**SUMMARY**

Dr. Somaiah Ahmed (CPSO# 86324)

## 1. Disposition

On July 26, 2017, the Inquiries, Complaints and Reports Committee ("the Committee") required family physician Dr. Ahmed to appear before a panel of the Committee to be cautioned with respect to the assessment and management of patients in the Emergency Department (ED) with acute coronary syndrome, and with respect to her professionalism.

## 2. Introduction

A family member of a deceased patient complained to the College that Dr. Ahmed failed to interpret the patient's EKG appropriately, to assess the patient, who was determined to be Canadian Triage and Acuity Scale (CTAS) Code 2, during the three hours she was in the ED, and to order analgesia, and that she made no effort to have the patient stay in the ED or to have her return after she left without being seen. The family member further complained that, during a family meeting after the patient's death, which Dr. Ahmed attended in her capacity as Chief of Staff, she failed to inform the family that she was the second ED physician present on the day the patient attended the ED.

Dr. Ahmed responded that her role on the day the patient attended was to review EKGs performed by the Triage nurse. She reviewed the patient's initial EKG, saw no evidence of a ST segment elevation myocardial infarction (STEMI), requested a 15-lead EKG, and saw no evidence of a STEMI on the second EKG either. Given no evidence of a STEMI, in Dr. Ahmed's view, she did not ignore an abnormal EKG result. Dr. Ahmed noted that the patient was not admitted, and that nursing staff did not ask for a physician to come and assess the patient, or to order analgesia.

With respect to the family meeting, Dr. Ahmed stated that the purpose of the meeting was to discuss process improvements, and that discussion of the details of the patient's care would have been distracting and may have elicited an emotional response from the family.

## 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."

## 4. Committee's Analysis

Dr. Ahmed's reading of the patient's EKG was crucial to the patient's further care, as nurses would rely on the physician's interpretation. Dr. Ahmed was correct in stating that the EKG did not show ST elevation. She was incorrect, however, in stating it did not show abnormal results. The EKG was abnormal, with ischemic changes in inferior and lateral leads; these should have raised concern. It should have been assumed that this patient had acute coronary syndrome until this was ruled out. Dr. Ahmed's failure to stream the patient to a monitored bed/acute care impacted the patient's subsequent experience in the ED.

Dr. Ahmed's lack of disclosure to the family of her involvement during the patient's attendance in the ED was unprofessional. Dr. Ahmed was Chief of Staff, and VP of medical affairs, and the Committee would have expected her to communicate with the family with honesty and integrity, regarding her role in the patient's care.

Both care and professionalism formed part of the caution to Dr. Ahmed.