SUMMARY

DR. OLAYIWOLA KASSIM (CPSO# 50889)

1. Disposition

On August 23, 2017, the Inquiries, Complaints and Reports Committee (the Committee) required pathologist Dr. Kassim to appear before a panel of the Committee to be cautioned with respect to failure to diagnose the pathology of carcinoid of the appendix.

2. Introduction

A patient complained to the College that Dr. Kassim failed to provide adequate care in reading the patient's pathology report in October 2011; specifically, Dr. Kassim failed to correctly diagnose the patient's appendix malignancy in 2011, causing a delay in treatment and possibly preventing the patient's recent terminal diagnosis. [Subsequent to lodging the complaint, the patient died.]

Dr. Kassim acknowledged that he missed the diagnosis in a setting of acute appendicitis and peri-appendicitis with fibrosis. He noted that in 2012 he made changes to his practice which would decrease the likelihood of a similar misdiagnosis in future. He explained that he revised his original report when he became aware several years later—after comparing pathology from the patient's subsequent cancer diagnosis to his original report—that he had failed to diagnose the presence of a carcinoid of the appendix in October 2011.

3. Committee Process

As part of this investigation, the Committee retained an Independent Opinion provider (IO provider) who specializes in pathology. 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/investigation. 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 the IO provider's opinion that Dr. Kassim did not meet the standard of care in failing to make the diagnosis of carcinoid of the appendix. The Committee acknowledged Dr. Kassim's opinion provider's view that there were mitigating factors involved in the missed diagnosis. The Committee further noted the IO provider's acknowledgement that there were several factors that may have contributed to the missed diagnosis and agreement that Dr. Kassim displayed good knowledge and due diligence when he discovered the error, taking proper steps at that point (including referring the patient for a second opinion and providing and addendum report to his October 2011 report).

In reviewing the investigative record, the Committee agreed with the patient's concern that there was a significant error in the years-long delayed diagnosis of cancer. The Committee noted that both its own IO provider and Dr. Kassim's opinion provider agreed that Dr. Kassim had misdiagnosed the cancer in October 2011. The Committee acknowledged the important changes Dr. Kassim had made to his practice and his appropriate response when he realized he had missed the diagnosis. Nevertheless, the Committee determined that, given the missed diagnosis of a terminal illness, it was reasonable to caution Dr. Kassim on the missed diagnosis.