SUMMARY

Dr. Gul Nawaz Sheikh (CPSO# 87428)

1. Disposition

On April 13, 2016, the Inquiries, Complaints and Reports Committee ("the Committee") required internal medicine specialist Dr. Sheikh to appear before a panel of the Committee to be cautioned with respect to consulting with a nephrologist and taking urgent action on a patient whose creatinine is elevated for days, and to documenting transfer of care to the next MRP, and writing a transfer note immediately so that it can accompany the patient on transfer.

2. Introduction

A deceased patient's family member complained to the College that Dr. Sheikh had failed to adequately treat the patient's kidney failure; had failed to transfer the patient to a hospital in another city for dialysis; had failed to assess, diagnose, and treat the patient's laboured breathing; had failed to assess, diagnose, or treat the patient's ongoing pain and difficulty voiding; had ordered blood thinners; and had failed to monitor his international normalized ratio (INR).

The family member also complained about Dr. Sheikh's conduct, alleging that he had blamed the family for stalling the patient's discharge to another hospital for dialysis; advised the family that if they wanted the patient transferred to a particular hospital in another city, they would have to find a bed for him, and an accepting physician; and, during a family meeting, had advised the family that in order to transfer the patient to the hospital they were requesting, he would have to discharge the patient, and the family would have to drive the patient to the Emergency Room of that other hospital.

Dr. Sheikh responded that he had provided appropriate medical care to the patient, including making efforts to have the patient transferred and following up with a physician whom the family thought could facilitate transfer. He noted that laboured breathing and difficulty voiding were not concerning issues during his period of care. He stated that the patient was on prophylactic anticoagulation and did not require INR monitoring. He denied the communications and statements attributed to him.

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." The Committee referenced Policy #4-12, *Medical Records*.

4. Committee's Analysis

The patient's renal function did not improve over the course of his hospital stay from November 1 to November 15. Dr. Sheikh was away (and therefore was not the Most Responsible Physician – MRP) from November 2 – 9. The Committee was at a loss to explain why Dr. Sheikh did not take active steps upon resuming the patient's care on November 10, such as calling the nephrologist who initially saw the patient in the hospital to discuss the case, or personally telephoning the nephrologist on-call at the hospital where the family wished admission, to discuss the case and get direction. The patient was sick, and the Committee felt that Dr. Sheikh should have initiated physician-to-physician discussion between himself and a nephrologist at a hospital which could have received the patient and provided dialysis, so as to arrange transfer.

Further, when the patient was transferred to another hospital for dialysis, Dr. Sheikh did not dictate a discharge note until three months later. Physicians transferring a complicated patient generally complete the discharge summary at time of discharge, and send a copy along to the receiving hospital. The College's Policy on Medical Records states that if the physician anticipates delay in dictating the discharge summary, they should send along a brief summary for the receiving physician. The Committee noted that Dr. Sheikh did not do this. Nor did he properly document transfer of care when he left on November 1.

The Committee did not find information in the chart to substantiate concerns that the patient had laboured breathing or pain/difficulty voiding, which warranted investigation. Ordering prophylactic blood thinners was acceptable care.

The Committee could not, on its review of documentation, substantiate the family's concerns about Dr. Sheikh's communications/conduct.