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 failed to provide him with appropriate care from 2010 to 2016. Specifically, the patient expressed concern that Dr. Hasnain decreased his pain medications without informing him or providing treatment for his withdrawal symptoms, directed him to fill his prescriptions at a specific pharmacy, refused to order an MRI scan to investigate the cause of the patient's severe back pain, performed a digital rectal examination (DRE) without first explaining the examination to the patient, and inappropriately ended the physician-patient relationship.

Dr. Hasnain responded that he informed the patient that he would be reducing the patient's narcotics dose for safety reasons and due to concerns of possible respiratory depression. He denied that he directed the patient to fill his prescriptions at a specific pharmacy, though he acknowledged that he keeps track of all controlled substances he prescribes and must know exactly which pharmacy the patient is using.

Dr. Hasnain stated that he ordered an MRI for the patient. He indicated he never performed a DRE on the patient but did refer the patient to his physician assistant for the examination, though the patient declined the DRE on two occasions. Dr. Hasnain indicated that he

terminated the patient from his practice because the patient sometimes demanded narcotic medications and behaved in a threatening manner toward office staff.

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 noted that Dr. Hasnain reduced the patient's narcotics in a methodical fashion and that the patient signed a narcotics contract that indicated he was fully aware of the plan to cut back on his narcotics. The Committee took no action on this area of concern.

The Committee found no information to support the patient's claim that Dr. Hasnain directed him to fill his prescription at a particular pharmacy. The Committee took no action on this area of concern aside from stating its expectation that physicians not direct patients to use a particular pharmacy.

The medical record indicated that Dr. Hasnain did order an MRI for the patient, so the Committee took no action on this aspect of the complaint. The Committee noted, however, that the medical record did not set out why the test was indicated in the patient's case. In fact, there was little indication in the record that Dr. Hasnain conducted an adequate neurological examination of the patient that resulted in findings that led Dr. Hasnain to order the MRI.

It was difficult for the Committee to ascertain from the medical record whether a DRE was ever performed on the patient and, if so, by whom. The patient indicated that Dr. Hasnain performed the test on him and that he did so roughly and without ensuring his privacy. Dr. Hasnain himself documented in the medical record in August 2013 that he did the examination, but in his response to the complaint he indicated that he did not perform a DRE on the patient.

Another templated note in the record indicated that the patient underwent a DRE in October 2015 and that the results were normal. It was not clear to the Committee who authored this note. Another entry in the record bearing the same date, written by Dr. Hasnain's physician assistant, indicated that the patient declined a DRE.

It was reasonable if Dr. Hasnain delegated the task of performing the DRE to his physician assistant as this type of examination is within the training of a physician assistant. It was concerning to the Committee, however, that the medical record was unclear on whether the patient, for whom a DRE was indicated, ever had this examination.

On the issue of the DRE, the Committee decided to take no further action aside from stating its expectation that physicians or physician assistants perform the examination in a private setting and explain to the patient ahead of time the nature of the examination so the patient knows what to expect.

The Committee was satisfied that Dr. Hasnain had reasonable grounds for deciding to terminate the patient from his practice; however, 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 via registered mail. Dr. Hasnain should have been fully aware of his obligations under the policy as he 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. In the Decision and Reasons for that complaint, released by the Committee at approximately the same time as Dr. Hasnain discharged the patient from his

practice, the Committee advised Dr. Hasnain to follow the College's *Ending the Physician-Patient Relationship* policy.

Despite the College's advice, it is apparent that Dr. Hasnain did not terminate the patient according to College policy in that he did not send a letter by registered mail to notify the patient of his decision to end the physician-patient relationship, but instead had a pharmacy employee hand-deliver a letter to the patient. 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 lacking in detail about the care he provided to the patient at any given clinical encounter (not only in the areas of DRE and neurological examination), but it was also often unclear to the Committee who saw the patient at specific appointments, Dr. Hasnain or the physician assistant.

Dr. Hasnain indicated to the College that his physician assistant 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 provided. 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.