

**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. Walid Al-Houssan (CPSO #85716)
(the Respondent)**

INTRODUCTION

The Complainant developed abdominal pain and bleeding a year after having an intrauterine device (IUD) inserted. She saw the Respondent to ensure the IUD was in place. The Complainant says that the Respondent did not do an examination but sent her for blood work and a pregnancy test. The following day, the Respondent called the Complainant into his office and informed her that she was pregnant. The Complainant reported that she was upset by the news, and the Respondent's lack of bedside manner made her uncomfortable. According to the Complainant, the Respondent was insensitive and did not discuss the dangers of being pregnant with an IUD or what she needed to do about it; he did advise her that she needed an ultrasound, but did not tell her where to get one or send her to the hospital for an emergency ultrasound.

Two days later, the Complainant fainted at work, and had to have emergency surgery for an ectopic pregnancy.

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

COMPLAINANT'S CONCERNS

The Complainant is concerned about the medical care and conduct of the Respondent. Specifically, she is concerned that he failed to:

- **Send her to the hospital when he learned she had an IUD and was pregnant;**
- **Provide her with any information regarding her present and future care, including where to get an ultrasound and blood work; and,**
- **Treat her in a professional manner when he made inappropriate comments regarding her behaviour upon learning she was pregnant.**

COMMITTEE'S DECISION

A Family Practice Panel of the Committee considered this matter at its meeting of July 25, 2019. The Committee required the Respondent to attend at the College to be cautioned in person with respect to his investigation and management of pregnant patients with lower abdominal

pain, and complete a specified continuing remediation and education program (SCERP) consisting of:

- Course work, including: the University of Toronto Medical Record-Keeping Course; the Canadian Medical Protective Association Documentation 1 and 2 modules; and the SAEGIS Successful Patient Interactions course
- One-to-one instruction regarding the identified issues of concern, and how to avoid them in the future
- Self-directed learning with regards to the College's *Medical Records* policy, and reflecting on his management of pregnant patients presenting with abdominal pain and/or vaginal bleeding
- Clinical supervision regarding his management and investigation of pregnant patients presenting with abdominal pain and vaginal bleeding, and his communications and record-keeping; and
- Reassessment of practice after completion of the educational program.

COMMITTEE'S ANALYSIS

As part of this investigation, the Committee retained an independent Assessor who practises Emergency Medicine. The Assessor opined that the Respondent did not meet the standard, displayed a lack of knowledge, skill and judgment, and exposed the Complainant to a risk of harm.

The Committee agreed with the Assessor's findings. The Respondent did not have a differential diagnosis and demonstrated no urgency. He should have, at a minimum, told the Complainant to go to the emergency room immediately. The severity of his error in this situation could have cost the Complainant her life.

The Committee also noted that the Respondent's documentation was very poor, his communication skills in this case were not acceptable, and he lacked insight into his errors. Overall, the Respondent showed very little insight into understanding the danger in this case or the emotions of someone who was avoiding pregnancy.

In addition to the very serious outcome for the patient, the Committee further noted that the Respondent has a long and concerning College history and that, despite multiple educational efforts, the Respondent has not brought his practice to an appropriate level. As a result, the Committee was of the view that more intensive education and supervision were required.