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. Gihad Mohammed Hisham Shabib (CPSO #71877)
(the Respondent)

INTRODUCTION

The Respondent performed a circumcision on the Complainant's baby (the Patient). The procedure was complicated by bleeding, infection and a poor cosmetic result. The Complainant contacted the College of Physicians and Surgeons of Ontario (the College) to express concerns about the Respondent's care and conduct.

COMPLAINANT'S CONCERNS

The Complainant is concerned about the Respondent's care and conduct in regard to her infant son's circumcision. Specifically, the Respondent:

- **Failed to explain the procedure and obtain informed consent**
- **Failed to correctly perform the procedure, including taking an excessive amount of time, leaving excess skin, using too many stitches, and using stitches that were not dissolvable**
- **Failed to provide any after-care instruction, or any information about complications and when to seek medical care**
- **Dismissed the Complainant's concerns regarding infection, saying, "It's just an infection," and offered to call a pharmacy with a prescription only when the Complainant asked several times. The Respondent did not offer to reassess the Patient.**

COMMITTEE'S DECISION

A General Panel of the Committee considered this matter at its meeting of October 2, 2019. The Committee required the Respondent to attend at the College to be cautioned in person with respect to inadequate medical records; failure to ensure and document informed consent; and communicating and providing treatment of a newborn with an infection over social media. 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

The Committee had a number of concerns in this matter. It was troubling that the Respondent had no medical record for the Patient. The Respondent did not document any information about the child, such as gestational age, actual age, weight, and whether there was a family history of bleeding. He did not document a consent discussion with the Patient's parents, nor did he make note of his surgical procedure, the materials he used or the follow-up plan.

There was no record to support the Respondent's statement that he advised the Patient's parents of the risks and benefits of the surgical procedure and obtained their informed consent. The Respondent indicated to the College that he obtains verbal consent for circumcisions. This may be sufficient, but without any documentation in the medical record about the information the Respondent conveyed in his consent discussion with the parents, it was impossible for the Committee to determine that he provided adequate information to obtain informed consent.

Similarly, it was not possible for the Committee to ascertain whether the Respondent provided post-procedure instructions. He stated that he advised the Complainant to schedule a follow-up appointment in one week; however, there was no documentation to confirm this.

With regard to the Respondent's surgical care, the Committee was concerned by the Respondent's statement that he leaves the room more than once for several minutes at a time after beginning the circumcision procedure. In the Committee's view, it is not at all routine for physicians to leave an operative procedure, particularly when the patient is a young child. It was particularly troubling to the Committee that the Respondent leaves the room when there is a clamp on the baby's penis.

It is occasionally necessary to put stitches in following circumcision. The Committee did not consider this aspect of the Respondent's care in and of itself to be concerning.

The Respondent diagnosed and managed the Patient's post-operative infection over social media. He made the diagnosis from images the Complainant sent to him via Facebook and prescribed treatment without ever re-examining the child. The Respondent's disregard for the standard of care and patient confidentiality was troubling to the Committee.

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 informed consent and review guidelines regarding medical records and professionalism.