

SUMMARY

DR. GEHAN RAFAAT GHALLY (CPSO# 69864)

1. Disposition

On June 6, 2018, the Inquiries, Complaints and Reports Committee (the Committee) ordered Family Medicine specialist Dr. Ghally to complete a specified continuing education and remediation program (SCERP). The SCERP requires Dr. Ghally to:

- attend and successfully complete the Medical Records course
- complete a self-study on the assessment, diagnosis and management of paediatric scoliosis; and review the College's policy on *Medical Records*
- undergo a reassessment of his practice six months following completion of the education program.

2. Introduction

A patient expressed concern that Dr. Ghally failed to provide adequate care and behaved in an unprofessional manner toward her. For example, Dr. Ghally delayed for over a year to transfer her records and failed to send her complete chart in an organized, comprehensible manner to her new physician; failed to protect her and her children from spousal abuse and enabled the patient's ex-husband to physically and mentally abuse the patient; inappropriately prescribed medications to mask the patient's emotional distress and told the patient to stay with her ex-husband; released medical information to the patient's ex-husband without consent; failed to complete a Criminal Inquiries Compensation Board form; and failed to diagnose the patient's daughter's back pain correctly, causing the daughter unnecessary pain and suffering.

Dr. Ghally responded that she would have counselled the patient with respect to victim abuse and provided support had she known that abuse was an issue, and stated that she always strives to provide compassionate care to her patients. She indicated that she continued the patient's medication, as recommended by the patient's psychologist and psychiatrist. She has

no information regarding how the patient's ex-husband knew her medication and dosage history, and believes that the care she provided to the patient's daughter was appropriate.

3. Committee Process

A General 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 had serious concerns about Dr. Ghally's charting in this case, noting that it was illegible, brief, and did not capture the clinical encounter. It was difficult for the Committee to understand much of what occurred with respect to Dr. Ghally's care of the patient and her daughter, given the inadequate records. The Committee noted that mental health assessments were nonexistent and the history and physical examination of patient complaints did not meet the standard of record-keeping. Dr. Ghally admitted these deficiencies and has taken a medical record-keeping course to address them.

The Committee also noted that Dr. Ghally was quite slow in transferring the patient's charts to her new family physician, and as such did not abide by the *Medical Records* policy with respect to timely transfer of records. Furthermore, once the records were finally transferred they were not complete.

The Committee also had some concerns regarding Dr. Ghally's management and treatment of the patient's daughter, who reported back pain lasting four to six weeks, which Dr. Ghally believed to be the result of over-use. The patient took her daughter to a walk-in clinic where a spinal x-ray confirmed scoliosis, which required surgery. In the Committee's view, if the walk-in

clinic physician recognized scoliosis and ordered x-rays, and if the condition was serious enough to require surgery, it should have also been recognized by Dr. Ghally over the course of two appointments. The Committee noted that the test for scoliosis is quite straightforward and the Committee questioned whether Dr. Ghally performed an appropriate assessment and examination of the back. Furthermore, the Committee felt that Dr. Ghally should have referred the patient's daughter directly to a pediatric orthopedic surgeon given the confirmatory x-ray, instead of referring her to a pediatrician, which ultimately caused unnecessary delay. Overall, the Committee was of the view that missing the diagnosis of scoliosis was a serious error, and that Dr. Ghally would benefit from remediation on the assessment and diagnosis of back pain in adolescents, as well as remediation with respect to her record-keeping.

The Committee saw nothing inappropriate with Dr. Ghally's prescribing, which in their view was reasonable given the patient's medical history, and which was apparently supported by the patient's psychiatrist. However, they noted that Dr. Ghally did not document her rationale for prescribing the medication in the record, as she should have, and therefore advised Dr. Ghally regarding documenting the indication for medication.

With respect to the patient's Criminal Injuries Compensation Board form, Dr. Ghally originally stated that she did not complete the form because she did not have a basis to make favourable comments. After the patient complained to the College, Dr. Ghally did complete the form, and commented that she could have better addressed this request. The Committee felt that Dr. Ghally caused undue delay by failing to complete the form in a timely manner, as she should have, and therefore advised her on timely and appropriate completion of forms.

With respect to the patient's concern that Dr. Ghally failed to protect her and her children from spousal abuse. Dr. Ghally stated that she asked the patient probing questions about spousal abuse, but that the patient did not reveal anything of concern. While many victims do deny the existence of spousal abuse, there were clearly red flags present. It would have been helpful for Dr. Ghally to specifically document them and any questions she asked the patient about them.

This might have led to an opening where options and solutions could have been explored. The Committee accepted a remedial agreement from the Respondent, acknowledging the need for education in the assessment of spousal abuse, specifically asking about and documenting potential abuse and interventions.

In terms of the remainder of the patient's concerns, the Committee was faced with only the conflicting information from the parties, and therefore took no further action.

This summary was amended following an appeal heard by the Health Professions Appeal and Review Board ("HPARB"), a decision by HPARB dated May 13, 2019, and the Committee's consideration of the matter on September 4, 2019.