SUMMARY

DR. SARITA SINGH (CPSO# 72363)

1. Disposition

On July 13, 2016, the Inquiries, Complaints and Reports Committee ("the Committee") ordered family physician Dr. Singh to complete a specified continuing education and remediation program ("SCERP"). The SCERP requires Dr. Singh to:

- review the College's policy on *Physician Behaviour in the Professional Environment* and the *Practice Guide: Medical Professionalism and College Policies*, and prepare written summaries of the relevant sections of each document, specifically the sections on service and altruism, communication with patients, and professional responsibility, with reference to how they are applicable to her situation as well as how she has made or plans to make changes to her practice;

- successfully complete one-to-one instruction, to be facilitated by the College, with respect to acceptable professional behaviour by a family physician practising in an Emergency Department (ED) (including accepting responsibility for duty of care and providing explanations for delays in the provision of care);

- submit a reflective report on what she has learned and how she has changed her practice as a result of the one-to-one instruction.

2. Introduction

A patient complained to the College about Dr. Singh's care and conduct when he attended an ED in July 2015 after a fishing accident which resulted in him having fish hooks (a treble hook) going through his top and bottom lips, closing his mouth. The patient was concerned that Dr. Singh failed to remove the treble hook from his lips despite telling him that she would, and that she left the hospital without doing so. The patient reported that he saw Dr. Singh when he first entered the ED, and she told him to attend the triage area. Dr. Singh and a nurse then snipped off the ends of the hook so that he could open his mouth. He stated that Dr. Singh said that she could remove the treble hook, but while nursing staff prepared the procedure tray, he saw Dr.

Singh leave the hospital. He stated that he waited a long time for her to return, and because he lost confidence in her ability to remove the hook, he left the hospital against medical advice and attended a different hospital where he had the hook removed.

Dr. Singh stated that the patient's condition was stable when he entered the ED and she told him to be triaged, as is the routine. She advised that she left the hospital as she wanted to get something to eat before she proceeded with the hook removal, as she was feeling hypoglycemic (had low blood sugar). She stated that she told one of the nurses, Mr. X, where she was going and that she would be away for 30 minutes. Dr. Singh maintained that she acted appropriately, but expressed regret that the patient was dissatisfied with the encounter. She advised that she was interested in pursuing a suggestion raised by the hospital's Director of Nursing to attend the Crucial Conversations course.

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. 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." In this case, the Committee referred to Policy Statement #3-16, *Physician Behaviour in the Professional Environment*.

4. Committee's Analysis

The Committee concluded that, given the painful and distressing situation in which the patient found himself, it would have been much more sensitive for Dr. Singh, when she first encountered the patient, to have assessed him and initiated management of his condition rather than directing him to register at triage; and to have left the issue of registration to be dealt with after the patient had been made more comfortable.

While Dr. Singh stated that she informed a nurse, Mr. X, that she would be getting something to eat and would be back in 30 minutes, the information Mr. X provided to the College did not

support this statement.Mr. X indicated that he could not recall where Dr. Singh went, or how long she was absent from the ED.

There were much more appropriate and acceptable approaches that Dr. Singh could have taken in this situation. In fact, the Committee felt that Dr. Singh could have simply proceeded with the removal of the hook (which would have been a relatively quick procedure) prior to leaving the hospital.

The Committee concluded that Dr. Singh demonstrated a lack of professionalism in deciding to leave the patient waiting in the procedure room with the hook still embedded, while she got something to eat (particularly without saying anything to the patient or ensuring that staff could adequately answer any concerns/questions he might have about where she had gone and when she might return). The Committee also noted that Dr. Singh failed to demonstrate any empathy towards the patient's situation, which would be stressful for anyone, and that she took no responsibility for causing him further distress through her actions.

The Canadian Medical Association's *Code of Ethics* sets out a physician's fundamental responsibilities, which include considering the well-being of the patient first, and treating patients with dignity and as a person worthy of respect. The College's *Practice Guide: Medical Professionalism and College Policies* sets out the values of the profession, which include compassion (defined as a deep awareness of the suffering of another coupled with the wish to relieve it), service (which includes putting the patient first), altruism (practising unselfishly and with a regard for others), and trust; and the College's policy on *Physician Behaviour in the Professional Environment* reinforces that the physician's primary responsibility is to act in the best interests of the individual patient. In the Committee's view, Dr. Singh's behaviour in this case failed to demonstrate the fundamental values expected of a physician.

Adding to the Committee's concern was the fact that Dr. Singh had a previous complaint to the College that raised issues about her professionalism, in which she was cautioned,. The Committee was troubled that it had another complaint about Dr. Singh before it demonstrating a lack of professionalism, and felt that Dr. Singh would likely benefit from educational initiatives in this area.