SUMMARY

DR. HUMA AFTAB ALAM (CPSO #81410)

1. Disposition

On November 23, 2016, the Inquiries, Complaints and Reports Committee ("the Committee") required family physician Dr. Alam to appear before a panel of the Committee to be cautioned with respect to failing to inquire about allergies before providing a prescription.

2. Introduction

The mother of a patient complained to the College that Dr. Alam prescribed medication to her son to which he was allergic, causing his death. The mother noted that her son, whose medical history included asthma, cystic fibrosis gene mutation and an allergy to NSAIDs (non-steroidal anti-inflammatory drugs), went to a walk-in clinic for musculoskeletal pain. Dr. Alam prescribed Vimovo, an NSAID. Her son developed breathing and pain issues that evening after taking the medication and died shortly afterward.

Dr. Alam responded that she prescribed Vimovo to the patient and would have told him to see a physician or go to the emergency room ("ER") if his symptoms worsened. She indicated that the Coroner contacted her to inform her of the patient's death. The Coroner asked her if the patient had any allergies. She reviewed the chart at that time and indicated that no allergies were noted in the chart.

Dr. Alam advised that she had not been able to review the patient chart since speaking to the Coroner, as the clinic has been unable to locate the chart since that time.

Dr. Alam indicated that patients at the clinic are asked to fill in a patient information sheet which has a section for allergies. She reported that she recalls looking at this page when she was speaking to the Coroner and noting that the patient had not listed any allergies.

It is her usual routine to explain to the patient the medication she is prescribing, the reason why she is prescribing it, and the side effects. This discussion usually includes any medication allergies. If the patient mentions an allergy, she will document it in the chart. There was no

mention of allergies in the chart, which means that the patient in this case did not tell her that he had any.

Dr. Alam indicated that, after speaking to the Coroner, she contacted the pharmacy where the patient filled the Vimovo prescription. Pharmacy staff advised her that the patient did not have any documented allergies on file.

Dr. Alam also indicated that it was not clear to her whether the patient had a true allergy to ibuprofen or an aspirin-exacerbated respiratory disease ("AERD"). She advised that most people with asthma and AERD receive counselling upon diagnosis not to take any anti-inflammatory medications (rather than avoid only ibuprofen). The patient in this case knew that she had prescribed him an anti-inflammatory medication. If the patient had informed anyone about his allergy or AERD, she would not have prescribed the medication for him.

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 Coroner's report indicated that the patient's death was due to NSAID-induced asthma and angioedema. The patient had a history of allergy to ibuprofen that neither Dr. Alam nor the pharmacy that dispensed the medication was aware of. In addition, the patient had asthma.

It is always important to be cautious about prescribing NSAIDs to patients with asthma that is active. In addition, it is the physician's responsibility to verbally inquire about allergies at the time of prescribing, and particularly when prescribing NSAIDs to an asthmatic patient. Even if the patient does not have a defined allergy, there is a correlation between NSAIDs and asthma.

The Committee was concerned about the apparent lack of documentation regarding whether Dr. Alam inquired about allergies when she provided the patient with the prescription for Vimovo. Dr. Alam informed the Coroner that the allergy section of the intake sheet was blank. The patient's mother indicated that her son was well aware of his allergy. In the Committee's view, if Dr. Alam had asked the patient about any allergies, there should have been documentation to this effect in the medical record.

Dr. Alam had possession of the patient's chart when she spoke to the Coroner, when she first learned about the patient's death. The chart was last seen in Dr. Alam's possession on that occasion.

The Committee was concerned both by the tragic outcome in this case and the lack of documentation to indicate that Dr. Alam inquired about allergies before prescribing an NSAID to an asthmatic patient with a history of ibuprofen allergy.