related to the complaint. The Committee always has before it applicable legislation and regulations, along with policies that the College has developed, which reflect the College's professional expectations for physicians practising in Ontario. Current versions of these documents are available on the College's website at www.cpso.on.ca, under the heading "Policies & Publications."

4. Committee's Analysis

The IO provider pointed out the record shows Dr. Ullah considered both deep vein thrombosis (DVT) and pulmonary embolism (PE) in his differential diagnoses for the patient. On this basis, the Committee concluded the Respondent did not fail to recognize the signs and symptoms of possible venous thromboembolic disease, and took no action.

The IO provider concluded Dr. Ullah did not meet the standard of practice and demonstrated a lack of judgement in relation to not initiating empiric anticoagulation therapy while waiting for confirmatory testing, noting there are scoring systems to estimate the likelihood of thromboembolic disease and that current guidelines and clinical practice would support the empiric administration of therapeutic anticoagulation in a case such as this. The Committee concurred that Dr. Ullah's actions in this case were not in accordance with national and international guidelines regarding anticoagulation of patients with a high pre-test clinical probability of PE, and the patient's previous history was not a contraindication to anticoagulation. The Committee was concerned about the scoring system Dr. Ullah relied upon, noting this is an area of medicine in which an intensivist should be well versed and that Dr. Ullah needs to learn how to manage this kind of clinical situation early on. For these reasons, the Committee decided to require Dr. Ullah to appear before a panel of the Committee to be cautioned and asked him to prepare a written report, as set out above.

While the IO provider noted Dr. Ullah could have considered doing a V/Q scan, the Committee agreed with Dr. Ullah that a V/Q scan was not necessarily indicated in this clinical scenario.

The IO provider was of the opinion that Dr. Ullah could have made additional efforts to facilitate timely IV access, and the Committee concurred and asked Dr. Ullah to address this in his written report.