

**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. Andrew G Vellathottam (CPSO #90562)
(the Respondent)

INTRODUCTION

The Respondent is the Patient's primary care provider. He practises with a physician assistant (PA).

In November 2023, the Patient attended an appointment with the Respondent's PA due to concerns about a lump on her right breast. An ultrasound was ordered, and the report noted right breast nodules with features suggestive of fibroadenomas. A referral to a surgeon was recommended, which the PA sent.

In April 2024, the Patient had another appointment with the PA where she reported changes to her right breast including a hardening of the lump and an inverted nipple. The PA referred the Patient for another ultrasound and then followed up with the surgeon, who had not responded to the November 2023 referral.

The Patient was later diagnosed with breast cancer.

The Patient contacted the College of Physicians and Surgeons of Ontario (the College) to express concerns about the Respondent's care and his supervision of the PA.

COMMITTEE'S DECISION

The Committee considered this matter at its meeting of February 5, 2025. The Committee required the Respondent to appear before a Panel of the Committee to be cautioned with respect to his failure to appropriately delegate and supervise physician assistants, to appropriately manage breast nodules, and to follow up on specialist referrals.

In addition, the Committee required the Respondent to complete a specified continuing remediation and education program (SCERP) consisting of the following elements:

- Clinical supervision for a minimum period of three (3) months (monthly meetings with the Clinical Supervisor, including a review of 15 charts per meeting; and at least one report back to the College from the Clinical Supervisor);
- Self-study (review, reflection, and discussion with his Clinical Supervisor of the College's policies or documents, *Delegation of Controlled Acts, Physicians Assistants: Delegation to Physician Assistants*, and *Transitions in Care*, and of

specified readings on working with PAs and the evaluation of breast masses and cancer); and,

- Reassessment of practice to take place six (6) months following the conclusion of the above noted supervision and learning.

COMMITTEE'S ANALYSIS

The Committee was concerned about the details documented in the Patient's chart when she presented with breast lump concerns, including an inadequate history and follow-up instructions.

The Committee was particularly concerned that during an April 2024 appointment at which the Patient reported changes to her breast, no physical examination was conducted. In addition, there was no escalation of investigations (i.e. urgent ultrasound, mammogram, and specialist referral were not initiated), as would have been appropriate.

The Committee was satisfied that the Respondent's office sent a referral to a surgeon in November 2023. However, the Committee was concerned that there were no follow-up inquiries made of either the surgeon or the Patient with respect to a consultation being arranged until April 2024. This was despite prior appropriate opportunities to follow-up with the Patient. The Committee was of the view that until the specialist sees a patient, follow-up on the care needed remains the responsibility of the referring physician.

While the chart notes and care recommendations were the PA's, the Respondent was responsible for the Patient's care and for supervising the PA.

The Committee was concerned that the Respondent was using his PA as a physician replacement rather than extender and that he failed to follow the College's policy, *Delegation of Controlled Acts*. In particular, the Respondent did not periodically reassess the Patient to ensure that the delegation was in the Patient's best interest when there was a change in her clinical status. Further, given the Committee's issues with the care the Patient was receiving, the Committee was concerned that the Respondent was not appropriately monitoring the PA, including reviewing the Patient's medical records to ensure the care provided through delegation was appropriate and met the standard of practice.

The Committee noted that the Respondent was not insightful in his response. He saw no issue with his management of the Patient's care or delegation to the PA and

therefore did not reflect on how the events of the case might change his practice in the future.

Given that the Respondent declined to sign the undertaking, the Committee therefore required that he complete the SCERP outlined above to address the educational needs identified in this case.

Based on the Committee's serious concerns about the Respondent's care and lack of insight, in addition to requiring the Respondent to complete the SCERP, the Committee decided to caution the Respondent, as set out above.