**SUMMARY**

**DR. HODA ABBAS AHMED EL RABAA (CPSO #89823)**

## 1. Disposition

On January 19, 2017, the Inquiries, Complaints and Reports Committee ("the Committee") required family physician Dr. El Rabaa to appear before a panel of the Committee to be cautioned with respect to the investigation and treatment of venous thrombosis and pulmonary emboli, maintaining adequate records, and altering records in an improper manner.

In addition, the Committee ordered Dr. El Rabaa to complete a specified continuing education and remediation program ("SCERP"). The SCERP requires Dr. El Rabaa to:

- Attend and successfully complete the next available session of the following courses, through a course provider indicated by the College:
    - The Medical Record-Keeping Course
    - The PROBE Ethics and Boundaries Course - Canada
- Participate in one-on-one instruction to understand how and why the identified issues are of concern and what she can do to avoid similar situations in the future
- Review the College's *Medical Records* policy and conduct self-study into the current diagnosis and management of possible stroke in young patients
- Draft written summaries of the above-noted policy and her self-study
- Practice under the guidance of a clinical supervisor acceptable to the College for six months. Areas to enhance include, but are not limited to (as identified by "CanMEDS" roles:
    - Medical expert role
        - recognizing the signs and symptoms of stroke in young patients

- Communicator (record-keeping) role
    - comprehensive documentation of encounters, including history, physical, diagnosis, management plans and patient instructions
- Professional role
    - Honesty and integrity in documentation without improperly altering documentation following the encounter

- Undergo a reassessment of her practice by an assessor selected by the College approximately six months after completion of the education program.

## 2. Introduction

A patient complained to the College that Dr. El Rabaa failed to recognize and diagnose the signs of a stroke. The patient reported that he went to a clinic on three occasions in October and November 2011. A physician other than Dr. El Rabaa saw the patient on the first occasion when he reported a headache, and then Dr. El Rabaa saw him when he returned twice to the clinic in early November 2011 with headache, finger numbness, and then sudden blackout vision. The patient, who was subsequently diagnosed with several small strokes that had occurred because of his newly diagnosed blood cancer, expressed his view that his strokes could have been prevented if Dr. El Rabaa had diagnosed him properly.

Dr. El Rabaa indicated that, at her first encounter with the patient, the physical examination was normal and there were no red flag symptoms. She documented that her differential diagnosis was tension headache secondary to stress and an excess of caffeine. Dr. El Rabaa indicated that the patient was alert and looked well at their second encounter, and she noted that her full neurological examination on that occasion was normal. Her diagnosis at that visit was possible migraine headache.

The College asked Dr. El Rabaa to provide the audit trail for her entries into the electronic medical record (EMR) for the patient. Dr. El Rabaa provided the audit trail and acknowledged that she made late entries into the patient's record in April 2016. She indicated that she reviewed the patient's record in April 2016 in light of the complaint to the College and was concerned

about the brevity of her notes. She corrected the record to reflect what she believed she had likely found when she saw the patient in November 2011.

Dr. El Rabaa indicated that she planned to enrol in a medical ethics course and reflect on the important topic of ethical practices in medicine.

## 3. Committee Process

As part of this investigation, the Committee retained an Independent Opinion provider ("IO provider") who specializes in family medicine. The IO provider reviewed the entire written investigative record and submitted a written report to the Committee.

The Family Practice Panel of the Committee, consisting of public and physician members, met to review the relevant records and documents related to the investigation. 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 IO provider opined that Dr. El Rabaa's care in this case did not meet the standard of practice of the profession in her record keeping and her neurological assesssments. The IO provider was of the view that Dr. El Rabaa's care displayed a lack of judgement in her decision to alter the documentation of her encounter notes, in not doing or documenting a neurological examination of the patient at their first encounter, and in not arranging urgent assessment of the patient during their second encounter when his symptoms had worsened.

The IO provider noted that Dr. El Rabaa may expose her patients to harm or injury if she falsifies records, does not do thorough assessments, or does not recognize when worsening of the patient's clinical condition requires additional assessment.

The Committee agreed with the IO provider's conclusion that Dr. El Rabaa's care of this patient was inadequate. The Committee noted that Dr. El Rabaa's walk-in assessment was poor and she failed to pick up on concerning symptoms, and that she conducted inadequate examinations and

failed to refer or investigate the patient appropriately. The Committee agreed that Dr. El Rabaa showed a lack of judgement in not recognizing the signs of a stroke, and in diagnosing first-time headaches in a young patient as migraines without further testing.

In the Committee's view, Dr. El Rabaa's care in this case brought into question her ability to provide appropriate care at a busy walk-in clinic, a setting that requires physicians to be able to detect when patients need in-depth care.

The Committee was disturbed by Dr. El Rabaa's apparent attempts to obfuscate the investigation by altering the medical record and to blame her conduct on panic and impulsivity. In addition, the Committee was aware that a concurrent investigation into another public complaint revealed that Dr. El Rabaa had improperly altered her medical records in that case.

In light of the above, the Committee decided that the two-fold disposition set out above was warranted in this matter.