SUMMARY

Dr. Mohamed Buhary Hussain Faizer (CPSO# 67210)

1. Disposition

On November 23, 2016, the Inquiries, Complaints and Reports Committee ("the Committee") required Dr. Faizer, a general practitioner, to appear before a panel of the Committee to be cautioned with respect to reviewing medication reconciliations to ensure that they are accurate in terms of the patient, the medication, and dosages.

2. Introduction

A patient complained to the College that during a hospital admission Dr. Faizer inadvertently ordered the wrong medications for her. In particular, she expressed concern that Dr. Faizer inappropriately ordered medications for her that were intended for another patient, which resulted in her being administered and consuming the wrong drugs and dosages, and that Dr. Faizer failed to disclose the medication error to her.

Dr. Faizer responded that while the complainant was in hospital he was not her Most Responsible Physician ("MRP") and saw her for supportive care only. He indicated that during this time a male patient with the same first name as the complainant's last name was admitted under his care. He explained that hospital policy is to create a medication profile for patients through the pharmacy and that while both patients were in hospital he signed a reconciliation for the male patient (the "medication reconciliation") that was inadvertently placed in the complainant's chart. He indicated that neither the pharmacy technician nor the nursing staff alerted him to this mistake and that he was unaware of it until he received the letter of complaint. He said that had he known about the error he would have disclosed it to the complainant.

The general surgeon who was the complainant's MRP while she was in the hospital indicated that when he looked at the complainant's medication list he saw two medications that he did not remember from his original surgical consultation. He stated that when he reviewed the complainant's chart he found that these medications belonged to another patient. He indicated that when he discovered that the complainant had received 48 hours' worth of wrong medication he immediately divulged the error to her. He subsequently monitored the complainant for

adverse outcomes and stated that in the end the error did not result in any demonstrable harm to the complainant and it did not prolong her stay in hospital.

A family physician who works at the hospital indicated that the hospital has investigated this matter and that as a result it has invested in an electronic medical record and ordering system to try to prevent similar mistake from occuring in the future.

3. Committee Process.

A panel of the Committee, consisting of both public and physician members, met in order 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 noted that Dr. Faizer seemed to want to deflect responsibility for the error to the pharmacy technician for putting his male patient's medication reconciliation in the wrong chart.

In the Committee's view, the error that occurred here was not the pharmacy technician's fault. It appeared from the record before the Committee that Dr. Faizer confused his male patient with the complainant because of their similar names and that he or someone else wrote medications for his male patient on the complainant's medication reconciliation, which he then signed, and which the technician then placed in the complainant's chart. The medication mixup that occurred was therefore due to Dr. Faizer's careless error. Dr. Faizer ultimately failed to review the medication reconciliation before he signed it, which resulted in the complainant being administered and consuming wrong medications for two days. This put the complainant at a risk of harm due to the type of medication she incorrectly received.

The Committee was therefore concerned about Dr. Faizer's carelessness in this particular case and was also concerned about his attempt to deflect responsibility for the medication mixup.

This is not the first time that Dr. Faizer has received a complaint regarding his record-keeping. In 2013,the Committee cautioned Dr. Faizer in person with regards to his medical records and in 2014 required him to completed a specified continuing education program in this area. Confusing patient records is another example of issues related to record-keeping.

The Committee did not accept Dr. Faizer's response that he was unaware of the error at the time. There is documentation that he was notified about it; hence his response is simply not believable. It appeared to the Committee that, despite being notified about the mistake in the medication reconciliation, and despite visiting the complainant on a daily basis, Dr. Faizer made no mention of the error to her. From the Committee's perspective, this conduct is unacceptable and not in accordance with College policies. The College's policy on *Disclosure of Harm* clearly states physicians must disclose incidents causing harm, along with the material consequences of the incident, and actions that have been taken and what is recommended to address the consequences, including options for follow-up. Even if no actual harm befalls a patient, which was fortunately the situation for the complainant, physicians should still disclose any "close calls" if there is a safety risk, as there clearly was in this particular case.