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. Hussein Luay Ali Al-Kazely (CPSO #87421)
(the Respondent)

INTRODUCTION

The Respondent provided periodic care to the Patient at a walk-in clinic from 2016 to 2021. In 2018, 2019 and 2021, the Respondent ordered blood work for the Patient which indicated an abnormally high platelet count.

The Patient was later diagnosed with polycythemia vera and passed away.

The Complainant contacted the College of Physicians and Surgeons of Ontario (the College) to express concerns about the care the Respondent provided to the Patient.

COMPLAINANT'S CONCERNS

The Complainant is concerned that the Respondent:

- **failed to report the result of blood tests in 2018 and 2019 which showed a high platelet count to the Patient and the Complainant who later found out that the Patient's platelet count was high when they attended the hospital in March 2021; and,**
- **failed to refer the Patient to a specialist related to the high platelet count.**

COMMITTEE'S DECISION

The Committee considered this matter at its meeting of March 6, 2024. The Committee required the Respondent to appear before a Panel of the Committee to be cautioned with respect to his failure to follow up on abnormal test results and his failure to maintain adequate medical records documentation.

In addition, the Committee required the Respondent to complete a specified continuing remediation and education program (SCERP) consisting of the following elements:

- The successful completion of the next available Medical Record Keeping Program (University of Toronto); Workshop: Test Results Follow-up, (Canadian Medical Protective Association (CMPA)); and the Commitment to Change program (CMPA)

- Self-directed learning (review and written summary of the College's policies, *Medical Record Documentation* and *Managing Tests*, and of specified readings on blood count and hematology, myeloproliferative neoplasms, and polycythemia vera)
- Reassessment of practice to take place six (6) months following the conclusion of the above noted education and learning.

COMMITTEE'S ANALYSIS

When it initially considered this matter in January 2024, the Committee had concerns about the Respondent's care and decided to direct staff to negotiate a voluntary undertaking with the Respondent (in addition to requiring the Respondent to appear for a caution). The Respondent elected not to sign the undertaking.

Upon reconsidering the matter in March 2024, the Committee remained concerned about the Respondent's care in this matter and noted the following:

- The Respondent did not appropriately manage the Patient's abnormal test results in 2018 and 2019 and missed several opportunities to identify and follow up on the Patient's abnormal laboratory results.

- The Patient's records indicate that the blood work the Respondent requested in February 2018 showed a platelet count of 500 (normal range is between 155 and 372). There was no follow-up appointment documented or any indication that the Respondent advised the Patient or her family physician of her abnormal results. The May 2019 blood work ordered by the Respondent showed a platelet count of 793 along with other notable results. While the Respondent advised the Committee that he discussed these results with the Patient and instructed her to follow up on them with her family physician, the chart note associated with that visit does not support this explanation.

- The Respondent's medical records documentation was inadequate. His entries in the Patient's chart are inappropriately brief and do not accurately reflect what the Respondent occurred during their encounters. For example, the Respondent documented very little about his conversation with the Patient and Complainant in March 2021, and nothing about the Patient's extremely high platelet count of over 3000.

- The Committee noted that the Respondent was not insightful in his response. He saw no issue with his management of the Patient's care and therefore did not reflect on how the events of the case might change his practice in the future.

- The Committee was aware that the Respondent's history with the College included several complaints in which the Respondent's medical record keeping and communication was at issue.

Given that the Respondent declined to sign the undertaking, the Committee therefore required that he complete the SCERP outlined above to address the educational needs identified in this case.

Based on the Committee's serious concerns about the Respondent's care, history, and lack of insight, in addition to requiring the Respondent to complete the SCERP, the Committee decided to caution the Respondent with respect to his failure to follow up on abnormal test results and to maintain adequate documentation.