SUMMARY

DR. ZUBAIDA SIDDIQUI (CPSO# 86158)

1. Disposition

On October 5, 2016, the Inquiries, Complaints and Reports Committee ("the Committee") ordered Dr. Siddiqui (Family Medicine) to appear before a panel of the Committee to be cautioned with respect to her error in reviewing the incorrect x-ray, not following up appropriately on an abnormal x-ray report, and the adequacy of her physical examination and failure to correlate her findings with the x-ray. She was also asked to provide written homework on her review of the College's policy on *Test Results Management*, setting out what she had learned and how she had changed her practice in this area.

2. Introduction

A patient complained to the College that Dr. Siddiqui missed diagnosing a fractured clavicle when the patient attended the emergency room (ER) following a fall while skiing, instead discharging the patient with a muscle sprain. The patient was also concerned that Dr. Siddiqui failed to follow up after receiving the radiologist's report of x-rays taken in the ER which identified the fracture.

Dr. Siddiqui acknowledged that she did fail to diagnose the shoulder fracture, as she reviewed the wrong images (she reviewed the shoulder images from another patient, erroneously believing them to be the correct images). She stated that she asked staff to contact the patient after she reviewed the x-ray report and became aware of the missed fracture, but staff was unable to reach the patient or leave a message. Dr. Siddiqui stated that she did not make further attempts to reach the patient as she assumed the patient would follow up with his family physician who had also been copied on the x-ray report.

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

The Committee noted that it was clear from the record that the patient experienced a shoulder fracture and that Dr. Siddiqui failed to diagnose the fracture when she assessed the patient. It noted that it was also clear that neither Dr. Siddiqui nor any member of her staff spoke with the patient after Dr. Siddiqui received the radiologist's report identifying the clavicle fracture, to ensure that the patient was receiving appropriate follow-up care for his fracture.

The Committee acknowledged that it is possible for an ER physician to miss a fracture when examining a patient, but it questioned whether Dr. Siddiqui should have in fact picked up on the fracture in this case. The Committee noted that the nurse documented a deformity (which would correlate with the fracture subsequently identified by the radiologist on the x-ray images), but that Dr. Siddiqui did not appear to pick up on this deformity (suggesting that she performed a relatively cursory examination), or if she did, she did not document it or correlate it with the x-ray images as one would expect.

The Committee was quite troubled by Dr. Siddiqui's failure to appropriately follow up with the patient after receiving the radiologist's report and becoming aware that she in fact missed a fracture. The Committee noted that Dr. Siddiqui had an obligation to ensure that the patient was being appropriately followed for his injury, and that it was wrong for her to simply assume that he would follow up with his family physician as instructed. The Committee was troubled by Dr. Siddiqui's lack of insight in this case, in failing to realize the importance of ensuring prompt and adequate follow-up of abnormal results.