SUMMARY

DR. MIRAZ BAIG (CPSO# 91318)

1. Disposition

On August 11, 2016, the Inquiries, Complaints and Reports Committee ("the Committee") ordered general practitioner Dr. Baig to complete a specified continuing education and remediation program ("SCERP"). The SCERP requires Dr. Baig to:

- Participate in self-directed learning with respect to his management and record-keeping practices, and take steps to enhance the legibility and comprehensiveness of his record-keeping.

- Practice under the guidance of a Clinical Supervisor acceptable to the College for a period of three (3) months, with respect to the CanMEDS roles of "Medical Expert" (including comprehensive assessments of trauma patients appropriate to the degree and mechanism of injury) and "Communicator (Record-Keeping)" (including legibility and comprehensive documentation appropriate for the patient's presenting problem).

- Undergo a reassessment of his practice by an assessor selected by the College approximately six months following completion of the period of clinical supervision outlined above.

2. Introduction

Patient A complained to the College that Dr. Baig failed to provide appropriate care to him in the Emergency Department for treatment of injuries following a cycling accident, in which he lost consciousness for a few minutes. In particular, Patient A was concerned that Dr. Baig failed to perform an adequate examination and order the appropriate diagnostic test that would have diagnosed the "burst" fracture of the T8 vertebra with which he was later diagnosed. In addition, Patient A was concerned that Dr. Baig ordered the wrong type of arm sling to stabilize his fractured left clavicle, which resulted in left ulnar nerve damage for which he has required surgery, and from which he has not fully recovered.

Dr. Baig maintained that he provided appropriate care to Patient A. He stated that Patient A did not communicate any concerns about back pain, and in any event he recalled examining Patient A's back (although he acknowledges he did not document the examination). Dr. Baig further stated that because Patient A did not report any headache or neck pain, a CT scan was not necessary. He noted that cervical spine x-rays were normal. He noted that he refers patients to orthopaedic surgery if necessary. He pointed out that he did not apply Patient A's sling, noting that nurses or ER staff apply slings. Dr. Baig submitted the report of another physician who practises Emergency medicine in support of the care he provided Patient A.

3. Committee Process

As part of this investigation, the Committee requested review of the chest x-rays for Patient A by an independent opinion ("IO") provider.

A Family Practice 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 Committee noted that the IO provider who reviewed the chest x-ray found no indication of a burst fracture of the T8 vertebra. The Committee further remarked that this type of fracture can be overlooked if not specifically sought out. This being the case, the Committee could not find fault with Dr. Baig's failing to detect a T8 fracture.

The Committee questioned, however, the thoroughness of Dr. Baig's assessment of Patient A, noting that with a T8 fracture, Patient A would have had tenderness over the area. The Committee noted too that Dr. Baig's charting is lacking in detail and does not document examination of the back.

Overall, the Committee had significant concerns about Dr. Baig's assessment of Patient A, given the nature and mechanism of Patient A's injuries. The Committee felt that Dr. Baig either

ignored or missed Patient A's documented abrasions above and below the left eye, and the patient's complaints of back pain. The Committee noted that trauma induced by a high-speed crash with facial abrasions and significant loss of consciousness requires assessment with a CT scan of the head and likely a cervical spine x-ray, yet Dr. Baig ordered neither of these investigations. The Committee also noted that lack of documentation of a back examination, despite Dr. Baig's assertion that he performed one. With respect to the sling, the Committee felt that a shoulder immobilizer, rather than a sling, would have been more appropriate, given that a sling causes the ulnar nerve to stretch at the elbow, and regrettably this appears to be what happened to Patient A. In addition, the Committee found Dr. Baig's response to the complaint not to be self-reflective, and felt that Dr. Baig offered minimal empathy to Patient A for his prolonged course of treatment and recovery.