SUMMARY of the Decision of the Inquiries, Complaints and Reports Committee (the Committee)
(Information is available about the complaints process here and about the Committee here)

Dr. Qanta Ayesha (CPSO #91308)
(the Respondent)

INTRODUCTION

The Complainant was under the Respondent's care from August 2014 to July 2018. In early 2017, the Complainant reported concerns of headache, neck, and shoulder pain to the Respondent, and subsequently presented with a persistent cough in addition to her other symptoms. In mid-2018, the Complainant was diagnosed with metastatic lung cancer. The Complainant contacted the College of Physicians and Surgeons of Ontario (the College) to express concern about the Respondent's care.

COMPLAINANT'S CONCERNS

The Complainant is concerned that the Respondent failed to provide appropriate care while acting as her family physician, in that, for example, the Respondent:

- **failed to take complaints of a persistent cough seriously, causing a delay in her diagnosis of lung cancer**
- **failed to follow up on diagnostic test results in a timely manner**
- **referred her to a stomach specialist for a biopsy although she should have been referred to a lung specialist**
- **failed to provide all the relevant information to the specialists on the referral.**

COMMITTEE'S DECISION

A General Panel of the Committee considered this matter at its meeting of July 24, 2019. The Committee required the Respondent to attend at the College to be cautioned in person with respect to the misdiagnosis and mismanagement of lung cancer, inadequate follow-up of abnormal test results, and improper modification of medical records. The Committee also requested that the Respondent provide the Committee with a written report with respect to the investigation of abnormal chest x-rays (including timely review of differential diagnoses, diagnostic methods to determine diagnosis, and the role of specific specialists in the management of cervical lymph nodes with an abnormal chest x-ray) and care of patients with lung cancer.

COMMITTEE'S ANALYSIS

- When the Complainant presented with a cough in December 2017, the Respondent's initial treatment with antibiotics and plan to see her again if there was no improvement was appropriate. The Respondent did not explain in the record her rationale for also treating the Complainant with prednisone, however.

- In February 2018, the Complainant presented to the walk-in clinic and was referred to the ER where a chest x-ray indicated a lung lesion. Thereafter, the Respondent saw the Complainant promptly to discuss this finding. However, from that point on investigations were not done in an efficient manner. There is no indication that the Respondent ordered an urgent CT scan, and it appears the Complainant may not have been given correct instructions as to the location to go to for the scan once ordered. The Respondent also did not follow-up with the Complainant when she did not receive a copy of the CT report. Furthermore, the Committee did not think that the Respondent tried to put together the Complainant's overall clinical picture—for example, she failed to recognize that a neck node (identified on ultrasound) and a chest x-ray positive for a nodule might indicate significant pathology (i.e., malignancy).

- The Committee noted that the Respondent's initial decision to refer the Complainant to a general surgeon, based only on the ultrasound diagnosis of a lymph node, was not inappropriate. Nevertheless, the Committee questioned why the Respondent did not call the surgeon once she received the Complainant's CT scan report indicating a lung mass to ensure this type of issue was within his scope of practice. Subsequently, the Complainant was referred promptly to a cardiovascular thoracic surgeon, although it was not clear whether the Respondent or the general surgeon made the referral. The Committee noted that if the general surgeon made the referral, it could not fault the Respondent for failing to provide all relevant information on referral. Regardless, the Committee pointed out that, had the Respondent been more diligent in ordering and acting upon the findings of the Complainant's investigations, the diagnosis may have occurred earlier. The Committee observed that it is difficult to know if this would have changed the outcome significantly, however.

- Another significant concern for the Committee was the Respondent's decision to alter the patient chart after the fact. Although the Respondent later stopped herself and restored the chart, this was a significant lapse in ethical judgement. The Committee noted, however, that the Respondent expressed remorse for her actions and has taken pro-active measures to improve her practice by enrolling in a medical record-keeping

course.

- The Committee identified concerns with respect to the Respondent's failure to investigate the Complainant's cough in a timely manner and lack of timely follow-up of diagnostic test results. The Committee also identified concerns about the Respondent's professional behaviour in making improper changes to the medical record. Given these concerns, the Committee determined that the caution and homework outlined above were the appropriate disposition of this complaint.