SUMMARY

DR. JAGDEEP SINGH (CPSO# 85963)

1. Disposition

On March 23, 2017, the Inquiries, Complaints and Reports Committee ("the Committee") ordered family and emergency medicine physician Dr. Singh to complete a specified continuing education and remediation program ("SCERP"). The SCERP requires Dr. Singh to:

- Complete the Medical Record Keeping Course through the University of Toronto
- Engage in self-directed learning, including review and written summaries of CPSO polices (*Medical Records* and *Test Results Management*) and clinical practice guidelines in the approach to dyspnea (shortness of breath) in the emergency setting
- Undergo a reassessment of his practice by an assessor selected by the College approximately one year following completion of the education program.

2. Introduction

A family member of an elderly patient complained to the College that Dr. Singh misdiagnosed the patient with pneumonia which was later determined to be pulmonary edema and failed to perform a complete assessment of the patient's symptoms of leg edema, edematous abdomen, shortness of breath, dizziness, and continuous burping.

Dr. Singh responded that he did assess the patient and, on physical examination, auscultation of the lungs revealed significant rhonchi and scattered wheezes. He explained that his interpretation of the patient's chest x-ray revealed findings consistent with pneumonia. He stated he advised the patient of the preliminary findings and also told him that a radiologist would read the x-ray within 24 hours. He offered the patient the option of antibiotics.

3. Committee Process

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

A Family Practice Panel of the Committee, consisting of public and physician members, met to review the relevant records and documents related to the complaint. 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

On the basis of its own review of the record and the IO provider's report, the Committee was of the view that Dr. Singh failed to perform a complete assessment and misdiagnosed the patient's condition. The Committee was concerned by Dr. Singh's care of the patient, which the IO provider stated failed to meet the standard of practice of the profession (with noted deficiencies in interpretation of findings of test results, medical management of the patient's respiratory status, anemia, renal failure, and congestive heart failure). In addition, the Committee noted that Dr. Singh's charting was illegible and required transcription, and his documentation about the care he provided was incomplete. The Committee was also concerned that Dr. Singh misread Patient A's chest x-ray as pneumonia (despite evidence of an enlarged heart, fluid in fissures, and pleural effusions) and that he also failed to follow up on the radiologist's interpretation of the x-ray (which reported pulmonary edema as opposed to pneumonia).

The Committee noted that while Dr. Singh has only been in practice in Ontario since 2008, in that time he has been the subject of two prior complaints related to prescribing and thoroughness of physical examination and assessments. The Committee was concerned that

Dr. Singh was again the subject of a complaint and that the concerns about his care had escalated.

The shortcomings in Dr. Singh's care and his history with the College led to the Committee's decision to order the education program outlined above.