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. Sarita Singh (CPSO #72363)
(the Respondent)

INTRODUCTION

The Patient, who was in his late 70s, had a medical history of cerebral palsy, Type II diabetes, hypertension, Bell's palsy, methicillin-resistant *Staphylococcus aureus* (MRSA), and gastrointestinal illness. He lived in a long-term care facility (nursing home). The Respondent was the Patient's attending physician at the nursing home.

In March 2018, the Patient's nursing home was under quarantine because of an influenza outbreak. In late March, the Patient experienced increased shortness of breath. When contacted by staff at the nursing home, the Respondent recommended Ventolin and indicated that she would see the Patient the following morning. Given that the Patient's condition was deteriorating, however, nursing home staff decided to send him to the Emergency Department (ER). The Respondent assessed the Patient in the ambulance on arrival at the ER, spoke to the family when they arrived at the hospital, and called nursing staff at the nursing home to ask why the Patient had been sent to the ER despite the quarantine. The Respondent indicated that she would send the Patient back to the nursing home. In the meantime, the Patient's condition deteriorated; he was taken from the ambulance into the ER where the Respondent determined that he had likely had a severe coronary event. The Respondent discussed the Patient's Do Not Resuscitate (DNR) status with the family (who held Power of Attorney for personal care for the Patient), as it was unclear in the Patient's advance directive. The Patient died early the following morning.

The Complainant contacted the College of Physicians and Surgeons of Ontario (the College) to express concern about the Respondent's care and conduct.

COMPLAINANT'S CONCERNS

The Complainant is concerned about unprofessional behaviour by the Respondent while the Patient was under her care in the ER in March 2018; for example, the Respondent:

- **reprimanded the nursing home nurses for sending the Patient, who was in quarantine, to the ER**
- **failed to explain the Patient's diagnosis and reasons for his death.**

COMMITTEE'S DECISION

A Family Practice Panel of the Committee considered this matter at its meeting of June 13, 2019. The Committee required the Respondent to attend at the College to be cautioned in person with respect to unprofessional behaviour and communications. The Committee also accepted an undertaking from the Respondent which provides that the Respondent will complete a period of clinical supervision, engage in professional education, undergo a reassessment of practice, and submit to ongoing monitoring by the College.

COMMITTEE'S ANALYSIS

The Respondent has an extensive history with the College. Given this history, the complaint and the concerns the Complainant raised caused the Committee significant concern about the Respondent's clinical care and professional conduct. The Respondent, however, indicated her willingness to enter into an undertaking with the College to address these concerns through remediation. The Committee accepted the Respondent's undertaking.

In addition to accepting the Respondent's undertaking, given the shortcomings in the Respondent's interactions with the Complainant, the Committee determined that it was also appropriate to require the Respondent to attend at the College to be cautioned in person with respect to her unprofessional behaviour and communications.