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. Anas Ahmed T Ben Musa (CPSO #72892)
(the Respondent)

INTRODUCTION

The Respondent is a vascular surgeon who works as a locum several days per month. The Complainant was referred to the Respondent in January 2018 for wet gangrene on the third toe of her right foot. It was the Respondent's clinical judgement that the Complainant's gangrene was improving significantly and there was no sign of active sepsis.

The Respondent next saw the Complainant in March 2018 and again in April 2018, at which time she asked for a second opinion about her toe. She attended a different hospital where she underwent a CT angiogram and stenting of the iliac arteries, as well as amputation of the gangrenous toe.

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

COMPLAINANT'S CONCERNS

The Complainant is concerned about the Respondent's medical care and conduct from January to April 2018. Specifically, the Respondent failed to:

- **Assess, diagnose and treat the blackened area on the right side of the nail bed of the third toe on the Complainant's right foot, despite her history of diabetes for 57 years**
- **Order a CT scan when he initially agreed to do so**
- **Treat the Complainant's concerns seriously with regard for her wellbeing.**

COMMITTEE'S DECISION

A Surgical Panel of the Committee considered this matter at its meeting of July 19, 2019. The Committee required the Respondent to attend at the College to be cautioned in person with respect to his failure to assess, diagnose and treat gangrene in an insulin-dependent diabetic patient and to maintain adequate medical records. The Committee also directed staff to negotiate an undertaking with the Respondent. The College subsequently received the Respondent's signed undertaking and it is posted on the College's public register.

COMMITTEE'S ANALYSIS

As part of this investigation, the Committee retained an independent Assessor who specializes in vascular surgery. The Assessor opined that the Respondent's initial assessment of the Complainant, his documentation and his follow-up care were substandard. The Assessor concluded that the Respondent's knowledge and judgement were lacking in that he did not actively and aggressively pursue the possibility of ischemic vasculopathy.

It was concerning to the Committee that the Respondent did not effectively manage the clinical situation in this case (a long-time insulin-dependent diabetic who presented with compromise of the vascular supply to her foot). The Committee agreed with the Assessor's conclusion that the Respondent's care showed deficiencies in several areas, including in his treatment of the diabetic foot (which was inadequate even after another physician contacted him regarding the Complainant's increasing pain), his communication (failing to outline the treatment plan, arrange for testing and organize adequate follow-up care) and his record keeping.

As a result of this investigation, the Committee decided to seek an undertaking with the Respondent and to require him to attend at the College to be cautioned. The Respondent's undertaking includes a requirement that he engage in education about diabetic skin and wound management.