

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

INTRODUCTION

The Complainant first saw the Respondent in 2014. Their last interaction was in September 2020.

The Complainant contacted the College of Physicians and Surgeons of Ontario (the College) to express concerns about the Respondent's conduct.

COMPLAINANT'S CONCERNS

The Complainant is concerned about the Respondent's unprofessional and aggressive conduct toward her as follows:

- **He tried to rush through her appointments with him and he scolded her while she was speaking and informed her that there is only one complaint per visit.**
- **He called her in May 2020 and stated that she wasn't seeing him enough, accused her of switching to another family doctor, and threatened to drop her as a patient if she did not book appointments to see him only.**
- **He told her to find another doctor, during an appointment with him in September 2020, after she told him that she had attended another walk-in clinic when he was away in the summer of 2020. When she showed him her blood test results, as ordered by the doctor at the other walk-in clinic, he yelled at her in the waiting area and rudely said that everything is fine despite one test not being within normal range.**
- **He humiliated her in front of his female receptionist and another clinic physician when she attended at the clinic to see the physician about taking her on as a patient. The Respondent, who was at the reception area, spoke angrily to her about her accusing him of telling her to switch physicians and told her to leave the clinic and not return after he had indicated he would give her 3 months before she had to find another physician.**
- **He requested her medical records from a physician without her consent.**

COMMITTEE'S DECISION

On April 8, 2021, the Committee considered this matter and decided that it was prepared to accept an undertaking from the Respondent. The Respondent declined to enter into an undertaking.

A General Panel of the Committee considered this matter at its meeting of June 9, 2021. The Committee required the Respondent to attend at the College to complete a specified continuing remediation and education program (SCERP) consisting of individualized coaching in communications, to be facilitated by the College; review and reflection on The Practice Guide of the College; and review of the College policies *Ending the Physician-Patient Relationship* and *Medical Records Documentation*, and the Canadian Medical Protective Association's article "Limiting discussion to one medical issue per visit: Know the risks", with a written summary for each topic provided to the College.

COMMITTEE'S ANALYSIS

Re: Unprofessional communications and conduct

The Committee is limited to a documentary review and where parties disagree as to their communications, it is unable to determine whose recollection is closer to the truth unless there is independent information to support either version of events. There was only witness information with respect to one interaction and that was from clinic staff and so not entirely independent.

Though the Committee was unable to know with certainty what occurred during any particular interaction between the Respondent and the Complainant, it noted that the Respondent had several prior College complaints in which concerns were raised about his communications.

The Committee was concerned that a pattern was emerging of communications complaints and believes that the Respondent can improve his communications and reduce complaints by working with a communications coach and reflecting on his communications with patients and how he is perceived.

In reviewing the investigative record, the Committee also observed that some of the Respondent's communications with the College investigator appeared to have lacked professionalism and were dismissiveness.

Re: Inappropriately terminated care

There was some uncertainty as to whether it was the Respondent or the Complainant who first suggested to end the physician-patient relationship. It is evident that the relationship ended on September 30, 2020, as the Respondent documented in the chart.

At that point, the Respondent should have followed the College policy on *Ending the Physician-Patient Relationship* and provided written notification of the termination to the Complainant as well, which he failed to do.

Re: Limiting patients to one issue or complaint per visit

Signs posted in the clinic, and the Respondent's description of his process, support that the clinic had a policy of one issue per visit. Having a starting point of patients believing they can only discuss one issue creates an environment in which patients already feel constrained on what they can discuss. This is further exacerbated if the Respondent is then reminding patients how busy he or the clinic is, and this may prevent patients from feeling they are able to take time to explain their medical issues.

Patients are not expected to prioritize their medical concerns or recognize which symptoms may reflect a more serious medical condition, nor are they expected to recognize what symptoms might be interrelated to one another and have a similar cause. In the Committee's view, having a rule or policy in place that patients can only report one issue per visit may not only upset patients but compromise providing comprehensive care insofar as patients cannot always determine which issues reflect a significant concern. They may also think one issue means one symptom which can lead to an incorrect diagnosis.

The Committee acknowledges that there is a balance in managing office flow with patient concerns. However, patients' health care needs should not be compromised by one's office administration.

Re: Medical Record-keeping

In the course of reviewing the chart with respect to this complaint, the Committee found the Respondent's documentation to be overly brief. As a result, there was a lack of clarity regarding the patient encounter and the care provided.

The Committee previously ordered the Respondent to complete education to improve his record-keeping. Given the records in this case, it seems the Respondent must continue to take steps to improve his record-keeping and implement this in his practice.

Re: Privacy/Confidentiality of medical records

The Committee took no further action on the concern respecting requesting the Complainant's medical records without her consent as this was done appropriately as part of the College complaint process.