Dr. Shamsa Milad Deeb (CPSO#80922)

1. Disposition

On November 4, 2015, the Inquiries, Complaints and Reports Committee ("the Committee") required obstetrician-gynaecologist Dr. Deeb to appear before a panel of the Committee to be cautioned with respect to her failure to provide a patient with laboratory test results in a timely manner, her lack of insight into the problems that arose in this case, her lack of availability when the patient and her family doctor attempted to contact her, and her poor medical record-keeping.

The Committee also accepted an undertaking from Dr. Deeb to practise under the guidance of a Clinical Supervisor acceptable to the College for 12 months, to engage in professional education in medical record-keeping, and to submit to a reassessment of her practice by an assessor selected by the College, within six months of the end of the period of Clinical Supervision.

2. Introduction

The patient attended Dr. Deeb who, in June 2012, performed an endometrial biopsy. The patient and her family physician reported difficulties in reaching Dr. Deeb. In 2014, another physician diagnosed the patient with adenocarcinoma, requiring surgery.

The patient complained to the College that Dr. Deeb failed to inform her of the results of her endometrial biopsy; failed to communicate with her when she attempted several times to obtain her results; and failed to provide the results of the biopsy to her family physician.

Dr. Deeb informed the College that her practice was to advise her patients of abnormal test results by phone or at a follow-up appointment. In addition, Dr. Deeb also suggests to patients that they follow up with the clinic for results, or if they require further assistance. Dr. Deeb never received the results of the biopsy, and never provided the patient with those results. Dr. Deeb also informed the College that she did not receive any messages from clinic staff relaying that the patient had attempted to contact her. Dr. Deeb did not receive a request for results from the patient's family physician.

3. Committee Process

A General Panel of the Committee, consisting of public and physician members, met to review the relevant records and documents related to the complaint, as well as College policies and relevant legislation.

4. Committee's Analysis

Dr. Deeb failed to ensure that she obtained the patient's test results, provided them to the patient, and arranged follow-up, contravening the College's Policy Statement #1-11, *Test Results Management*; failed to communicate with the patient or provide follow-up after a procedure of significant importance to the patient's well-being; failed to communicate with the referring family physician; and failed to keep adequate records.

Although she described appropriate protocols for office management in her communications with the College, Dr. Deeb did not provide any explanation as to how the test result was missed in this case, or as to how she was not informed of the patient's or her family doctor's repeated efforts to contact her. The Committee was concerned to note that Dr. Deeb appeared to have little insight into her obligation to obtain test results and report them to the patient, an obligation which she had failed to meet in this case.

The Committee was satisfied that any potential public safety concerns arising from the deficiencies in Dr. Deeb's practice could be adequately addressed by her entering into an undertaking which provided for a period of Clinical Supervision and education, to be followed by a reassessment. The Committee was also of the view that Dr. Deeb would benefit from attending at the College to be cautioned regarding her practice, office management and documentation in this particular case.