

SUMMARY

Dr. Ejaz Ahmed Ghumman (CPSO#86121)

1. Disposition

On April 13, 2018, the Inquiries, Complaints and Reports Committee (the Committee) required general surgeon Dr. Ghumman to appear before a panel of the Committee to be cautioned with respect to inadequate medical record-keeping, management and treatment of sigmoid volvulus, and the indications for ileostomies.

2. Introduction

In August 2013, Dr. Ghumman performed a laparotomy, division of adhesions, resection of sigmoid and colostomy (Hartmann's procedure) for management of a sigmoid volvulus on a male adult patient. In February 2014, Dr. Ghumman performed a reversal of Hartmann's (reanastomosed the colon) on the patient. The patient complained to the College that during the reversal of Hartmann's operation on the left side, Dr. Ghumman created a loop ileostomy on the right side, without explaining the rationale or explaining preoperatively that it could be a possibility; that Dr. Ghumman secured the loop ileostomy improperly, which caused it to prolapse; that Dr. Ghumman discharged the patient home prematurely after the reversal of Hartmann's procedure; that Dr. Ghumman failed to perform closure of the loop ileostomy in a timely manner, causing the patient's bowels to close; and that Dr. Ghumman had not been honest with the patient regarding the prolapse of the stoma or about a barium enema test.

Dr. Ghumman provided an explanation of his actions in this case, and his counsel provided the College with an opinion from another surgeon (Dr. Smith) commenting on Dr. Ghumman's care. Further, the College obtained an Independent Opinion from a general surgeon.

3. Committee Process

A Surgical 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 Committee identified several problems with Dr. Ghumman's approach in this case, as had the independent opinion provider. Problems included:

- deficiencies in medical record-keeping (including accepting and signing off on documentation which was erroneous)
- a judgment error in placing a drain adjacent to the bowel anastomotic site, as such placement could have had impact on healing
- questionable judgment in proceeding to ileostomy, as ileostomy is not without morbidity, and as there has been a steady move away from performing these, even with some complicated rectal resections; further, Dr. Ghumman's rationale that he ileostomy because of perceived proximal small bowel problems did not, in fact, provide a justification
- questionable judgment in doing the 2014 emergency Hartmann's Procedure in the first place, as emergency surgery is rarely required in situations like the patient's and is usually done only if there is non-viable sigmoid.

In reaching a disposition, the Committee noted the fact (which is a matter of public record) that the College's Discipline Committee placed Dr. Ghumman under supervision for one year, beginning in July 2017, and that he has done significant remediation as part of that supervision,

which post-dates the care in this case. Further, the Committee was reassured by the fact that Dr. Ghumman still has to undergo College-mandated reassessment, as set out in the 2017 order of the Discipline Committee.

Taking into account Dr. Ghumman's College history, including the supervision and the upcoming reassessment, and the Committee's concerns about his care of the patient in this case, the Committee concluded that the most appropriate disposition was to require Dr. Ghumman to attend the College to be cautioned.