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. Azhar Mahmood Malik (CPSO #57290)
(the Respondent)

INTRODUCTION

The Complainant was transferred via CritiCall from one hospital emergency room (ER) to another with symptoms of significant pain and vascular compromise of his left leg. The Respondent (a general surgeon who also does vascular surgery) accepted the transfer and was the Complainant's Most Responsible Physician (MRP).

The Complainant contacted the College of Physicians and Surgeons of Ontario (the College) to express concerns about the Respondent's care and conduct, as follows:

COMPLAINANT'S CONCERNS

The Complainant is concerned that the Respondent conducted himself in an unprofessional manner and inadequately assessed him and inadequately managed his care during his admission. Specifically, the Respondent

- **Failed to adequately assess the Complainant, manage his pre-operative pain, or recognize the severity of his condition;**
- **Communicated with the Complainant in an inadequate manner, including failing to sufficiently inform him about his treatment plan and the risks and benefits of surgery;**
- **Contributed to a delay in the Complainant receiving surgery, which potentially precipitated his development of ongoing post-operative symptoms including left leg numbness, pain, decrease in balance, and swelling;**
- **Directed a course of treatment which he knew or ought to have known was, at best, inadequate (blood thinners); and,**
- **Ended his interaction with the Complainant on one occasion because, "Well, by then it was midnight", as per a quote from a statement allegedly made by the Respondent at a meeting with the Complainant and three witnesses.**

COMMITTEE'S DECISION

A Surgical Panel of the Committee considered this matter at its meeting of July 5, 2019. The Committee directed an undertaking and required the Respondent to attend at the College to be cautioned in person with respect to the principles of limb salvage in the face of ischemia and his responsibility to exercise good judgment when accepting patients through CritiCall.

The Respondent signed an undertaking which included clinical supervision, a practice reassessment, the University of Toronto Medical Record Keeping Course, the CMPA Documentation Modules 1 and 2, the Learning Module of the Society of Vascular Surgery Self-Assessment Program, the Saegis Course: Effective Team Interactions, and a review and written summary of the College's *Medical Records, Consent to Treatment, Disclosure of Harm, and The Practice Guide* policies.

COMMITTEE'S ANALYSIS

Re: Failed to adequately assess the Complainant, manage his pre-operative pain, or recognize the severity of his condition
-AND-
Re: Directed a course of treatment which he knew or ought to have known was, at best, inadequate (blood thinners)
-AND-
Re: Contributed to a delay in the Complainant receiving surgery, which potentially precipitated his development of ongoing post-operative symptoms including left leg numbness, pain, decrease in balance, and swelling

- As part of this investigation, the Committee retained an independent Assessor who specializes in vascular surgery. The Assessor opined that the Respondent's care was below standard in this case. He determined that the Respondent also did not document the Complainant's lack of motor function, and that delaying the Complainant's surgery was very poor judgment.

- The medical record shows that the Respondent examined the Complainant and deferred his pain management to another physician in the Intensive Care Unit (ICU). However, unlike the physician he referred to, the Respondent failed to recognize that the severity of the Complainant's pain was due to ischemia in his leg, and did not document critical clinical features of severe ischemia (including uncontrollable pain and muscle weakness).

- The Respondent ordered the correct test, which showed severe ischemia (a surgical emergency). Yet, the Respondent chose to prescribe anticoagulants to the Complainant overnight and do another angiogram the next day. While the Respondent did not err in prescribing anticoagulation medication until surgery was available, he erred by using it as a replacement for timely surgical intervention. This delay could have exposed the Complainant to life and limb-threatening complications.

- While the Committee recognized that the Respondent provided information from another physician that agreed that delaying surgery was good judgment, the Committee agreed with the College's Assessor that delaying the Complainant's surgery created a major risk to the Complainant's well-being and represented a major error in judgment.

- The Committee noted that there is no conclusive information that would indicate the delay caused the Complainant's post-operative symptoms. Therefore, the Committee took no further action in that regard.

- Given all of the above, the Committee concluded that an undertaking with educational components including supervision) and a caution from the College with regards to the principles of limb salvage would be the appropriate disposition.

Re: Communicated with the Complainant in an inadequate manner, including failing to sufficiently inform him about his treatment plan and the risks and benefits of surgery

- The Committee is limited to a documentary review only. In reviewing the record, the Committee could not conclude whether or not there was inadequate communication between the Complainant and Respondent.

Re: Ended his interaction with the Complainant on one occasion because "well, by then it was midnight", as per a quote from a statement allegedly made by the Respondent at a meeting with the Complainant and three witnesses

- The Respondent explained that he did not think a major vascular surgery could be safely done in his community hospital setting until the full team was present the following morning. However, if this was the case, then the Respondent should never have accepted the referral from CritiCall in the first place.

- The ER the Respondent works in is a referral centre for vascular emergencies, and needs to be able to provide such care expediently. Accepting such a referral when the care could not be provided displayed poor judgment. The fact that the Respondent seemed unequipped to act expediently on the referral raises questions about whether the Respondent is able to provide appropriate care with regards to emergency vascular surgery. This further highlighted the need for further education, clinical supervision, and attending the College to be cautioned regarding his practice.