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 a rectal lesion that had increased in size. The Respondent performed a flexible sigmoidoscopy on the Complainant and excised 10 polyps, but did not excise the rectal lesion (which he described as a "scarred blood clot"). He stated in his operative report that he chose not to excise the lesion due the Complainant's history of incontinence. The Complainant was upset that the lesion was not removed. Subsequently, the Complainant contacted the College of Physicians and Surgeons of Ontario (the College) to express concerns about the Respondent's care.

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 failed to listen to the Complainant's presenting problem and follow the referral that was sent, and performed a procedure unnecessarily when the appointment should only have been a consultation; was flippant and dismissive towards the Complainant when assessing the lesion post-procedure; and has traumatized the Complainant by this situation and has still not provided an answer regarding the presenting problem

The Committee determined that the care the Respondent provided the Complainant was poor, and unacceptable in a number ways, including:

- Incorrectly booking the Complainant for a colonoscopy requiring unnecessary bowel preparation with pico salax, with potential harm including, syncope and kidney injury
- Unnecessary sedation for sigmoidoscopy

- Exposing the Complainant to the risks inherent with sedation and advancing the colonoscope well beyond the sigmoid colon, thus increasing the risk of bowel injury
- Assessing the rectal lesion after the procedure as opposed to beforehand, when this was the purpose of the referral
- Providing an unrecognized diagnosis for the rectal lesion of “scarred blood clot”.

In the Committee’s opinion, the care provided by the Respondent to the Complainant was not acceptable given the shortcomings in the consent discussion process and thus the inability of the Complainant to provide fully informed consent or to adequately communicate a concern about not being assessed for the issue on the referral form. Moreover, the Respondent failed to take the time to understand the Complainant’s concerns, despite the discrepancies between the referral form and the procedure booked for the Complainant. In general, the Committee believes the Respondent recommended and carried out a treatment that was not in the Complainant’s best interests.