

## **SUMMARY**

### **DR. HARRY S. HIMAL (CPSO# 31420)**

#### 1. Disposition

On September 16, 2016, the Inquiries, Complaints and Reports Committee (“the Committee”) required General Surgeon Dr. Himal to appear before a panel of the Committee to be cautioned with respect to post-surgical care and follow-up after hemorrhoid surgery.

#### 2. Introduction

A patient complained to the College that Dr. Himal failed to appropriately manage her post-procedural care after he performed a hemorrhoid banding (ligation) procedure. Specifically, she was concerned that Dr. Himal failed to assess whether her post-procedural bleeding had stopped, did not provide her with appropriate discharge instructions, and did not offer proper follow-up care when she contacted him by telephone after the procedure to report heavy bleeding. The patient also expressed concern that Dr. Himal neglected to inform her of the details of the procedure beforehand.

Dr. Himal responded that he did inform the patient about the details of the surgery. He said there was some oozing during the procedure and he had to pack the area with gauze and apply pressure, but the oozing stopped and the patient was transferred to the recovery room. He described that there was no bleeding in the recovery room after the procedure, that the patient received standard discharge instructions, and that the patient never spoke to him to report heavy bleeding.

#### 3. Committee Process

A Surgical 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](http://www.cpso.on.ca), under the heading “Policies & Publications.”

#### 4. Committee's Analysis

Dr. Himal had not documented details of his pre-procedure discussions with the patient. The Committee drew his attention to the College's Policy Statement #3-15 on *Consent to Treatment*, which describes how consent must be informed, and when and what physicians should document regarding consent discussions.

The Committee noted that it is unusual during a ligation procedure for a patient to require packing and was of the view that this circumstance alone should have prompted Dr. Himal to take the clinical situation very seriously. The Committee noted that the ten minutes of documented observation before the patient was discharged was insufficient and that Dr. Himal should have delayed the patient's discharge to allow for extended monitoring. The Committee also expressed the view that Dr. Himal's failure to reassess the patient for ongoing bleeding prior to discharge was a further shortcoming.

The Committee was unable to know for certain what discharge information Dr. Himal provided to the patient, beyond his own notation in his consultation letter that he instructed her to email him regarding her progress, but it was of the view that he should have ensured greater clarity around both discharge instructions and follow-up.

In terms of further follow-up, and the patient's assertion that Dr. Himal provided her inadequate instructions by telephone when she called to report heavy bleeding after the procedure, the parties provided competing accounts on this point. Based on the information before it, the Committee was unable to reconcile these accounts. However, considering the patient's bleeding during the procedure required packing and pressure, which would suggest a patient at increased risk of short-term complications and to whom clear lines of communication and follow-up are of utmost importance, the Committee believed that Dr. Himal should have ensured a more definite follow-up plan was in place and clearly documented this in the clinical record.

Given the clinical shortcomings which the Committee identified in this case, it determined the appropriate disposition was to require Dr. Himal to attend at the College to be cautioned in person with respect to post-surgical care and follow-up after hemorrhoid surgery.