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. Ahmed Sherghin (CPSO #54840)
(the Respondent)

INTRODUCTION

The Complainant contacted the College of Physicians and Surgeons of Ontario (the College) to express concerns about the Respondent's care of her spouse's bladder cancer.

The Respondent first saw the Patient for assessment of gross hematuria (blood in the urine). A bladder tumour was identified, and the Respondent conducted a transurethral resection of the Patient's bladder tumour. A pathology report following the procedure revealed high-grade bladder cancer with invasion into the bladder muscle. The Respondent conducted a radical cystectomy with the creation of an ileal conduit in October 2020.

After various follow-up appointments with the Patient, an August 2021 computed tomography (CT) scan showed an increase in the size of pulmonary nodules as well as multiple liver metastases. The Patient was then referred to a cancer centre where chemotherapy was discussed and declined. The Patient passed away in November 2021.

COMPLAINANT'S CONCERNS

The Complainant is concerned that the Respondent:

- **failed to make a referral to an oncologist or for chemotherapy/radiation treatment despite pathology showing cancer was present in the lymph nodes;**
- **stated that the Patient was cancer free, and a referral would be a waste of resources;**
- **dismissed concerns of shadows on the lung CT scan and failed to follow radiologists' recommendations of a three-month follow-up; and,**
- **failed to give the file back to the family physician for follow-up or a referral to an oncologist after the urological treatment was completed.**

COMMITTEE'S DECISION

The Committee considered this matter at its meeting of July 19, 2023. The Committee required the Respondent to appear before a Panel of the Committee to be cautioned

with respect to his failure to employ a multidisciplinary approach to cancer treatment, including multidisciplinary cancer conferences (MCC).

The Committee also decided to accept an undertaking that is now posted on the public register.

COMMITTEE'S ANALYSIS

Failed to make a referral to an oncologist or for chemotherapy/radiation treatment despite pathology showing cancer in the lymph nodes
- and -
Stated that the Patient was cancer free and that a referral would be a waste of resources
- and -
Dismissed concerns of shadows on the lung CT scan and failed to follow radiologists' recommendations of a three-month follow-up

As part of this investigation, the Committee retained an independent Assessor who specializes in urology.

The Assessor opined that the Respondent did not meet the standard of practice of the profession by failing to employ a multidisciplinary approach to treatment decisions involving muscle invasive cancer. The Assessor noted that the Respondent never made use of an MCC when making care decisions regarding the Patient and only initiated individual consultations with specialists later than was appropriate.

The Assessor further opined that the Respondent showed an error in judgement when he assessed the extent of the Patient's cancer and opted for an observational approach rather than involving medical oncology interventions at an earlier date. This also suggested a lack of knowledge of the potential benefit of medical oncology for patients with muscle invasive bladder cancer. However, once metastatic disease was noted by the Respondent, chemotherapy was discussed with the Patient, showing that the Respondent understood its potential role.

The Assessor did not opine that the Respondent posed a risk of harm to patients.

The Committee agreed that the Respondent did not meet the standard of practice of the profession and displayed an error in judgement by not utilizing a multidisciplinary approach for the Patient's care.

The Committee was also of the view that the Respondent's actions in this case could

expose patients to the risk of harm. There were multiple occasions at which the Respondent should have discussed chemotherapy and a referral to a cancer center with the Patient. In not recognizing the seriousness of a patient's cancer and therefore not recommending the most appropriate interventions, the Respondent could pose harm to patients.

The Committee was also concerned by the Respondent's history, which included prior public complaints regarding the Respondent's care and patient management. In addition, the Respondent's response to this complainant did not demonstrate adequate reflection or insight into how he might handle this type of scenario differently in the future.

Taking all these concerns together, the Committee determined that it was appropriate to caution the Respondent.

Failed to give the Patient's file back to the family physician for follow-up or a referral to an oncologist after the urological treatment was completed

The Committee took no action with respect to this area of concern.