SUMMARY

DR. HAIDER HASNAIN (CPSO #64959)

1. Disposition

On July 13, 2017, the Inquiries, Complaints and Reports Committee (the Committee) required family physician Dr. Hasnain to appear before a panel of the Committee to be cautioned with respect to appropriate medical record keeping and termination of the physician-patient relationship.

2. Introduction

A patient complained to the College that Dr. Hasnain behaved in an unprofessional manner toward her from January to September 2016. Specifically, the patient expressed concern that Dr. Hasnain would not ask her the purpose of her visit and would communicate with her only through a nurse, failed to refer her to a pain specialist or other specialists, decreased her pain medication by half without informing her, allowed his office staff to inform her that he would not see her to discuss her pain medications, and inappropriately ended the physician-patient relationship.

Dr. Hasnain responded that he and the patient discussed the benefits of reducing her narcotic dosage and the importance of taking only the prescribed dose of pain medication, as he indicated to her that he would not refill her prescription early. He indicated that he terminated the physician-patient relationship with the patient at her request but that he would take extra care in the future to make sure that the patient intended to terminate the physician-patient relationship.

3. Committee Process

A Family Practice 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 was unable to determine from the documentation whether Dr. Hasnain's decision to reduce the patient's narcotics dose was reasonable. There was little documentation in the medical record to describe the causes of the patient's pain and the Committee could not find details of Dr. Hasnain's examinations of the patient in the medical record.

Dr. Hasnain used an opioid tool and monitored the patient through urine drug screens, which was appropriate. It was not clear from the record, however, how the results of the urine drug screens were conveyed to the patient or whether the results influenced Dr. Hasnain's prescribing.

The lack of documentation meant that the Committee was unable to determine why Dr. Hasnain altered the patient's narcotics dose or whether he discussed the change with her as he claimed. With regard to this specific area of concern, the Committee noted that Dr. Hasnain is currently practising under supervision as a result of a disposition in a separate College matter. Given that this supervision is intended to assist Dr. Hasnain in improving issues with his prescribing, the Committee was of the view that no additional action was required in the current matter with regard to prescribing. The Committee therefore stated only that it expects physicians to communicate with patients about changes to their medications.

The patient and Dr. Hasnain provided differing versions of events about the end of the physician-patient relationship. According to the patient, she learned during her hospital admission that Dr. Hasnain had informed another physician that he, Dr. Hasnain, would no longer provide her with medical care. She indicated that Dr. Hasnain never communicated with her about his decision to discharge her from his practice.

Dr. Hasnain acknowledged that he did indicate to the patient's physician during her hospitalization that he could no longer act as her physician, but he maintained that he had already ended the professional relationship at the patient's request after she stated in his office that she was "done with Dr. Hasnain." Dr. Hasnain stated that he reviewed the College's *Ending the Physician-Patient Relationship* policy while responding to this complaint and it is his practice to comply with the policy when he terminates the physician-patient relationship, including by sending the patient proper notice.

The College's policy on ending the physician-patient relationship sets out the requirement that the decision to terminate must always be communicated to the patient in writing. Dr. Hasnain should have been fully aware of his obligations under the policy as he had recently responded to a separate patient complaint, lodged at the College in March 2016, on the issue of inappropriately terminating a patient from his practice.

There was no documentation in the medical record regarding the patient's decision to leave the practice. The patient's signature did not appear on the Primary Health Care Request to Remove a Patient form that Dr. Hasnain's office sent to the Ministry of Health and Long-Term Care. There was no way to confirm that the patient was terminated from the practice at her request as the form indicated. Furthermore, it was not apparent to the Committee that the statement members of Dr. Hasnain's staff claimed the patient made to them was sufficient indication that she wanted to leave the practice. Given the lack of clarity with regard to the patient's wishes, it was important that Dr. Hasnain document clearly in the medical record that he would no longer be seeing the patient and notify her of this fact through a letter sent by registered mail. As he

did not do so, and in light of his history in regard to inappropriately terminating patients from his practice, the Committee decided that a caution was warranted on this issue.

As indicated above, the Committee had concerns about Dr. Hasnain's medical record-keeping. Not only were his notes overly templated and, in the case of the patient, lacking in detail about her clinical situation (including the cause of her pain), his examinations, and any discussions he had with the patient about the efficacy of her medications or his decision to reduce her doses, but it was also often unclear to the Committee who saw the patient at a given encounter, Dr. Hasnain or the nurse.

While it is reasonable that the nurse handles some patient encounters and provides some prescriptions, the Committee expects that Dr. Hasnain would see patients himself when a change to their medical treatment has been made (or is needed) and follow-up of the change is warranted. It was not apparent to the Committee that Dr. Hasnain, not the nurse, saw the patient in these circumstances.

Dr. Hasnain indicated to the College that the nurse makes a note in the medical record after seeing the patient and he signs off on the note when he completes his billing, which can be weeks or even months after the encounter.

Notes should be completed contemporaneously with the medical care. In the Committee's view, Dr. Hasnain should have a better mechanism for ensuring that he bills for the services he provides that involves less delay in signing off on the notes in the medical record.

In light of the above, the Committee decided that it was appropriate to add to the caution the issue of inadequate and unclear records.