

SUMMARY

DR. PRADEEP JOHN ALEXANDER (CPSO #73447)

1. Disposition

On March 22, 2017, the Inquiries, Complaints and Reports Committee (“the Committee”) ordered orthopedic surgeon Dr. Alexander to complete a specified continuing education and remediation program (“SCERP”). The SCERP requires Dr. Alexander to:

- Attend and successfully complete the next available session of the following courses:
 - The Medical Record-Keeping course, through a course provider indicated by the College
 - Two Canadian Medical Protective Association webinars on medical records
- Successfully complete one-to-one instruction to the satisfaction of the College
- Review the following College policies and clinical practice guidelines:
 - *Medical Records* policy (#4-12)
 - *Consent to Treatment* policy (#3-15)
 - *The Practice Guide: Medical Professionalism and College Policies*
- Prepare written summaries of the above-noted policies and guidelines and submit them to the College to ensure completeness of the review
- Engage in focused educational sessions, in person, with a clinical supervisor acceptable to the College for a period of six months
- Undergo reassessment approximately six months following completion of the educational plan.

In addition, the Committee required Dr. Alexander to appear before a panel of the Committee to be cautioned with respect to his continuing pattern of behaviour that has not improved despite College interventions.

2. Introduction

A patient complained to the College that Dr. Alexander failed to provide him with appropriate care and communicate in a professional manner between 2013 and 2016, while the patient was under Dr. Alexander's care for a right foot Haglund's deformity.

The patient expressed concern that Dr. Alexander failed to inform him of the potential risks and benefits of an arthroscopic procedure to remove the Haglund's deformity, chose to remove the deformity arthroscopically though he was not trained to do so and this is not the standard of care, and caused iatrogenic damage to the posterior tibial nerve at the right ankle during surgery. In addition, the patient expressed concern that Dr. Alexander failed to follow up on the results of tests he ordered and failed to communicate with him at all once the nerve damage was confirmed. The patient reported that Dr. Alexander was callous and dismissive in his attitude toward him.

Dr. Alexander indicated that it is his practice to discuss the risks of surgery with his patients and that, during his consultation with the patient in this case, he would have explained the risks of nerve damage, infection, stiffness, and possible tearing requiring conversion to open surgery. Dr. Alexander indicated that he has a form that patients sign and date after he has explained the risks, but his office has been unable to locate the patient's signed form in this case.

Dr. Alexander indicated that he is fully qualified and trained to perform ankle arthroscopy, but he acknowledged that the patient's posterior tibial nerve was damaged during the surgery in March 2014. He expressed regret for this. Dr. Alexander noted that the patient's tests indicated abnormalities but the results were not conclusive, meaning that they did not require immediate follow-up. Dr. Alexander denied that he was callous or dismissive in his communication toward the patient.

3. Committee Process

As part of this investigation, the Committee retained an Independent Opinion provider (“IO provider”) who specializes in orthopedic surgery. 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.cpsso.on.ca, under the heading “Policies & Publications.”

4. Committee’s Analysis

The IO provider opined that there was clear evidence that Dr. Alexander’s care of the patient fell below the expected standard in four specific areas:

- Informed consent, specifically in the lack of clear documentation surrounding the risks and issues related to surgery
- Routine post-operative follow-up
- Follow-up or discussion of test results
- Medical documentation.

The IO provider was of the view that Dr. Alexander’s care of the patient demonstrated a lack of skill, knowledge or judgement in relation to the four areas specified above and that these deficiencies exposed the patient to risk of harm.

The IO provider did not find that Dr. Alexander’s surgical care of the patient was inappropriate on the basis that the patient experienced a surgical complication. The IO provider noted that it was impossible from the documentation to determine if Dr. Alexander took the appropriate precautions to avoid the injury, but that it would be reasonable to assume Dr. Alexander took these precautions given his assertion that he performs this type of procedure regularly.

The Committee agreed with the IO provider's conclusion that the fact that the patient experienced a trocar-related nerve injury was not an indication of inappropriate surgical care. Trocar-related nerve injury is a rare but known complication of this difficult surgery.

The Committee also agreed with the IO provider's conclusion that Dr. Alexander's management of the patient was characterized by inadequate communication, follow-up and documentation, and that the consent process was lacking.

In this case, the proposed surgical procedure was relatively challenging and it was not apparent from the documentation that Dr. Alexander informed the patient of the risks and benefits of the procedure to ensure that he had the patient's informed consent. According to his letter of complaint, the patient had the impression from his brief and casual discussions with Dr. Alexander that the procedure was a simple one. There is no documentation to indicate that Dr. Alexander discussed with the patient the particular risks of the arthroscopic approach, which allows for less visualization of the nerve and therefore involves a slightly greater chance of damaging the nerve than with an open incision.

Though Dr. Alexander reported that he discussed the risks and benefits of the surgery with the patient, he could not produce the standard form he uses in these discussions.

The Committee accepted Dr. Alexander's explanation that he is trained in the arthroscopic approach and has completed approximately 70 of these procedures to date. The Committee was satisfied that there is support in the literature for taking an arthroscopic approach to surgery for a Haglund's deformity.

Following the procedure, the patient advised Dr. Alexander that he was experiencing numbness and other symptoms. The testing showed the possibility of injury to both the peroneal and posterior tibial nerves. With this indication that the surgery had resulted in tibial nerve damage, Dr. Alexander should have provided appropriate follow-up. Instead, he reassured the patient on more than one occasion that his recovery was normal and the symptoms would improve. It appeared to the Committee that Dr. Alexander was not appropriately responsive to the patient's ongoing concerns.

Dr. Alexander claimed that he told the patient to make an appointment after he underwent electromyogram (“EMG”), a claim that the patient denied. In the Committee’s view, Dr. Alexander should not have put the onus on the patient to follow up but should likely have arranged an appointment after the booking date for the EMG and certainly after receiving the EMG result. Overall, Dr. Alexander should have been more meticulous in both his follow-up and his post-operative communication with the patient.

The Committee noted that some of the themes in this matter (inadequate pre-operative communication in the form of the consent discussion and poor post-operative communication demonstrated by inadequate follow-up care and test result management) have been the focus of previous College interventions with Dr. Alexander. Taking into account Dr. Alexander’s failure to correct his deficiencies in light of the Committee’s previous dispositions in these areas, the Committee decided to require Dr. Alexander to attend at the College to be cautioned in person with respect to his continuing pattern of behaviour that has not improved despite College interventions and has resurfaced in the current complaint.

Furthermore, the Committee decided to require Dr. Alexander to complete the SCERP to address the documentation and clinical management issues arising from this matter.