SUMMARY

DR. ZUBAIDA SIDDIQUI (CPSO# 86158)

1. Disposition

On September 19, 2018, the Inquiries, Complaints and Reports Committee (the Committee) required family medicine specialist Dr. Siddiqui to appear before a panel of the Committee to be cautioned with respect to accurate assessment and diagnosis of patients in the office setting and accurate recording of assessments and what the patient was told, particularly with respect to test results and treatment options.

The Committee also ordered Dr. Siddiqui to complete a specified continuing education and remediation program (SCERP). The SCERP requires Dr. Siddiqui to:

- Practice under the guidance of a Clinical Supervisor acceptable to the College for six (6) months to address educational needs identified by the CanMEDS roles of Medical Expert and Communicator (Record Keeping). Among other things, the Clinical Supervisor will:
    - meet with Dr. Siddiqui no less than every month (for an initial meeting and monthly meetings for a total of seven [7] visits)
    - observe Dr. Siddiqui in her office practice for a full shift at each of six (6) visits
    - review a minimum of 15 charts at each meeting
    - report to the College on a quarterly basis
- Undergo a reassessment of her practice by an assessor selected by the College approximately six (6) months following completion of the SCERP
- Successfully complete the next available sessions of the following courses:
    - CMPA eLearning Module, “Documentation: Charting Medical Records”
    - CMPA eLearning Module, “Documentation II: Principles of Medical Record Keeping”

- Engage in self-directed learning, including review of the College's *Medical Records* policy and preparation of a written summary of up to 2,000 typed words to be submitted to the College within three (3) months to ensure completeness of review.

2. Introduction

A family member of the patient complained to the College that Dr. Siddiqui failed to provide appropriate care to the patient in that Dr. Siddiqui: forgot to inform the patient of an ultrasound result that showed a 10 mm nodule on the pancreas; failed to follow up on ultrasound results; and failed to connect the sudden onset of diabetes to the nodule on the patient's pancreas. The patient died seven months after undergoing the initial ultrasound.

Dr. Siddiqui responded that she did discuss the ultrasound results with the patient and reviewed the potential diagnosis and treatment options. She claimed that the patient declined a CT scan or other testing or treatment and requested that she (Dr. Siddiqui) withhold the diagnosis from the patient's family members.

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 many inconsistencies and misleading comments in Dr. Siddiqui's response to the complaint, and pointed out that the documentation does not support Dr. Siddiqui's account of what occurred. Furthermore, the patient's family members indicated that

one of them accompanied the patient to visits with Dr. Siddiqui and must question Dr. Siddiqui's claim that it was evident to her by the patient's choice of words and non-verbal cues that "nothing else was to be discussed" [with the family member].

Dr. Siddiqui also insisted that on the basis of the patient's wish not to treat or do anything about the pancreatic nodule, she took no other action apart from monitoring the patient's blood sugar when the patient developed new onset, uncontrolled diabetes.

The Committee found no information in the record to support Dr. Siddiqui's claim that the patient was fully aware of the diagnosis for months yet actively and deliberately refused treatment.

The Committee found that Dr. Siddiqui's documentation of her care of the patient was poor. The Committee also noted that Dr. Siddiqui demonstrated little insight regarding the potential for treating patients with an early diagnosis of pancreatic cancer and proportion of cases with a good outcome. This meant the patient had no opportunity to opt for surgical treatment as a result of Dr. Siddiqui's failure to follow up on the significant results of the ultrasound.

The Committee observed that Dr. Siddiqui's records of the care she provided the patient differ from her response to the complaint. The Committee was highly suspicious that Dr. Siddiqui's account of what occurred was a fabrication that she created after learning the patient had died and could not challenge her account of the care. The Committee had concerns about the reliability of aspects of Dr. Siddiqui's submissions, and was troubled by its impression that Dr. Siddiqui had not been honest in her communications with the College.

The Committee noted that Dr. Siddiqui has been practising in Ontario since 2010 but has been the subject of several complaints to the College, including a caution about not following up appropriately on an x-ray report and the adequacy of the physical examination and correlation with the x-ray. The Committee's concern about Dr. Siddiqui's care in this case was compounded

by the fact that the Committee had considered another, similar complaint at the same meeting as the present matter.

On the basis of its concerns about Dr. Siddiqui's poor assessment and management of the patient in this case, and taking into consideration Dr. Siddiqui's history with the College and the questions about her honesty in her communications with the College, the Committee issued its caution and ordered a SCERP as outlined above.