SUMMARY of the Decision of the Inquiries, Complaints and Reports Committee (the Committee)

(Information about the complaints process and the Committee is available at: https://www.cpso.on.ca/Public-Information-Services/Learn-About-Our-Complaints-Process**)**

Dr. Ashraf Shafik Mikhail (CPSO# 82379)
(the Respondent)

INTRODUCTION

The Complainant contacted the College of Physicians and Surgeons of Ontario (the College) to express concerns about the care the Respondent provided to a family member (the Patient). The Respondent gave the Patient, who he was seeing for the first time, a prescription for Oxycodone 80 mg, b.i.d. (taken twice a day). The Patient took the medication as directed, and died two days after seeing the Respondent. The Coroner attributed the Patient's death to mixed drug (i.e., oxycodone, oxymorphone and cyclobenzaprine) intoxication.

COMPLAINANT'S CONCERNS

The Complainant is concerned that the medication (Oxycodone) dosage which the Respondent prescribed was too high for the Patient.

COMMITTEE'S DECISION

The Committee considered this matter at its meeting of December 12, 2018. The Committee accepted the Respondent's undertaking (described further below), and directed him to attend at the College to be cautioned in person with respect to narcotics prescribing, proper assessment, diagnosis and treatment of the Patient and medical record keeping.

COMMITTEE'S ANALYSIS

The Respondent documented a fairly brief examination which, in the Committee's view, was missing key elements such as an abdominal examination, notation of the degree of pain or its location, the level of the paravertebral and bony tender areas, and documentation of vital signs.

The Respondent's contemporaneous notes did not document any of the Patient's previous attempts at pain control. He ordered Oxycontin at a level double the maximum the Patient had been taking.

The Respondent had no significant previous complaints or investigations history with the College. This appeared to be a single case of poor judgement in prescribing very high dose narcotic to a patient whom the Respondent had never seen before, after a superficial assessment of her severe acute pain.

The Respondent's undertaking, which also may be viewed on the College's public register, includes terms requiring clinical supervision of his prescribing of narcotic drugs, narcotic preparations, controlled drugs, benzodiazepines and other targeted substances, and other monitored drugs for minimum of six months; professional education in the prescribing of controlled substances, including narcotics; and a re-assessment by an assessor selected by the College.

The caution will provide a forum for the Committee to relay to the Respondent in person its concerns about his care, prescribing and documentation in this case.