SUMMARY of the Decision of the Inquiries, Complaints and Reports Committee (the Committee)
(Information is available about the complaints process here and about the Committee here)

Dr. Ashwin Maharaj (CPSO #67100)
(the Respondent)

INTRODUCTION

The Complainant was referred to the Respondent, a general surgeon, for assessment of hemorrhoids. The Complainant saw the Respondent on three occasions and underwent rubber band ligation (RBL) treatment during the first two appointments. At the third appointment, the Respondent recommended non-OHIP-covered treatment for hemorrhoids at a cost of $6000, as he felt the RBL was not working for the Complainant. He referred the Complainant to another clinic location for further assessment and treatment. The Complainant did not return to the Respondent and instead sought a second opinion. According to the Complainant, he was advised that his condition did not require surgery and that it should be treated with medication. The Complainant subsequently contacted the College of Physicians and Surgeons of Ontario (the College) to express concerns about the Respondent's care and conduct.

COMMITTEE'S DECISION

A Surgical Panel of the Committee considered this matter at its meeting of March 22, 2024. The Committee required the Respondent to appear before a Panel of the Committee to be cautioned with respect to failure to obtain informed consent and the need to reflect on his ethical obligations as a physician with respect to what is best for patients. The Committee also agreed to accept an undertaking from the Respondent.

COMMITTEE'S ANALYSIS

Concerns that the Respondent did not give the Complainant enough information or obtain a signed consent prior to performing a medical procedure; and recommended an expensive treatment on a non-OHIP-covered basis, and failed to follow up with the Complainant regarding the treatment plan despite reassurances he would do so

As part of this investigation, the Committee retained an independent Assessor who specializes in general surgery. In summary, the Assessor opined that:

- If the Complainant's statements are true, then the Respondent did not meet the standard of care with respect to obtaining informed consent for the banding procedure. The patient must have knowledge of the success rate, the number of treatments required, the possibility of discomfort during the procedure, and risk of serious complications (infection) in a small number of cases.

- The Assessor identified aspects of the Respondent's knowledge and skill that could perhaps have been improved, but did not identify a definitive lack in these areas, or a lack of judgement.

- The Assessor did not identify a risk of harm to patients in this instance, but reiterated that if the Complainant's assertions are true, the Respondent performed RBL on the Complainant without having met the standard with respect to consent to treatment.

The Committee acknowledged that a report from the Respondent's opinion provider disagreed with the Assessor's view that the Respondent's care of the Complainant did not meet the standard of practice of the profession. Regardless, the Committee preferred the Assessor's opinion.

Overall, the care provided by the Respondent to the Complainant failed to meet the standard of practice of the profession given the shortcomings in the consent discussion process, and thus the inability of the patient, in this case the Complainant, to provide fully informed consent.

The Committee's concern about the Respondent's care of the Complainant was amplified by similar concerns brought to the Committee's attention in three other complaints, which the Committee considered concurrently with the Complainant's matter.