

SUMMARY

DR. LAKHA SINGH (CPSO# 82982)

1. Disposition

On June 6, 2016, the Inquiries, Complaints and Reports Committee (“the Committee”) ordered psychiatrist Dr. Singh to complete a specified continuing education and remediation program (“SCERP”). The SCERP requires Dr. Singh to:

- Engage in self-directed learning, through a review of *The Practical Guide to Mental Health and the Law in Ontario*, and complete a written report on the document, including changes she has made or plans to make to her practice.
- Engage in focused educational sessions with a clinical supervisor acceptable to the College, in the following topics:
 - appropriate assessment of psychiatric patients presenting in the Emergency Room (ER);
 - appropriate use of collateral information to assess risk;
 - appropriate review of medical records to assess risk;
 - knowledge of details of the *Mental Health Act* pertaining to involuntary admission; and
 - appropriate communication with family members about patients presenting with a psychiatric emergency.
- Undergo a reassessment, with an assessor selected by the College, approximately three months following completion of the educational program above.

2. Introduction

Family members of the patient complained to the College that Dr. Singh failed to perform a complete and thorough psychiatric assessment of the patient at a hospital, in that she failed to

recognize that the patient required admission for treatment of her mental illness; she failed to thoroughly review the patient's record at the hospital; and she failed to speak with and/or obtain collateral information from them as family members. The family members also complained that Dr. Singh failed to maintain patient confidentiality in that she remained in the nursing station while discussing the patient's personal health information with them. They described how, after Dr. Singh would not admit the patient, the patient had ongoing difficulties and was later committed by a judge to a mental health facility for a period of assessment.

Dr. Singh responded that the patient had been taken to the hospital by police, and the ER physician had placed her on a Form 1 (*Application by Physician for Psychiatric Assessment*). Dr. Singh said it was her overall assessment that the patient did not meet the criteria for certification and involuntary admission under the *Mental Health Act*. She said she offered the patient a voluntary admission, but the patient refused, and on this basis, she discharged the patient and referred the patient for outpatient follow-up. Dr. Singh said she reviewed the patient's medical record. She explained that because the patient did not give consent for her to speak with family members for collateral information, she limited her interaction with them to collecting information necessary for conducting an acute safety assessment. Dr. Singh described the physical limitations of the hospital setting, which sometimes limited the ability to maintain confidentiality as much as would be wished for; she noted that the set-up is now improved at the hospital. Dr. Singh acknowledged that upon being notified of this complaint, she realized her initial dictated consultation note was not available in the patient's record; she had a clear recollection of the events and thus entered a late note into the chart; she also has now changed how she records her dictations so missing dictations can be traced and located.

3. Committee Process

A Mental Health 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

The Committee had several serious concerns about Dr. Singh's approach in this case. The Committee did not think that Dr. Singh's assessment of the patient was adequate, and Dr. Singh appeared to have applied overly restrictive criteria in evaluating the patient. The Committee pointed out that a Form 1 allows 72 hours for observation whether or not the patient at first seems to need involuntary admission. The Committee noted that a Form 1 gives an important window for a full assessment that almost always includes review of a patient from a longitudinal (versus a snapshot or cross sectional) perspective. The Committee felt that the medical record contained documentation to justify a more cautious approach in this case.

The Committee stated that in an emergency, ways can be found to obtain vital (collateral) information, without compromising confidentiality.

The Committee said it would have been preferable to speak to the family members in a more private setting, and while the hospital's physical set-up was part of the issue, even within a busy ER, physicians need to strive to maintain patient and family confidentiality at all times. The Committee stated that the missing consultation note made it difficult to determine if Dr. Singh had reviewed the patient's previous health records.

The Committee determined that a specified continuing education and remediation program was appropriate, as it was of the view that Dr. Singh has important learning to do, based on what took place in this case.