

**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. Ghias Ud Din Butt (CPSO# 108064)
(the Respondent)**

INTRODUCTION

The Complainant contacted the College of Physicians and Surgeons of Ontario (the College) to express concerns about the care the Respondent (Internal Medicine) provided to the Patient, who is the Complainant's family member.

The Patient attended the Emergency Department (ED) via ambulance with shortness of breath, nausea and vomiting. In the ED, laboratory work and investigations were ordered, including a chest x-ray and an electrocardiogram. After an assessment in the ED, the Patient was admitted with a diagnosis of pneumonia and his care was transferred to the Respondent.

That night, another physician was the internist on call. Nursing reported the Patient was unstable. That physician requested the Patient's immediate transfer to the Intensive Care Unit (ICU). Records indicate the Patient had what appeared to be a grand mal seizure. The Patient was transferred to the ICU, at which time he went into cardiac arrest, was intubated and resuscitated.

The next day, the Patient was transferred to an ICU at a tertiary care centre. The Patient passed away in hospital several days later.

COMPLAINANT'S CONCERNS

The Complainant is concerned that the Respondent as the most responsible physician (MRP), failed to provide adequate medical care to the Patient. Specifically, the Respondent:

- **failed to repeat bloodwork despite the critical laboratory values;**
- **failed to reassess the Patient's respiratory status despite his deteriorating condition; and**
- **failed to notify Respiratory Therapy.**

COMMITTEE'S DECISION

An Internal Medicine Panel of the Committee considered this matter at its meeting of May 10, 2021. The Committee required the Respondent to attend at the College to be cautioned in person with respect to:

- inadequate documentation, including failing to document an adequate review of the laboratory results, a proper differential diagnosis and plan for follow-up;
- ensuring handover to the incoming most responsible physician (which should occur regardless of the severity of the patient's illness);
- failing to recognize the severity of the illness, including blood tests (such as renal function, lactic acid and electrolyte tests) that were abnormal and required urgent follow-up;
- failing to communicate with other services (e.g. ICU); and
- failing to appreciate the role of the physician as leader of the health care team and assume responsibility for leading patient care.

The Committee also accepted an undertaking from the Respondent.

COMMITTEE'S ANALYSIS

Re: failed to repeat bloodwork despite the critical laboratory values

-AND-

Re: failed to reassess the Patient's respiratory status despite his deteriorating condition

-AND-

Re: failed to notify Respiratory Therapy

As part of this investigation, the Committee retained an independent Assessor who specializes in Internal Medicine. The Assessor opined that the Respondent did not meet the standard of practice in treating the Patient; displayed a lack of skill, knowledge and judgement; and his clinical practice exposed this patient to harm.

In particular, the Assessor noted the Respondent failed to act on critical test results that showed the Patient had pneumonia and sepsis, severe metabolic acidosis and early multiple organ dysfunction syndrome. The Patient required prompt treatment, timely follow-up with repeat investigations and early referral to the ICU, none of which was done. The Respondent also did not follow up on the Patient despite his worsening hypoxia (low oxygen in the blood) and increasing oxygen requirements. The lack of timely repeat testing, follow-up, and intervention contributed to the Patient's worsening metabolic acidosis.

The Committee agreed with the Assessor's conclusions, and that the Respondent's care of the Patient was deficient in multiple ways.

The Respondent's documentation was also inadequate. The Respondent told the College that he dictated a note but did not know why it was not transcribed and that

hospital records never informed him that it was incomplete. Relying on the handwritten records available, the Committee noted the Respondent did not document a reasonable assessment, differential diagnosis or treatment plan for this Patient.

Even if there was a missing completed consultation note , given the care the Respondent provided and the orders he made, it is evident he did not recognize the Patient's profound metabolic abnormalities indicating septic shock, renal failure, acidosis, and the need for aggressive fluid resuscitation and an immediate ICU consultation.

The Respondent failed to repeat blood tests, which should have been done within the hour following admission and repeated as needed. If the Respondent thought the tests were ordered, then he did not follow up on the initial severely abnormal results.

The Respondent indicated that he reassessed the Patient at a certain point, but there is no record of this or that he re-evaluated the Patient at any time. The Respondent also did not provide proper handover of the Patient to the next on-call internist.

The Respondent did not recognize his role as leader of the health care team and assume responsibility for leading patient care.

The Respondent has had a prior College complaint in which concerns were raised about his failure to follow up on concerning test results and the Committee required the Respondent complete remediation in this area. This further elevated the Committee's concern in this case.

As a result of this investigation, the Committee had concerns about the Respondent's recognition and reassessment of critical illness, management of sepsis, medical record-keeping, and effective patient handoffs and teamwork. In addition to cautioning the Respondent on these subjects, the Committee accepted an undertaking from the Respondent, with terms to include six-months of clinical supervision; professional education in the recognition and reassessment of critical illness, management of sepsis, medical record-keeping, and effective patient handoffs and teamwork; and a reassessment of the Respondent's practice.