COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA

IN THE MATTER OF
A HEARING UNDER THE *HEALTH PROFESSIONS ACT*,
RSA 2000, c. H-7

AND IN THE MATTER OF A HEARING REGARDING
THE CONDUCT OF DR. ASHIF SHIRAZ JAFFER

DECISION OF THE HEARING TRIBUNAL OF THE COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA

June 10, 2025

I. INTRODUCTION

1. The Hearing Tribunal held a hearing into the conduct of Dr. Ashif Shiraz Jaffer on April 29, 2025. The members of the Hearing Tribunal were:

   Mr. Don Wilson (public member) as Chair;
   Dr. Randall Sargent;
   Dr. Marelise Kruger; and
   Ms. Leanne Axelsen (public member).

2. Appearances:

   Mr. Craig Boyer, legal counsel for the Complaints Director;
   Dr. Ashif Shiraz Jaffer;
   Ms. Karen Pirie, legal counsel for Dr. Jaffer.

   Mr. Jason Kully acted as independent legal counsel for the Hearing Tribunal.

II. PRELIMINARY MATTERS

3. There were no objections to the Hearing Tribunal's composition or jurisdiction to proceed with the hearing.

4. Pursuant to section 78 of the *Health Professions Act* ("HPA"), the hearing was open to the public. There was no application to close the hearing.

III. CHARGES

5. The Amended Notice of Hearing, dated April 23, 2025, listed the following allegations:

   1. On June 11, 2021, you did display a lack of knowledge of or lack of skill and judgment in the provision of professional services to your patient, particulars of which include one or more of the following:

      a. Attributing the patient's complaints of abdominal pain to dehydration and heat exhaustion despite a lack of support for that conclusion;

      b. Deciding to discharge without adequate medical evidence to support that decision;

      c. Failing to record in the patient's chart a discussion of the risk of discharging the patient home given the presenting history and findings recorded in the patient's chart.

6. The parties noted that June 11, 2021 was a typo in the Amended Notice of Hearing and agreed that the alleged incidents occurred on June 12, 2021.

7. Dr. Jaffer admitted the allegations as set out in the Amended Notice of Hearing, and as amended by the parties' agreement, (the "Allegation") and agreed that the conduct set out in the Allegation amounted to unprofessional conduct under the HPA. The hearing proceeded by way of an Agreed Exhibit Book and a Joint Submission on Sanction ("Joint Submission") by Dr. Jaffer and the Complaints Director.

IV. EVIDENCE

8. The following Exhibits were entered into evidence during the hearing by agreement:

Exhibit 1: Agreed Exhibit Book, containing Tabs 1 to 8:

Tab 1: Notice of Hearing dated October 17, 2024

Tab 2: Amended Notice of Hearing dated April 23, 2025

Tab 3: Complaint by [redacted], October 16, 2023

Tab 4: Dr. Jaffer Response, March 11, 2024

Tab 5: Medicine Hat Regional Hospital ER Records, June 2021

Tab 6: AHS Letter, June 13, 2021

Tab 7: Expert Opinion from Dr. [redacted], May 14, 2024

Tab 8: Addendum Report by Dr. [redacted], May 24, 2024

Exhibit 2: Admission and Joint Submission Agreement, dated April 24, 2025

V. SUBMISSIONS

Submissions on behalf of the Complaints Director

9. Mr. Boyer advised that the hearing arose out of a complaint by the spouse of a patient who had passed away after having gone to the emergency department at the Medicine Hat Regional Hospital and where there was one attendance with Dr. Jaffer on June 12, 2021.

10. Mr. Boyer provided a brief overview of the allegations set out in the Amended Notice of Hearing and which were being admitted to by Dr. Jaffer.

11. Mr. Boyer reviewed and summarized the materials found in the Agreed Exhibit Book. This information indicated that the patient attended the hospital first on June 11 where they were seen by a different doctor and were discharged

home. The patient came back on June 12 and saw Dr. Jaffer and was discharged home again. The patient came back to the hospital on June 13 and it was discovered that he had extensive abdominal bleeding that required a blood transfusion. The patient was being prepared for transport to the Foothills Hospital in Calgary but tragically, the patient did not survive.

12. Mr. Boyer also reviewed the response from Dr. Jaffer and the records of the patient's visits to the hospital. He also reviewed an expert opinion, and a related addendum, which was obtained by the Complaints Director and which stated that Dr. Jaffer did not meet the expected standard of care.

13. Mr. Boyer submitted that Dr. Jaffer acknowledged that he failed to meet the standard of care when he saw and assessed and then discharged the patient on June 12, 2021. He submitted that the evidence in the Agreed Exhibit Book supported the admission of unprofessional conduct.

Submissions on behalf of Dr. Jaffer

14. Ms. Pirie confirmed that Dr. Jaffer was agreeable to accepting the admission of unprofessional conduct.

VI. FINDINGS REGARDING ALLEGNATIONS

15. The Hearing Tribunal reviewed the evidence submitted by the parties and considered the submissions of counsel. The Hearing Tribunal accepted Dr. Jaffer's admission and found the Allegation set out in the Amended Notice of Hearing was proven, that the proven conduct amounted to unprofessional conduct under the HPA.

16. The evidence demonstrates the patient presented to the Emergency Department on June 11, 2021 with complaints of abdominal pain, constipation and poor appetite which had been ongoing for 1 week. It was noted on the chart that he had a history of alcohol use. The patient was diagnosed with dehydration/acute renal failure and told to return the following day for reassessment. His hemoglobin was 107g/L.

17. The patient returned to the Emergency Department on June 12, 2021 where he was seen by Dr. Jaffer. Dr. Jaffer obtained additional history that the patient worked outside, putting him at risk of heat exhaustion given excessively warm weather and decreased fluid intake. The patient's abdomen was noted to be soft and with no indication of any tenderness or pain.

18. The patient was given intravenous fluids and had bloodwork redrawn. His renal function had improved and his hemoglobin was noted to be 90g/L, then 83g/L, after fluid resuscitation. It was noted that the patient was an alcoholic and no hematemesis, hematochezia or melena stool was noted. The patient's vital signs remained stable and normal throughout a 4-hour observation stay.

19. Dr. Jaffer concluded the patient had symptoms of dehydration, which improved with intravenous fluids. He diagnosed the patient with "dehydration/heat exhaustion".

20. Dr. Jaffer also communicated to the patient's family there was concern for a gastrointestinal bleed. The patient was discharged home with a plan for him to call another doctor to arrange an urgent endoscopy. Unfortunately, the following day, the patient had a massive GI bleed. He re-presented to the Emergency Department via EMS and passed away despite resuscitative efforts.

21. The Expert Opinion from Dr. [redacted] found that Dr. Jaffer did not meet the acceptable standard of care for an experienced physician licensed in family medicine who also works in the Emergency Department. Dr. Jaffer initially appropriately assessed the patient, ordered appropriate investigations, reassessed the patient at later times and re-ordered a hemoglobin level. However, despite a hemoglobin drop to 83g/L, which was down from 107g/L the day prior, the patient was discharged.

22. The Expert Opinion found that the decision to discharge the patient was an unsafe plan and that it would have been more prudent to keep the patient in the Emergency Department and recheck hemoglobin either later in the evening or in the morning to truly differentiate if the hemoglobin drop was all dilutional vs bleeding. The expert observed that patients who present early in the course of suspected gastrointestinal bleeds may not present with signs of overt blood loss and that the patient had risk factors for developing significant GI bleeding given the noted history of alcohol use.

23. If the patient was going to be discharged home, Dr. Jaffer should have explained the risks of being sent home, including the concern of an underlying GI bleed, and this should be documented.

24. The expert also noted that the patient had an elevated urea level on June 12 despite a significant improvement in his creatinine. An elevated urea to creatinine ratio can occur when a patient is suffering from an upper GI bleed.

25. With respect to documentation, the Expert Opinion stated that when a physician suspects a possible acute GI bleed, it is best to document the presence or lack of risk factors as well as signs and symptoms of a GI bleed. For example, documenting a history of alcoholism, NSAID use, anticoagulation, past history of GI bleed and other issues can all point towards possible GI bleeds. Bleeding can present with hematemesis, hematochezia, melena, malaise, fatigue, dyspnea, exertional dyspnea, jaundice, abdominal pain, distention or weight loss and it is important to note early in the course of the illness the patient may not notice melena.

26. Accordingly, the evidence demonstrates:

    a. Dr. Jaffer did not meet the standard of care and displayed a lack of knowledge of or lack of skill and judgment in the provision of professional services.

    b. There was information to indicate the possibility of a GI bleed and there was a lack of information to support a conclusion that the patient's complaints were connected to dehydration and heat exhaustion. The drop in hemoglobin experienced by the patient is not consistent with dehydration.

    c. There was a lack of medical evidence to support a discharge of the patient as the information indicated the patient should have been kept for further observation.

    d. Dr. Jaffer did not document a discussion of the risks connected to discharging the patient home in light of the issues documented, including the concern of a GI bleed.

27. Dr. Jaffer also admitted to failing to meet the expected standard of care in his assessment, treatment and discharge of the patient on June 12, 2021.

28. This evidence demonstrates that the Allegation is proven on a balance of probabilities.

29. Turning to the issue of whether Dr. Jaffer's conduct was unprofessional conduct, Dr. Jaffer admitted his conduct amounted to unprofessional conduct. The Tribunal accepts this admission and finds that Dr. Jaffer engaged in unprofessional conduct.

30. When Dr. Jaffer attributed the patient's complaints to dehydration and heat exhaustion despite a lack of support for that conclusion and discharged the patient without adequate medical evidence to support that decision and failed to record a discussion of the risk of discharging the patient home, he displayed a lack of knowledge of or lack of skill or judgment in the provision of professional services. This is supported by the Expert Opinion conclusion that his conduct did not meet the expected standard of care.

VII. SUBMISSIONS REGARDING SANCTION AND COSTS

31. The parties presented the Hearing Tribunal with a Joint Submission on sanction and costs.

Submissions by Counsel for the Complaints Director

32. Mr. Boyer reviewed the legal test for a decision-maker in considering a joint submission. He stated the test is set out by the Supreme Court of Canada in *R.*

v. Anthony Cook 2016 SCC 43. The Supreme Court stated that the proper legal test for a decision-maker is the public interest test:

> *Under the public interest test, a trial judge should not depart from a joint submission on sentence unless the proposed sentence would bring the administration of justice into disrepute or would otherwise be contrary to the public interest.*

33. In his submissions to the Hearing Tribunal, Mr. Boyer also reviewed the factors in the decision of *Jaswal v Medical Board (Nfld)* 1996 CanLII 11630 (NLSC) and the application of those factors to Dr. Jaffer.

34. Mr. Boyer stated that Dr. Jaffer was experienced and not a junior physician. He stated that while the patient had a significant outcome, he was a complex patient who had a history of other health concerns which could lead to the complication of abdominal bleeding that was the ultimate cause of his passing.

35. Mr. Boyer reviewed five previous College discipline decisions what were similar in the sense that they involved physicians, primarily in the emergency room setting, who had been presented with a patient and who were found to have failed to meet the standard of care in the degree of assessment and the decisions made in the treatment provided to the patients. These cases included:

    a. Dr. Thlape, who had failed to actually see a patient in a long-term care facility and failed to meet the standard of care. He was given a reprimand and required to undertake a program in practice improvement and to pay costs.

    b. Dr. Hudson, who had a similar incident where she saw a patient who had previously come to the Emergency Room complaining of acute abdominal pain and who had been discharged home. The patient then self-medicated and overdosed on fentanyl, so the cause of death was unrelated to the care decisions. However, there was unprofessional conduct related to the decision to discharge the patient without further investigation. Dr. Hudson received a reprimand and the payment of costs. The Tribunal also acknowledged that Dr. Hudson had already made changes to their practice and the hospital had made changes to its charting system to make sure key information was available to physicians.

    c. Dr. Halse, who failed to order a CT scan for a patient presenting with symptoms or signs of a stroke at the ER. He was given a reprimand; restricted from supervising medical learners as there was a medical student under supervision who was involved in the care; required to undergo a practice review; and ordered to pay 75% of costs.

    d. Dr. Mailo, who failed to follow up with a patient seen in the ER department after a radiologist interpreting the x-ray report had indicated

further imaging should be taken. Dr. Mailo was given a reprimand; ordered to take coursework and fulfil a learning plan; and ordered to pay two-thirds of the costs.

e. Dr. Jabbari-Zadeh, who failed to undertake an adequate assessment and failed to conduct an adequate physical examination and engaged in poor charting. He was given a reprimand; ordering to undergo a practice review; and ordered to pay 60% of costs.

36. Mr. Boyer submitted these cases demonstrated the sanctions that were warranted when patients are seen in an emergency room setting and discharged without an adequate assessment and evaluation.

37. Mr. Boyer stated that the joint submission being proposed was a reprimand; and that Dr. Jaffer undertake at his own cost a number of professional development courses, including online work through the Institute of Health Care Improvement, the Open School modules on Quality Improvement (being the modules QI 101 to QI 105, as well as Patient Safety, being PS 101 to PS 105), as well as undertaking the University of Calgary Cumming School of Medicine Clinical Reasoning Course. Mr. Boyer provided information on the Clinical Reasoning Course and how it addressed competencies, patient safety, and quality of patient care.

38. Mr. Boyer also stated that there was an agreement for Dr. Jaffer to pay 25% of the costs. He stated the costs were estimated to be about $4,200 as of late March.

39. Mr. Boyer submitted the joint submission was balanced and reasonable as it was based on deterrence, being the reprimand and the requirement to pay some costs, and also remediation, which was the coursework identified. He submitted it was also consistent with other decisions and that it addressed the concerns identified in the hearing.

Submissions on behalf of Dr. Jaffer

40. Ms. Pirie submitted that she echoed Mr. Boyer's submissions on the deference that was to be given to a joint submission. She also submitted that while Dr. Jaffer was an experienced physician, he was taking this complaint as an opportunity to refresh his clinical reasoning and thinking by doing the coursework. She submitted that the proposed penalty was appropriate under the *Jaswal* factors and was consistent with the cases cited by Mr. Boyer, which were cases with a single emergency attendance and clinical decision making. She submitted that the penalty serves as both an opportunity for specific learnings and also general deterrence.

Questions from the Hearing Tribunal

41. The Hearing Tribunal questioned the parties as to whether there was any consideration given to ongoing monitoring. Mr. Boyer advised that there could be follow-up from the Complaints Director regarding the learning outcomes from the coursework and Ms. Pirie advised that this situation would not warrant more direct ongoing monitoring as it was a single event in an emergency room situation that was complex and which was to a large extent a judgment call.

VIII. FINDINGS REGARDING SANCTION AND COSTS

42. After hearing the sanction submissions of both counsel and adjourning for deliberations, the Hearing Tribunal accepted the sanctions and costs jointly proposed by the parties.

43. The Hearing Tribunal considers the proposed sanctions to be appropriate and reasonable with regard to the *Jaswal* factors, including: the nature of the conduct as discussed in this decision which included that it was a judgment call made in an emergency department setting; Dr. Jaffer's experience as a physician; the impact his conduct had on the patient while recognizing the complex situation; the admission and other mitigating circumstances; and the consideration of the sanctions imposed in similar circumstances where patients are seen in an emergency room setting and discharged without an adequate assessment and evaluation.

44. While the patient tragically passed away, the Tribunal recognizes that they were a complex patient who had a history of other health concerns which could lead to the complication of abdominal bleeding that was the ultimate cause of his passing.

45. The Hearing Tribunal also considered the penalty in light of the principle that joint submissions should not be interfered with lightly. It did not find that this proposed sanction would bring the administration of justice into disrepute or that it was otherwise contrary to the public interest.

46. The jointly proposed penalty appropriately addresses specific and general deterrence through the reprimand and coursework, as well as rehabilitation and remediation through the coursework. The sanctions protect the public and enhance public confidence in the regulation of the profession.

47. With respect to costs, the Hearing Tribunal took into consideration the fact that costs were included in the Joint Submission and that Dr. Jaffer was agreeable to paying a portion of the costs.

48. The conduct at issue is sufficiently serious in the view of the Hearing Tribunal that a costs order is appropriate. The Hearing Tribunal does not consider

payment of 25% of the costs of the investigation and hearing to be punitive and did not consider it unfair or unreasonable.

IX. ORDERS

49. As stated at the conclusion of the Hearing, the Hearing Tribunal makes the following Orders:

    a. Dr. Jaffer shall receive a reprimand.

    b. Dr. Jaffer shall undertake, at his own cost, the following professional development courses: Institute for Healthcare Improvement Open School modules on Quality Improvement (QI 101 to QI 105) and Patient Safety (PS 101 to PS 105); and the University of Calgary, Cumming School of Medicine Clinical Reasoning Course, all of which are to be completed by December 31, 2025 or on a later date acceptable to the Complaints Director if there is a lack of available enrollment which prevents completion of the courses by December 31, 2025.

    c. Dr. Jaffer shall pay 25% of the costs of the investigation and hearing, payable on terms acceptable to the Complaints Director.

Signed on behalf of the Hearing Tribunal by the Chair:

Mr. Don Wilson

Dated this 10th day of June, 2025.