SUMMARY

DR. SHIRAZ HASSANALI ISMAIL (CPSO #27189)

1. Disposition

On May 17, 2017, the Inquiries, Complaints and Reports Committee ("the Committee") required general practitioner Dr. Ismail to appear before a panel of the Committee to be cautioned with respect to his failure to check the patient's creatinine level prior to initiating Pradaxa (an anti-coagulant medication) and discuss the medication change with the family.

2. Introduction

The son of a patient complained to the College that Dr. Ismail failed to provide adequate care to his father at a long-term care facility in June and July 2015. The son expressed concern that Dr. Ismail failed to consult with the family when he changed the patient's medication from Coumadin to Pradaxa, which is known to cause bleeding, and failed to see a rapid deterioration in the patient and send him to the hospital for acute care.

Dr. Ismail explained his decision to change the medication from Coumadin to Pradaxa and noted that he expected to discuss the patient's medications with the family at an upcoming scheduled meeting. When he learned that the family had postponed the meeting, he attempted unsuccessfully to call the family and then left a message with nursing staff to convey his telephone number to the family and notify them as per protocol about the change in the patient's medication.

According to Dr. Ismail, it is his invariable practice to order creatinine levels or have recent creatinine results available prior to making the switch in medication. He noted that it appears in this case that the night nurse on staff failed to use his template requisition form and instead ordered only basic blood work.

Dr. Ismail indicated that it was his understanding that, prior to the medication being administered, the laboratory would call to advise in the event that the patient's creatinine levels were abnormal and that the pharmacy would not dispense the medication without receiving a copy of the blood work confirming the patient's creatinine levels. He also noted that he left on vacation and, when he returned, he learned that the patient had died.

3. Committee Process

As part of this investigation, the Committee retained an Independent Opinion provider ("IO provider") who is a general practitioner involved with chronic and long-term care. The IO provider reviewed the entire written investigative record and submitted a written report to the Committee.

A General 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 IO provider opined that it would have been prudent and good practice for Dr. Ismail to have obtained a creatinine level on the patient prior to switching him from Coumadin to Pradaxa, particularly as the patient was elderly and had undergone nephrectomy. The IO provider concluded that Dr. Ismail demonstrated a lack of knowledge and judgement in making this change in the anticoagulation approach without demonstrating that the change was necessary or that the dosage of Pradaxa was appropriate. He further noted that Dr. Ismail failed to communicate with the patient's family the reasoning for his recommendations.

The Committee agreed with the IO provider's conclusion that Dr. Ismail's care of the patient was inadequate in a number of areas, particularly in his decision to prescribe Pradaxa. As the IO provider noted, Dr. Ismail did not have a baseline creatinine level and did not seem to recognize the need for this, despite being aware of the patient's prior nephrectomy and known renal failure. Though Dr. Ismail stated that it is his standard practice to order a creatinine level, it did not happen in this case and the result was that Dr. Ismail ordered a change to the patient's anticoagulant without the requisite blood work and without ensuring the family had provided consent for the medication change.

It was concerning to the Committee that Dr. Ismail did not appear to recognize that it was his responsibility to ensure that he checked the patient's creatinine clearance for a medication he ordered. It appeared to the Committee that Dr. Ismail tried to deflect the responsibility for the medication being administered without the requisite blood work to the laboratory and the pharmacy.

Dr. Ismail should have had a discussion with the patient's family regarding the risks and benefits of switching the patient to Pradaxa. This was especially necessary as Dr. Ismail was using the medication off-label and in light of the patient's history of nephrectomy and renal failure.

The Committee recognizes that Dr. Ismail had a plan to discuss the change in medications with the family during a scheduled meeting that the family cancelled. Dr. Ismail did not make subsequent attempts to contact the family, however, and there is no evidence in the record that nursing staff consulted with the family.

Based on the above, the Committee decided to require Dr. Ismail to attend at the College to be cautioned in this matter.

The Committee noted that Dr. Ismail was not in attendance when the patient's condition deteriorated, as he was on vacation at that point. The patient was in the care of nursing staff

and on-call physician who made the decision to send the patient to hospital for acute care. The Committee saw no reason to take action on this aspect of the complaint against Dr. Ismail.