SUMMARY

DR. NATAVARLAL HIRALAL SHAH (CPSO# 27638)

1. Disposition

On April 20, 2016, the Inquiries, Complaints and Reports Committee ("the Committee") ordered general practitioner Dr. Shah to complete a specified continuing education and remediation program ("SCERP"). The SCERP requires Dr. Shah to:

- Complete self-directed learning in anti-coagulation management, thyroid disease management, and medical record-keeping;
- Enter into a six-month period of low-level clinical supervision with respect to management of patients in long-term care facilities as well as the above-identified clinical management and record-keeping.
- Undergo a reassessment six months after the clinical supervision period has ended consisting of a chart review and interview with an assessor acceptable to the College.

2. Introduction

A family member of a patient in a long-term care facility complained about Dr. Shah's management of the patient's chronic conditions, given that the patient ultimately required a partial foot amputation. The family member was also concerned about the quality of Dr. Shah's communications with the family about the patient's condition.

Dr. Shah stated that he monitored the patient's chronic conditions on a regular basis. He pointed out that he relied on nursing staff to monitor and document the patient's conditions between his visits (including his blood pressure readings and blood test results), and that he would review their charting when he visited the patient. He indicated that he was sorry that the patient's condition deteriorated (requiring a partial amputation) but maintained that he provided appropriate care at all times. Dr. Shah indicated that as the family members were not normally present at the time of his visit, he kept them informed by passing along information through the

medical staff. He noted that the family was free to contact him at his office if they had questions or concerns.

3. Committee Process

A 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 patient had complex medical issues and was maintained on multiple medications. In reviewing the nursing home notes, physicians' orders and laboratory reports, the Committee concluded that Dr. Shah failed to deal proactively with several of the patient's health issues, and that this lack of active management may have contributed to the overall decline in the patient's health. The Committee pointed out that despite concerning laboratory findings, Dr. Shah failed to make medication adjustments to address these issues, and also failed to document in the record his reasons for not making adjustments. The Committee also noted that although Dr. Shah and the consulting physicians addressed many of the patient's issues during his hospitalizations, it was not clear from the record whether Dr. Shah followed up vigilantly on the recommended laboratory testing after the patient's discharge back to the long term care facility.

The Committee felt that Dr. Shah's communication with the family was not frequent, and concluded that Dr. Shah could have made more effort to contact the family to discuss numerous aspects of the patient's care, particularly when the hospital admissions began. The Committee pointed out that the attending physician is responsible for discussing care with the patient (or the patient's substitute decision maker), and that it is not sufficient to simply delegate the task to nursing staff.

The Committee noted that Dr. Shah had minimal history with the College despite many years of practice.