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. Seema Chowdry (CPSO# 83893)
(the Respondent)

INTRODUCTION

The College received information from the Ontario Health Insurance Plan (OHIP) division of the Ministry of Health and Long-Term Care raising concerns about the Respondent's medical record-keeping, ordering of medically unnecessary tests and prescribing practices.

Subsequently, the Committee approved the Registrar's appointment of investigators to conduct a broad review of the Respondent's practice.

COMMITTEE'S DECISION

A General Panel of the Committee considered this matter at its meeting of June 3, 2020. The Committee required the Respondent to attend at the College to be cautioned in person with respect to record-keeping and appropriate billing, including the appropriate use of templates and using due diligence when selecting an electronic medical records (EMR) system/service provider. The Committee also accepted an undertaking from the Respondent.

COMMITTEE'S ANALYSIS

As part of this investigation, the Registrar appointed an independent Assessor to review a number of the Respondent's patient charts, OHIP billings, and audit trail charts for certain charts, and to interview the Respondent and submit a written report to the Committee.

The Assessor's eventual report pointed out the difficulties surrounding the audit trail information received. The Assessor identified concerns about the Respondent's record-keeping, including around the use of templates. The Assessor identified areas of concern in the Respondent's clinical care, including (but not limited to): prescribing issues (and documentation of same); lack of examinations when indicated; gaps in knowledge in basic aspects of family practice; making recommendations for routine stress tests when not recommended by current guidelines; and inappropriate management of abnormal test results.

The Assessor noted that the Respondent had stated that some of the above issues were remedied due to recent changes in her EMR. However, the Assessor opined that in

14/20 charts, the care the Respondent provided did not meet the standard of practice, in 13/20 charts the Respondent displayed a lack of knowledge, lack of skill, or judgement and in 4/20 charts the Respondent's clinical practice, behaviour or conduct was likely to expose her patients to harm or injury (though record-keeping concerns made it difficult to evaluate).

The Respondent acknowledged she needs to improve her record-keeping. She described that she discontinued the use of templates and now completes all her notes before the end of day, and has moved to a more efficient and user-friendly EMR. The Respondent also outlined a series of proposed steps to remediate the concerns raised. The Respondent stated that she has never knowingly billed OHIP for services not provided. She was willing to complete the Ontario Medical Association (OMA) e-Learning modules on OHIP billing.

While recognizing the Respondent's expressed commitment to improving her practice, including her record-keeping, the Committee was concerned about the wide-ranging deficiencies identified in the investigation. The Committee noted that the Respondent has been cautioned in writing and referred to OHIP during a previous investigation regarding inappropriate billing and yet subsequent to that, a further OHIP review identified ongoing issues. The Committee accepted the Assessor's conclusions around the Respondent's clinical care and record-keeping. The Committee pointed to College policy on record-keeping that emphasizes how templates must be used with care and how physicians need to choose an EMR with due diligence and carry out research in advance of making this choice for themselves and their practice.

The Committee decided to caution the Respondent in person with respect to record-keeping and appropriate billing, including the appropriate use of templates and using due diligence when selecting an electronic medical records system/service provider. As noted above, the Committee also accepted an undertaking from the Respondent. This consisted of a period of clinical supervision, professional education in family medicine, including coursework and self-study, and reassessment of the Respondent's practice.